

University of Warwick institutional repository: <http://go.warwick.ac.uk/wrap>

**A Thesis Submitted for the Degree of PhD at the University of Warwick**

<http://go.warwick.ac.uk/wrap/4188>

This thesis is made available online and is protected by original copyright.

Please scroll down to view the document itself.

Please refer to the repository record for this item for information to help you to cite it. Our policy information is available from the repository home page.

PREGNANT IN BRITAIN : A SOCIOLOGICAL  
APPROACH TO ASIAN AND BRITISH WOMEN'S  
EXPERIENCES

by

HILARY YVONNE HOMANS

Submitted for the degree of Ph.D. in the  
University of Warwick, Department of  
Sociology

July 1980

## C O N T E N T S

	<u>Page</u>
Acknowledgements	
Summary	
INTRODUCTION	i - x
<u>CHAPTER ONE</u> <u>SOCIAL REPRODUCTION</u>	
Introduction	1
SOCIAL REPRODUCTION	3
Patriarchal Social Relations	7
Reproduction of material goods - the distribution of food by sex	10
Reproduction of the mode of production	16
i) Patriarchal social relations in rural India	18
ii) Asian women in Britain	22
Role of the State in Britain	26
Reproduction of the labour force	32
HUMAN REPRODUCTION	38
REPRODUCTION OF THE MODE OF PRODUCTION OF HEALTH CARE AND HEALTH KNOWLEDGE	41
Reproduction of knowledge about health care	41
i) Reproduction of medical knowledge	41
ii) Reproduction of lay knowledge of health and illness	49
Reproduction of the mode of production of health care	50
The implications for pregnant women	51
<u>CHAPTER TWO</u> <u>LITERATURE REVIEW</u>	
Introduction	56

	<u>Page</u>
ANTHROPOLOGICAL LITERATURE	58
Criticisms of traditional anthropology	60
Feminist anthropology	62
Anthropological literature which is useful for an analysis of pregnant women who are members of ethnic minority groups	65
Research into ethnic minority groups in Britain	70
Pain as discussed in anthropological literature	77
PSYCHOLOGICAL LITERATURE	
Pain as discussed in psychological literature	79
Pregnancy as crisis	80
"Behaviour" in pregnancy	85
THE MEDICAL DEFINITION OF PREGNANCY AND ANTE-NATAL CARE	87
Hospitalisation of births debate	92
Criticisms of obstetrics from within the medical profession	93
The WHO ideals	94
Differences in medical practice	96
CONSUMER OR PRESSURE GROUP VIEWS	98
THE SOCIOLOGICAL VIEW OF PREGNANCY AND ANTE-NATAL CARE	100
Pregnancy as "illness" or the adoption of the "sick role"	100
Sociological literature which adopts medical definitions	104
Ante-natal care and social class	108
Pregnancy as legitimate	111
Location of sociological research into pregnancy	114
FEMINIST LITERATURE ON PREGNANCY AND ANTE-NATAL CARE	118



<u>CHAPTER THREE</u>	<u>METHODOLOGY</u>	<u>Page</u>
	Introduction	123
	RESEARCH TOPIC	125
	THE COMPARATIVE METHOD	126
	KNOWLEDGE OF POPULATION TO BE STUDIED	127
	INTERVIEWING NON-ENGLISH SPEAKING PEOPLE	
	Extent of the problem	131
	The social anthropological approach	132
	Methods used to solve the language problem	137
	Choosing an interpreter	139
	Translation problems	145
	Problems encountered when using an interpreter	147
	POPULATION STUDIED	149
	PILOT STUDY	151
	DRAWING UP THE SAMPLE	152
	QUESTIONNAIRE DESIGN	154
	RESPONSE RATE	159
	EXCLUDED FROM FINAL SAMPLE	160
	Non-attenders at the clinic	161
	Concealed programmes	163
	IN-DEPTH INTERVIEWING	163
	Using a tape-recorder	170
	Non-response for the in-depth interview	174
	TRANSCRIPTION OF TAPES	175
	DATA ANALYSIS	175
<u>CHAPTER FOUR</u>	<u>THE SAMPLE</u>	
	Introduction	177

RELATIONSHIP OF ASIAN POPULATION TO INDIGENOUS POPULATION	
a) General population	178
b) Asian population	179
c) Result of migration	182
Area of residence	183
Type of housing	184
Employment	185
DISTRIBUTION OF MATERNAL HEALTH SERVICES IN COVENTRY	
Domiciliary or community services	187
Hospital based material health services	191
DETAILS OF THE WOMEN STUDIED	
Age    i) Age at first interview	197
ii) Age of respondents at first pregnancy	197
iii) Age of respondents at first marriage	198
Parity	198
Marital status of respondents	199
Social network of respondents	
i) Family network	200
ii) Friends	202
Length of education	203
Language - Asian respondents only	205
Employment status of respondents in current pregnancy	207
Caste - Asian respondents only	208
Religion	210
PROBLEMS WITH CLASSIFICATION	211
OUTCOME OF PREGNANCY	218

CHAPTER FIVE

SOCIAL CONTROL OVER REPRODUCTION

Introduction	221
CONTROL OVER FERTILITY	
a) Fertility control in India	223
b) Fertility control in Britain	226
Ideologies of Reproduction	227
Control over access to resources	232
TABOOS WHICH REGULATE SEXUAL RELATIONS	235
Menstrual taboos	236
Control maintained through keeping women ignorant	
a) knowledge of menstruation	238
b) knowledge of sexual relations	242
Some consequences of lack of information about sexual relations	249
DOCTORS' DEFINITION OF WOMEN	251
Doctors and sexual taboos	254
WOMEN'S PERCEPTION OF SEXUALITY IN PREGNANCY AND CHILDBIRTH	259
Summary	264

CHAPTER SIX

PREGNANCY AS A STATUS PASSAGE

Introduction	265
STATUS OF WOMEN AS REPRODUCERS	267
TRANSITION FROM PREGNANCY TO CHILDBIRTH	280
Concessions	
i) Cravings	282
ii) Abatement of pollution potential	292
iii) Concessions made by the State	292
Prohibitions	295

	<u>Page</u>
SEPARATION OF PARTURIENT WOMAN FROM SOCIETY	308
RE-INTEGRATION OF THE MOTHER INTO SOCIETY	316
Summary	320
<u>CHAPTER SEVEN</u>	<u>PREGNANCY AS HEALTH</u>
Introduction	321
PERCEPTIONS OF HEALTH IN PREGNANCY	323
HEALTH MAINTAINANCE IN PREGNANCY	324
Importance of diet in maintaining health in India	328
British women's knowledge of diet during pregnancy	339
Tensions with the medical model - weight increase in pregnancy	345
HEALTH RESTORATION - The Discomforts of Pregnancy	351
Incidence of discomforts	351
Women's perceptions of discomforts in pregnancy	353
Person consulted and form of treatment prescribed	356
a) traditional recipes	356
b) medical prescriptions	363
c) the Chemist's shop	374
Summary	376
<u>CHAPTER EIGHT</u>	<u>PREGNANCY AS PATHOLOGY</u>
Introduction	380
FIRST ATTENDANCE AT GP	384

WOMEN'S EXPECTATIONS AND EXPERIENCES OF  
CONSULTANT CARE

Expectations of the ante-natal clinic	391
Women's experience of ante-natal care	395
i) structure of the clinic	396
ii) pregnant women as patients	400
long waits	403
children in the clinic	406
Communication in the clinic	409
Depersonalisation in the clinic	415
MEDICAL PROCEDURES DURING PREGNANCY AND CHILDBIRTH	417
Undermining women's confidence	420
Lack of information	422
Faith in medical knowledge	
"They must know"	429
"For the sake of the baby"	432
Access to medical procedures	434
The limitations of medical intervention	
a) women with experience	437
b) pregnancy and childbirth as "natural"	440
c) fatalistic beliefs	443
Summary	445

EXPERIENCE vs EXPERTISE

CHAPTER NINE

EXPERTISE - THE DIVISION OF LABOUR  
AMONG THE EXPERTS

Introduction	447
--------------	-----

	<u>Page</u>
DIVISION OF LABOUR	453
The division of labour in the hospital setting	456
i) who does what?	456
ii) how the women perceive the division of labour in the hospital	459
The division of labour among the domiciliary health workers	471
i) who does what?	471
ii) how the women perceive the division of labour in the community services	474
Family doctor	475
General practitioner	477
Variations in practice	481
Domiciliary midwives	487
 PARENCRAFT CLASSES	
Background to classes	496
Content of classes	498
The beliefs of midwives and health visitors as expressed through classes	
a) pregnancy and childbirth as normal and/or natural	500
b) pregnancy and childbirth as requiring scientific management	502
 BOOKLETS ISSUED AT THE ANTE-NATAL CLINIC	504
The experts' perception of women	505
The experts' perception of pregnancy	507
Scientific intervention in pregnancy	509
The dominance of medical knowledge	511
Summary	512

EXPERIENCE vs EXPERTISE (continued)

CHAPTER TEN

EXPERIENCE

Introduction	514
THE DIVISION OF LABOUR AMONG THE SOCIAL NETWORK	515
Division of labour in household tasks	517
a) male partners	519
b) female relatives	523
Lay advice and support during pregnancy and childbirth	529
a) advice and support provided by male partners during pregnancy	
i) supportive role	530
ii) policing role	533
at birth	537
b) advice and support provided by female relatives and friends in pregnancy and childbirth	543
FURTHER SOURCES OF SUPPORT AND ADVICE	
1. Parentcraft classes	550
a) Attendance at classes	
i) Reason women gave for not attending classes	551
ii) Source of information about classes	553
iii) Reasons for attendance at classes	554
b) Women's perceptions of classes	555
2. Literature	
1. Clinic booklets	556
a) women who used the clinic booklet	556
b) information gained from the booklet	560
c) other literature used	561

	<u>Page</u>
3. Television programmes	563
a) Reasons for not watching the television programmes	565
b) Women who found the programmes useful	568
c) Television as a medium for raising women's expectations about hospital practice	570
d) Differences between the programmes watched	573
DIVERSITY OF INFORMATION	575
a) When to go to the hospital in labour	576
b) Breast or bottle?	578
Summary	583
CONCLUSIONS	585
RECOMMENDATIONS	602
BIBLIOGRAPHY	609
<u>APPENDICES</u>	
<u>APPENDIX A - METHODOLOGY</u>	
INFORMANTS USED	A1
VISITS	A2
MEDIA	A6
i) Television	A6
ii) Slides	A7
iii) Books	A8
iv) Leaflets	A8
v) Asian translations	A9



	<u>Page</u>
LITERATURE/DOCUMENTS USED	A10
HOSPITAL RECORDS	A10
Information obtained from hospital records	A13
QUESTIONNAIRE	A14
LETTER GIVEN TO WOMEN AFTER FIRST INTERVIEW	A25
LETTER SENT TO WOMEN WHO DID NOT ATTEND (DNA) CLINIC	A26
Responses to (DNA) letter	A28
CHECK LIST USED FOR IN-DEPTH INTERVIEWING	A30
<u>APPENDIX B - TABLES</u>	B1-B25
<u>APPENDIX C - PUNJABI WEDDING SONG</u>	C1-2
<u>APPENDIX D - THINGS TO BE AVOIDED DURING     PREGNANCY</u>	D1
<u>APPENDIX E - CLASSIFICATION OF FOODS ACCORDING     TO THE AYURVEDIC TRADITION</u>	E1

<u>TABLES</u>	<u>APPENDIX B and page no. in text</u>	<u>Page</u>
I	Percentage of confinements booked, by place of birth of mother	B1
II	Total births by place of birth of mother	B1
III	Live births by birthplace of mother Britain 1971-1975	B2
IV	Respondents' length of residence in Coventry	B2
V	Live births by birthplace of mother - Coventry 1971-1975	B3
VI	a) Type of house lived in by respondents b) Tenure of property - British final sample only	B4 B4
VII	Occupation of respondents' husband/boyfriend at time of second interview	B5
VIII	Respondents' present or last occupation (if not in paid employment) at time of first interview	B5
IX	Sex of General Practitioner of women studied	B6
X	Nationality of " " " "	B6
XI	Number of women in sample presenting at GP in each trimester	B6
XII	Number of weeks pregnant respondents first went to their GP	B7
XIII	Maturity on first ante-natal visit by place of birth of mother by trimester	B8
XIV	Number of women in sample presenting at Consultant ante-natal clinic in each trimester	B9
XV	Number of respondents who attended Parentcraft classes in current or previous pregnancy	190
XVI	Time taken travelling to Consultant clinic	191

		<u>Page</u>
XVII	Mode of travel to Consultant clinic	192
XVIII	Total number of women attending the Consultant clinic during the five weeks of interviewing - Analysed by Consultant in attendance	193
XIX	Consultant of women interviewed	193
XX	Length of time respondents spent at clinic	194
XXI	Respondents' preference for location of ante-natal care	B10
XXII	Age of respondents at first interview	B11
XXIII	Age of respondents at first pregnancy	B11
XXIV	Age of respondents at marriage	B12
XXV	Parity of respondents a) initial sample	B13
XXVI	Parity of respondents b) final sample	B13
XXVII	Number of previous pregnancies which did not result in a live baby	B14
XXVIII	Marital status of respondents at time of first and second interview	B14
XXIX	Family network of respondents at time of second interview	201
XXX	Respondents' length of education	204
XXXI	First language of Asian respondents	206
XXXII	Number of respondents in paid employment at time of first interview	208
XXXIII	Caste of Asian respondents	209
XXXIV	Religion of respondents	211
XXXV	Birth weight of babies born to women studied	B15
XXXVI	Birth weight of baby by country of origin of mother	B15

		<u>Page</u>
XXXVII	Birth weight of babies born to women studied - by parity	218
XXXVIII	Percentage of Special Care Baby Unit admissions of total live births by place of birth of mother	B16
XXXIX	Number of inductions as percentage of total number of hospital births 1966-1976	B17
XXXX	Number of respondents who had medical intervention at time of delivery	B17
XXXXI	Method of delivery by place of birth of mother Coventry 1977-1978	B18
XXXII	Number of days respondents spent in hospital after delivery	219
XXXXIII	Method of feeding respondents adopted while in hospital	220
XXXXIV	Number of women breastfeeding in Coventry Maternity hospital 1966-1976	B18
XXXXV	Respondents' source of information about pregnancy and childbirth at time of first pregnancy	B19
XXXXVI	Knowledge of sex education by religion - Asian respondents only	244
XXXXVII	Sex of doctor respondents would prefer if they had the choice	
	a) For ordinary care	B20
	b) For internal examinations	B20
XXXXVIII	Time interval between respondents' marriage and birth of first child	B20
XXXXIX	Women's intention to stay at home or engage in paid employment after the birth of the baby	B21
L	Respondents' desired sex of child	279
LI	Women's response to question: How would you describe your health at the moment?	
	a) Initial sample	B22
	b) Final sample	B22

		<u>Page</u>
LII	Number of women who thought exercise and rest were important at their first and second interview	325
LIII	a) Complaints respondents mentioned suffering from during pregnancy	B23
	b) Number of respondents suffering from medically defined complaints	B23
LIV	Women's response to question 'Did anyone tell you to go to the GP when you did?'	B24
LV	Women's response to the question 'Do you think there is a "correct" time to go to your GP when pregnant?'	B24
LVI	Response to question: Do you think that it makes any difference to your health if you go to the GP later than you did?	389
LVII	Source of child care for under school age children at time of clinic appointment	408
LVIII	Source of information about induction and epidural - British sample only	439
LIX	Respondents' use of clinic booklet during pregnancy	557
LX	Women's exposure to television programmes on pregnancy and childbirth at the time of first interview	B25
LXI	Reasons given for not wanting to breastfeed	579

FIGURES

1.	Consultation pattern of Asian women for discomforts of pregnancy	377
2.	Consultation pattern of British women for discomforts of pregnancy	378
3.	Differences between knowledge and perspective of pregnant women and medical expert	452
4.	Preference for person performing ante-natal care	495

## ACKNOWLEDGEMENTS

Acknowledgement must be made to all the women participating in this study who generously gave of their time to share their pregnancy experiences with me. Bhupinder Dhesi, a more than competent interpreter, was essential in collecting data from non-English speaking women. She has also provided friendship throughout, an insight into Punjabi culture and instruction in various Indian culinary skills. The Birmingham Interpreting and Translation service (BIT) proved efficient in translating and transcribing Asian tapes, and I am particularly grateful to Jayashree Sondhi and Sue Bishton.

Relevant statistics were supplied by the Regional Health Authority and local maternity hospital; health care staff in the consultant ante-natal clinic facilitated the interviewing process; domiciliary health care staff permitted access to Parentcraft classes; the Area Health Education Officer provided numerous useful contacts, such as, the English language co-ordinators who kindly arranged meetings with English language tutors and tutees; and staff at Coventry and Leamington Community Relations Offices supplied invaluable information about local Asian organisations.

The Social Science Research Council (SSRC) are to be thanked for funding three years post-graduate study and the Health Education Council for awarding a grant to cover interpreting and translating costs.

My theoretical ideas have developed through meetings of Birmingham-Coventry Feminist Research workshop and Sociology of Health and Illness seminars at the University of Warwick. Excellent supervision and sustained support have been received from Professor Margaret Stacey. The responsibility for typing the final draft lies with Brenda Waller who also made encouraging comments.

My final acknowledgement is to my son Mark, who provided my own pregnancy experience, and has patiently waited for the completion of this thesis. Thanks to everyone who helped with child care, in particular, my mother Cicely Pearce, and David Hemson.

## SUMMARY

Human reproduction should not be viewed independently from social reproduction, for to do so limits the perspective of the observer. This thesis examines the limitations of previous studies of human reproduction from an anthropological, psychological, medical and sociological view point. It proposes an alternative feminist perspective which looks at the totality of the pregnancy experience as expressed by the women themselves.

Although all women perceive fundamental experiences in common, related to their status as women in male dominated societies, it is argued that there are significant socially determined differences between women in the way they react to these experiences. To establish the extent to which all women have pregnancy experiences in common and to which they have different experiences, two separate groups of women (South Asian and indigenous British) were selected for study. These women were interviewed twice during their pregnancy (using a questionnaire and in-depth interviewing) in an attempt to determine their expectations and experiences of the maternal health services and the extent to which their social class, ethnic background and parity, shaped these experiences.

Differences in utilisation of services emerge which are based on the women's social class, length of education, cultural background and parity. Tensions are apparent between lay beliefs about health and illness in pregnancy and the medical model which treats all pregnant women as potentially pathological. The clinical model of pregnancy overlooks the social meaning of pregnancy to the woman and her social network and thus is inadequate in this respect.

Inevitably, the amount of support and advice pregnant women receive from their social network varies considerably and is closely related to social class and cultural background.

The thesis concludes with suggestions for structural changes in society which are necessary if women are to have autonomy over their actions (particularly in relation to reproduction). These changes involve the erosion of sex, class, and race differences in society, which at present ensure that certain groups are better able to manipulate services to their needs. A list of practical recommendations is detailed suggesting specific points which, if implemented, would make women's future pregnancy experiences richer and more rewarding.



## INTRODUCTION

This thesis focusses on pregnancy and the organisation of the maternal health services as experienced by two groups of pregnant women. The aim of the thesis is to determine the extent to which the status of the pregnant woman and the social arrangements of the ante-natal care services in Britain reflect and/or reproduce dominant values in our society. To this end two groups of women were chosen for study - one group had been born in Britain and were white, the other group were women who were born in South Asia (mainly the Punjab) and had since migrated to Britain. This second group of women were selected for study because: i) they constituted a sizable proportion of the clinic population under study (11%) and ii) my theoretical stance is that women of different class and ethnic backgrounds do have similar experiences in pregnancy and childbirth. For example, women manifest similar fears about their health and that of the forthcoming baby. What I shall argue is different and varies according to the woman's parity, social class and ethnic background, is the way in which pregnant women cope with these experiences, for example, who they consult, the amount and kind of knowledge they acquire and the course of action they follow.

I am not arguing that women themselves constitute a separate social (or sex) class as do some feminist writers (example, Jeffreys; Hamner et al in Scarlet Women No.5) for to do this would

be to ignore women's different material conditions and different states of cognitive knowledge. On the other hand, it should be recognised that during pregnancy and childbirth there are certain fundamental concerns facing all women and these transcend social class and cultural boundaries. Social factors (such as, class, parity, ethnic background, marital status, religion) however do affect the woman's expectations of the maternal health services and the way in which they use them.

Therefore, for an explanation of women's behaviour in pregnancy I consider it necessary to analyse human reproduction in terms of social reproduction, that is, the reproduction of the social totality. In Chapter One I develop a theory of social reproduction which incorporates into it the facet of human reproduction which I argue is integral to it. The development of this approach is thus an attempt to close the gap between personalised accounts of pregnancy as experience (Hart 1977; Graham 1979) and recent Marxist feminist theoretical discussions of social reproduction (cf Edholm et al., 1977).

The merits and limitations of other work on pregnancy and childbirth are discussed in detail in Chapter Two. Writings from disciplines other than sociology are included in an attempt to assess the present state of knowledge about pregnancy and the use of the maternal health services. As very little is known about the health and health care needs of ethnic minorities in Britain an assessment of this literature is included.

Chapter Three contains a detailed description of the methodology used and a discussion of the advantages and constraints of using an interpreter for the non-English speaking Asian women. Biographic details of the women studied are portrayed in Chapter Four, together with information about the organisation of the maternal health services in Coventry. The subsequent Chapters are organised in a manner which attempts to relate the theoretical ideas discussed in Chapter One to the empirical data collected. This link between theory and practice is an important one and raises two methodological questions which need discussing further. Firstly, to what extent is it possible to relate theory to practice in an empirical study? and secondly, how far is it possible to be objective in research in the social sciences?

i) The relation of theory to practice

In the social sciences there is a continual debate as to when the "theory" of the research is formulated; is the theory clearly formulated at the beginning of the research, or is it generated out of the data?

There is a considerable body of thought within research methods which states the necessity of defining a framework in which to carry out the research. This type of research has a very definite beginning with the initial conception of the

project; an intermediary period when the actual research is carried out; and an end when the data is collected, processed, and produced in a neat conclusive fashion. In this framework the methods by which the data is collected are pre-determined, and every possible precaution is taken to ensure against the intrusion of bias and inaccuracy into the project. This view is essentially statistical and relies on comparing the results of the project with some form of "average". Moser and Kalton (1972), Brown and Harris (1978) are proponents of this view, they see the purpose of research to test a hypothesis suggested by sociological theory. In order to do this "testing" Moser and Kalton (1972) argue for the setting up of a controlled method to which the survey can approximate. Thus, with careful design, matching and control by measurement they consider it possible for the survey to come very close to "the ideal of the study" (p. 11 ). The great danger here is that many researchers may be tempted to manipulate their data to fit the theory so as to obtain the "ideal" result. The fore-going method bears a striking resemblance to research in the natural sciences which start with an object, followed by the method, result and conclusion. However, in the social sciences it is not possible to "control" the population being studied as it is in the natural sciences, for people are not particles.

The inability to "control" the subject matter in the social sciences has led other researchers to argue for more flexibility in the methods used. Shipman (1972), although viewing research as being divided into "stages", has a more creative approach to

the subject. He considers the initial hunch (informed by theory) to be the link between the theory and the problem, and it is not until after the data has been collected that the theory is developed, involving analysis and generalisation. Using these methods Shipman argues research is not mechanical but creative, and "the quality of the research is largely determined by the nature of the discipline concerned and the quality of the theory that generated the imagination". (p.5).

Different disciplines in the social sciences use a variety of research techniques as part of their methodology. For example, anthropologists may need to spend a period of time researching the population to be studied and learning the language before going into the field. Their data is usually collected by the researcher becoming a participant observer, watching the group under study in its natural habitat. Often the anthropologist has the problem of dissociating her/his own value judgements from the data collected (cf Horton 1971) and of course this problem is also one facing sociologists. More recently the informal methods of anthropology (particularly participant observation) have been used by sociologists. This research technique has been widely used in studies of deviance and criminology where the "known" presence of the researcher could have an adverse effect on the group being studied (Becker 1963; Nash 1973; Whyte 1954). Medical sociologists have also used participant observation to analyse their own experiences with health care workers (Davis and Horobin 1977). A problem with this method of research is that the sample consists of any person who passes through the group under

study, and it also includes any event happening during the course of the field work. Moreover, using informal techniques is sometimes difficult to justify, as Whyte (1954) says he often wondered whether just hanging around on a street corner was an active enough process to be dignified the term "research".

These two methodological approaches are radically different - at the one end there is the view that advocates starting the research with a clearly defined hypothesis and then working through various clearly defined stages to "test" this hypothesis. At the other extreme there is the idea that you should not go into the field with any pre-conceived notions of how you are going to go about the research or what you expect to find - you participate in the life of the group and your data is collected through your observations. Given the impracticabilities of both these extremes there is no reason why some form of compromise cannot be reached, combining both formal and informal methods. And this is in fact what most researchers do, e.g. Willmott's study of adolescent boys in East London (1969): Stacey's study of Banbury (1960) and Dalton's Men who Manage (1959).

For the purpose of this research it was decided to combine the two approaches. It was not possible to rigidly plan the research in advance with insufficient practical knowledge of half the population under study, i.e. the Asian women. Moreover, research which combines both formal and informal techniques is not lineal, as it takes into account information obtained informally outside the selected sample. Only by including chance meetings

and overheard conversations can a composite picture of the population under study be drawn. Also it is impossible rigidly to plan at the outset of the research how to gain access to the population under study. There is the question of being granted access to the institution where the research is to be located; in this case the hospital clinic. Additionally, there is the problem Gold (1977) refers to, i.e. the way in which the medical setting may constrain social research. But over and above this, one has to rely on the co-operation of the people in the sample and the way the research is presented to them is crucial. That people refuse to be interviewed is in itself important and may indicate a problem overlooked by the researcher.

One way of gaining access to a population about which little is known (in my case, the Asian women) is to establish an initial contact and rely on the "snowballing" effect Polsky (1971, p.129) refers to. This technique leads to a number of interesting contacts being established in an informal and friendly manner. In relation to conversations, both informal (with contacts and informants) and formal (in this context meaning those with the women in the sample, although the interviews were both structured and unstructured) it is impossible as a researcher to engage in them without having an effect on the population under study. As far as this research is concerned, the fact that the women were interviewed twice (once in the formal clinic setting where they answered a "structured" questionnaire, and then later in their own home where both the surroundings and the nature of the interview were both less formal and structured) meant the initial encounter had an effect on the women. At the second meeting the women knew I was coming and they had a rough idea of the topic to be discussed (i.e. pregnancy and the maternal health

services), they were therefore reflective.

In empirical research therefore, the presence of the researcher has an influence on the population being studied. For this reason I would argue it is short-sighted to go into the "field" with a very strict research design based on a previously constructed theory. Flexibility of methods and the ability to develop a theory while collecting and analysing the data leads to research which bridges the hiatus between theory and practice. In this method, theory and practice feed into each other. It is not possible to regard social research as static, being conducted in a vacuum. It is to a certain extent self-generating and takes place in a network of social relations - these relations are ongoing and cannot be confined purely to the research period. For instance, in this research some close friendships have been made and contacts are still maintained with many of the workers in the maternal health services.

ii) The question of objectivity

The question of objectivity is probably most acute for those researchers who have chosen to use participant observation as their research technique. This method did not appeal to me as a researcher as it would mean becoming pregnant in order to participate fully; therefore it was not a case of choosing this technique as opposed to others. However, some sociologists have studied pregnancy through participation, e.g. Hart (1977); Comaroff (1976) but they end up with an account that is very



subjective, which tells one more about them personally than what pregnancy means to different women. Moreover, I wanted to distance myself from the women although being sensitive to their condition; in this way a reciprocal relationship was established in which we (both the women and myself) provided each other with information. By not being over-involved with the women it was possible to study them in the role of researcher, rather than being one of them.

However, it is difficult as a researcher to distance oneself from the group being studied, and this was heightened by the fact that I had myself experienced pregnancy and childbirth. It was therefore necessary to guard against over-identifying with the sample. This problem of distancing did not arise in relation to some of the health care workers (particularly the male doctors) - they for one effectively maintained their professional distance from me as a researcher, and I did not have the same empathetic feelings with them. This research therefore has a very definite feminist flavour, it is written by a woman, about women, and is on a subject only women can experience at first hand.

The problem of objectivity is not only on a personal plane, i.e. at the level of my own feminist awareness, it is also at a theoretical level in terms of my own knowledge and understanding of the subject. My sociological training and theoretical interest in Marxist feminist analyses, combined

with a concern for the women studied, has greatly influenced the outcome of this research. I would argue that every researcher takes preconceived notions with them when they enter the field, and it is only by being aware of these pre-conceptions the researcher can portray an accurate study.

Finally, as research is often (hopefully always) motivated by the investigator's personal interest in the subject, I feel there is a moral obligation on the part of the researcher to be accountable to the population studied. It is important to ensure that research findings are not restricted to the ivory towers of academia, but are disseminated among the people who can effect change. This thesis therefore concludes with a list of recommendations the author hopes will be incorporated into every day practice.

CHAPTER ONE

SOCIAL REPRODUCTION

Introduction

As this thesis addresses the question of the extent to which dominant values in our society are reflected when a woman is pregnant, it seems imperative to examine the relationship between human (biological) reproduction and social reproduction, i.e. the reproduction of the social totality. For any society to be able to continue, several facets of reproduction are necessary. It is difficult theoretically to separate these facets of reproduction from each other and at some junctures they become particularly closely merged. The following is an attempt to isolate the aspects of social reproduction which appear fundamental to a study of human reproduction.

Firstly, in order to survive every society must create material goods, for example, food, buildings. These goods are produced in the context of a certain mode of production, for example, feudal or capitalist. Different modes of production give rise to different social relationships, for example, capitalist relations of production involve a social division of labour which is the class system. In order to be able to maintain the mode of production, labour power must be reproduced and this is done at two levels: i) at the social level - this implies the care and socialisation of future workers along with the servicing of present workers. This form of reproduction of labour power takes place in the home and is associated with a sexual division of labour;

ii) biological or human reproduction. The creation of new life is essential to the reproduction of all societies, but the context in which this reproduction takes place depends on the dominant social relations, (which I shall argue are patriarchal in the sense commonly used in feminist debate)<sup>1</sup> and the mode of production. In the case of human reproduction in western capitalist society, it is necessary to look at the mode of production of health care as pregnancy and childbirth are located in the medical setting. In the maternal health services certain social relationships are reproduced, for example, a social division of labour based on sex, class and race, and a hierarchical organisation of services based on the superiority of medical knowledge over other forms of knowledge about health and health care in pregnancy. The mode of production of knowledge about health and illness also needs to be considered in this context, because it gives rise to different states of cognitive knowledge.

The status of women as reproducers is important in this discussion as the status tends to vary according to the mode of production and the value placed on children. For instance, women in rural India attain status when they become mothers, particularly if they give birth to a son. On the other hand, women in Britain who play a role in both production and reproduction may find their status as mothers more ambiguous and even changing over time depending on the needs of production. These points will be discussed in more detail later in the chapter on status passage (Chapter 6) as will the way in which women gain experience through becoming mothers. The woman's previous pregnancy experience, her state of cognitive knowledge and her material conditions all affect

<sup>1</sup>Patriarchy has a precise technical definition in anthropology and is used differently in the feminist debate (see page 7 ).

her expectations and experiences when she is pregnant. What I intend to do therefore is to extend the theoretical analysis of social reproduction to include the behaviour manifested by the pregnant woman in relation to i) her social network and ii) health care professionals. To do this I will elaborate the theory of social reproduction making links with the empirical data wherever possible.

#### SOCIAL REPRODUCTION

The way in which human reproduction relates to social reproduction has already been briefly outlined. What is necessary at this stage is a more general discussion of social reproduction and how it has been used by other writers, for the theory of social reproduction has a long history. It was used by Marx and Engels in 1846 when they wrote about the four constituents of social reproduction necessary for the reproduction of the social totality (German Ideology 1970). They consider these constituents to be, the production of the means to satisfy needs such as, eating, drinking, housing, clothing, i.e. "the production of material life itself" (p.48) Secondly, the production and creation of new needs. Thirdly, human reproduction, which to them includes "the relation between man and woman, parents and children" as constituted within the family. The final component in their analysis is that a certain mode of production is always combined with a certain "mode of co-operation" which is itself a "productive force". (p.50)

More recently, feminist writers have used an analysis of social reproduction in an attempt to understand the nature of women's oppression in society, particularly in capitalist social formations. The radical and revolutionary feminists, Beechey (1979) argues, have not come to grips with the relationship between patriarchal social relations and the social relations of production, that is, between sex classes and social classes (pages 68-71). Marxist feminists, on the other hand, are "committed to the attempt to understand the relationship between patriarchy and other aspects of the organisation of modes of production." (Beechey, 1979, p.71). In a similar vein Edholm et al. (1977) argue that social reproduction

"must refer to the reproduction of the conditions of social production in their totality and not to reproduction of only certain levels of the total social system.....Any theory of social reproduction has therefore to reveal what the basic structures of a given mode of production are, and then to demonstrate the necessity for their continued existence in order to ensure the continued existence of the mode of production itself." (p. 105)

The limitation of this analysis is that it does not include an adequate explanation of the way in which human beings are reproduced. Meillasoux (1975) attempts to remedy this by relating reproduction of labour power to "control over human reproduction and with the 'means' of that reproduction : women" (p.108, quoted in Edholm et al., 1977). However, Mackintosh (1977) criticises Meillasoux for making human reproduction into a "special case" which is not related to the social totality (p.126). Mackintosh's theory of social reproduction attempts to resolve this problem:

"No conceptualisation of a particular mode of production is complete unless it can account for the reproduction of the people within the system and of the system as a whole. In order to do this, three elements have to be considered : the social relations of production, the social relations

of human reproduction, and the method by which the reproduction of the system is ensured or enforced. The form taken by the social relations of human reproduction is the patriarchal relation of men to women which dominates the relations of human sexuality and reproduction. Without this element, an important contradiction within the mode of production is missing, and the reproduction of the people within it is not explained." (p.126)

This final point of Mackintosh is of paramount importance here, for it points to the necessity of beginning with an analysis of the patriarchal relation of men to women in the sphere of reproduction. From this starting point I would want to go further and argue for an analysis which also incorporated into it the relationship between human sexuality and reproduction and the organisation of medical care. It is this latter point which has been missing from many previous feminist analyses of human and social reproduction.<sup>1</sup> It is an important point because there appears to be a close relationship between patriarchal social relations, the professionalisation of medicine and the capitalist mode of production. How the women studied experienced this relationship is detailed in the chapter on social control over reproduction particularly in terms of control over sexuality and fertility (Chapter 5).

Before going into detail about pregnant women's experiences it is necessary to spell out more precisely what the components of a theory of social reproduction are and how this affects all women from different modes of production (although certain social relations are dominant in particular social formations). First then I shall start with an analysis of the social relations involved in reproduction,

---

<sup>1</sup>Ann Oakley in her work on sex and gender (1972; 1974), the history and organisation of maternal care (1976) and her accounts of the women's experiences (1979), has covered all of these areas, although they have not necessarily been related to each other.

that is, the patriarchal relations of men to women; 2) the reproduction of material goods, paying specific attention to the distribution of food by sex; 3) reproduction of the mode of production, paying particular attention to the differences between capitalist and agrarian modes of production, e.g. Britain and rural India and the way in which different modes of production give rise to different social relationships; 4) reproduction of the dominant ideology of the State in Britain; 5) reproduction of the labour force: a) the servicing of male workers by women in the family; and b) the care and socialisation of children (future workers) by women; 6) human reproduction, that is, the biological reproduction of the future workforce; 7) a) reproduction of the mode of production of knowledge about health and illness; and b) reproduction of the mode of reproduction of health care.

Empirically, it is difficult to separate out these different facets of reproduction and there are inevitably some areas of overlap. For instance, the distribution of food in society is closely linked to the patriarchal relations of men to women. In other instances, the dominance of one facet of reproduction over another is apparent and this will be referred to in the context of Asian women both in their country of origin, India, and upon migration to Britain. What follows then is an attempt to forge a link between the theoretical and empirical data which will provide the basis for an understanding of pregnant women's experiences within a patriarchal capitalist society.



1) Patriarchal social relations

Feminists have used the concept of patriarchy in an attempt to analyse women's everyday experiences and also to understand the basis of women's oppression in society. A succinct summary of the different feminist perspectives and how they each use the concept of patriarchy is provided by Beechey (1979). The origins of patriarchal social relations has been a subject of particular interest to recent feminist writers (Firestone 1971; Millet 1972; Mitchell 1974; Critique of Anthropology 1977). However, I do not propose here to engage in this debate for even if it were possible to locate the exact historical moment and cause of women's oppression, one could not assume a unilineal historical development which would further our analysis of women's oppression as it is today in different societies.

On the other hand, it is not sufficient for us to accept that women's oppression is the result of them "naturally" being the weaker sex, as Marx (1970) suggests. He says the division of labour between the sexes developed "by virtue of natural pre-disposition (e.g. physical strength, needs, accidents, etc.)" (p.51). For as Mitchell (1974) argues "It is thus not on account of their 'natural' procreative possibilities but on account of their cultural utilization as exchange objects (which involves an exploitation of their role as propagators) that women acquire their feminine definition." (p.407-408)

Oakley (1974) similarly argues that sex differences are culturally determined. Moreover, she states that the ideology of

sex values are 1) couched in terms of female inferiority to the male and 2) biological facts are used to support this assertion. These sex values are, she argues, a "perfect reflection of (male dominated) social reality." (p.154) The dominant feature of all social relations being that they are patriarchal.

The system of patriarchal social relations which accords men dominance over women is crucial to this debate. One consequence of this system is the dichotomy between the male public world of work and the female private sphere of the home and domestic work. This dichotomy is visible in most societies whatever their mode of production, but it is most marked in class societies. As Sacks (1975) says "class societies make a sharp dichotomy between the domestic and public spheres of life, and this domestic power is not translatable into social power or position in the public sphere." (p.229) This basic dichotomy leads to differences in the way men and women perceive themselves and each other. Simone de Beauvoir (1949) makes this point clear when she says:

"With man there is no break between public and private life : the more he confirms his grasp on the world in action and in work, the more virile he seems to be; human and vital values are combined in him. Whereas women's independent successes are in contradiction with her femininity, since the 'true' woman is required to make herself object, to be the 'Other'."(p.291)

Because women have always been the "Other", the subordinate partner in male-female relationships, de Beauvoir (1949) claims that women "have no history", no past, no religion of their own; no

solidarity of work and interest as have the proletariat."

(p.19) A similar point is made by Sacks (1975) in her analysis of male-female relations:

"Men are more directly exploited and more often collectively so - a situation which gives them the possibility of doing something about it. Women's field of activity and major responsibility is restricted to the household, which neither produces nor owns the means of production for more than domestic subsistence, a level of organisation at which little can be done to institute social change in a class society." (p.231)

The isolation of women in the domestic sphere of production reinforces their dependency upon men. However, women's dependency on men is not "natural", nor is it due only to women's reproductive capacity (as writers such as Firestone 1971 would lead us to believe). It is the result of women being excluded from the public world of production of social use-values. By locating women in the home as unpaid workers their financial and emotional dependency on the male head of household is maintained. Women have thus become dependent on men, they are not essentially so. This is well summed-up by de Beauvoir (1949):

"When an individual (or group of individuals) is kept in a situation of inferiority, the fact is that he (she) is inferior. But the significance of the verb to be must be rightly understood here; it is in bad faith to give it a static value when it really has the dynamic Hegelian sense of 'to have become'. Yes, their situation affords them fewer possibilities. The question is : should that state of affairs continue?." (p.24)

The reproduction of patriarchal social relations serves to deny women equality with men. However, what must not be overlooked here is the fact that in class societies some women are in a position to oppress and exploit other women of a lower class (and

men too). This is also true in racially divided societies particularly in the slave societies of the American South and in countries such as South Africa. Here also some women dominate other women and some men.

Therefore some women who have certain material advantages are in a better position to negotiate and determine the means of their existence. This is particularly noticeable in a hospital or clinic situation where middle class white women have a greater knowledge of their entitlements and are in a better position to determine what happens to them (Chapter Eight), though they are themselves very aware of the dominant social relations present in the hospital.

Patriarchal social relations are also in evidence in the distribution of food in a society, that is, in the reproduction of material goods.

2) Reproduction of material goods - the distribution of food by sex

The material mode of production is concerned with the means to satisfy needs; one of these needs is the production of food, which is essential to the continuance of the human species. The way in which food is produced in a given society depends upon the mode of production, for example, whether agrarian or industrial capital. In an agrarian society the food is produced by the collectivity and distributed amongst themselves in exchange for

other goods. There is no cash relationship involved. Amongst the villagers of rural Punjab crops produced are cooked and prepared for consumption by the women of the household. The kitchen is the domain of women, but both men and some women work in the fields. Most women are usually involved in such duties as milking, grinding grain and taking food to the men, except at harvest time when their help is required in the fields. Trade within the village is usually carried out without cash, payment for goods being in grain, eggs or ghee (clarified butter) (Gordon et al., 1971, p.74).

In industrialised societies much of the production of food is now carried on outside of the home. As Delphy (1977) says:

"Operations such as the manufacture of bread, clothes and preserved foods which were once part of household activities are now performed outside of the home. Today bakeries, clothing manufacturers and canning and freezing companies sell labour which was, in the past, supplied without pay by women. This manufacturing is considered as production and is officially incorporated into the national product. The labour involved in it is considered to be productive and the individuals who perform the work are producers - which was not the case when these goods were created by the unpaid labour of women" (p.9)

In industrial capitalist societies there is a sharp distinction between social production by men outside the home, and the transformation of raw materials for consumption by women which takes place inside the household. This sexual division of labour in the production of food appears in most societies. Gough (1975) looks at the 175 societies classified by G. P. Murdoch and states that in 97% of them hunting is confined to men and in the remaining 3% it is

predominantly a male pursuit. In 60% of the societies, women are responsible for the gathering of wild plants, fruits and nuts, and in another 32% gathering is mainly women's work.

If we turn now from the production of food to its distribution we find that the distribution between the sexes is not always equal whatever the mode of production of that society. For instance, Bridget O'Laughlin (1973) notes sexual asymmetry in the distribution of food amongst the Mbum of Africa. She looks at the sexual skewing of food consumption which permits men to eat certain privileged surplus foods (chicken and goats) and relates this ideological practice to a particular contradiction with respect to women. Within Mbum society this food restriction is upheld through the threat of reproductive failure and sterility if the prohibition is transgressed. Moral guilt is thus assigned to women making them vulnerable to male dominance. There is at this point an ideological merging of the reproduction of social relations with the reproduction of labour, and a moral linking of a cultural practice (food taboos) to that which is biologically necessary, that women bear children (p.316).

Although in most societies women have control over the distribution of food, they are responsible for preparing and serving the food, women often observe dietary prohibitions imposed on them by men (or in some cases older women). In some instances these prohibitions relate to which foods women can eat, the amount they can eat and the location of the eating place. Amongst traditional Muslims "the men eat first and the wife and children eat later unseen by the man." (Rose, 1969). What the wife and children eat is often less in quantity and of poorer quality than the men. This is similar to the traditional practice in working class families in

Britain. Smith's (1964) study of rural families showed that:

"The wife in very poor families, is probably the worst fed in the household. On Sundays she generally obtains a moderately good dinner, but on other days the food consists mainly of bread with a little butter or dripping, plain pudding and vegetables for dinner or supper, and weak tea." (p.199)

The Maternity: Letters from Working Women (1915) show that even pregnant and nursing mothers often went without food. For example, "She finds she has to feed the rest of her little family, and goes without her own food" (Letter 102) and "The mother when funds are low, goes without much food pleading headache etc., so as to try and blind her husband" (Letter 122) "I looked after my husband and children well, but I often went short of food myself, although my husband did not know it." (Letter 128) A later study in 1938 showed that women in large families bore the "brunt of unemployment" and showed "obvious signs of malnutrition." (Pilgrim Trust, p.139) Even more recent Dennis et al., (1956) showed that women in a Yorkshire mining community served "a heavy meal for their families" and "a mere snack for themselves." (p.243)

The situation in most societies is that food distribution is sexually skewed<sup>1</sup>, men eating before women, eating more than women, whilst women are denied certain foods often because they are claimed to affect their reproductive potential. The restrictions on food may be instituted through religion, as Katona-Apte (1975) says of the situation in India: "It is not unusual to find households where the women are vegetarians but the males are not. Vegetarianism

---

<sup>1</sup>In those societies in which women are responsible for the distribution of food, it is often in the absence of the menfolk. For instance, Brown's (1970) study of the Iroquois showed that "women's power was rooted in a predominantly female organisation of domestic life and agricultural labour; men spent long periods away from home hunting and warring, and women worked together, controlled the distribution of foodstuffs, decided on marriage and generally dominated community concerns." (Rosaldo 1973, p.37).

amongst females may be rationalised on religious grounds, thus leaving more (or all) of the high protein foods for the males." (1975). Hindu women studied in this thesis admitted to being vegetarian while their male partners were not; it is possible to view this sexual imbalance in the distribution of food as the result of male dominance. <sup>1</sup> Edholm et al., (1977) take this notion even further when they provocatively ask "can we see the common practice that food is offered to men, then to children and young adults as an unconscious fertility inhibitor?" (p.113) Their argument is that women who are malnourished are less likely to conceive and carry to term a live baby. We can do nothing but speculate on this suggestion at this stage, but it does open up an interesting area of discussion.

In addition to the sexual distribution of food, there are in class societies, class differences in diet. Harrison (1973) refers to the tremendous variation between working class and middle class diet in Britain in the mid-nineteenth century. (p.89-93 and 113-135) and Sacks notes the difference between Ganda women from ruling and peasant families (1975, p.227).

A contradiction appears in this analysis of the distribution of food by sex and class when women become pregnant. The pregnant woman in most societies is accorded respect because:- 1) her status is temporarily raised as the potential bear<sup>er</sup> of either an heir (as in British upper class families) or a son who will be financially responsible for the parents in old age (as in Punjabi families - see Morpeth 1979); 2) her pollution potential is abated when she is pregnant. The raising of a pregnant woman's status is referred to

---

<sup>1</sup>As Okely (1977) in her study of gypsies says "Ritual control of sex is connected with control of the consumption of food" (p.68).



by Kitzinger (1978) when she discusses three societies in which "a woman has little value until she becomes a mother" (p.245). This theme is also developed in the chapter on status passage (Chapter 6), as is the notion of abatement of pollution potential in pregnancy. What is interesting in terms of the distribution of food in pregnancy is that there is a heightening or tightening up of some of the food restrictions and some new prohibitions are added. This occurs at the same time that women who are pregnant are allowed to eat certain foods normally forbidden (Kitzinger 1978).

Paige (1977) argues that the association of food restrictions with women's reproductive powers is one of four main prohibitions on all pregnant women. The four restrictions she isolates are: a) restrictions on social activities; b) restrictions on personal conduct of women; c) food taboos; d) sex taboos, (p.145). The foods which are forbidden to pregnant women are usually those foods which are believed to have a detrimental effect upon the developing embryo. Thus Mbum women "do not eat certain foods, e.g. bony headed fish, meat of antelopes with twisted horns, snakes - for fear of physical deformation of the child in the womb." (O'Laughlin, 1973, p.302)

When a woman is pregnant there are three specific aspects of the distribution of food which affect her: i) cravings - these I shall argue are socially constructed and class based (see Chapter 6), ii) food prohibitions - these are usually enforced by older women in the belief that the food would harm the foetus (see Chapter 6); iii) food prescriptions - certain foods are seen to be beneficial to the developing foetus. This advice is given by older women (usually the mother or mother-in-law) (see Chapter 7) or by health care

professionals, e.g. Health Visitors at Parentcraft classes  
(Chapter 9).

Certain restrictions and alterations of diet in pregnancy appear universal regardless of the mode of production of the society. However, in other instances, the mode of production plays a more important part in determining the nature of social relations in that society, as the following section shows.

### 3) Reproduction of the mode of production

The reproduction of the mode of production is essential for the material continuation of any particular society in its present form. Whilst the production of material goods is essential to the perpetuation of that society, the particular mode of production is not. When a society changes from one mode of production to another, for example, from an agrarian mode of production to a capitalist one, there is not necessarily a change in the nature of these relations of men to women. So for example, patriarchal social relations have persisted in socialist societies such as the Soviet Union and Cuba.

Patriarchal social relations tend to persist despite changes in the mode of production because the organisation of the family is such that there is a privatised sphere of domestic production in which women are located. This dichotomy is sustained by a sexual division of labour which assigns tasks on the basis of sex. In a capitalist mode of production the division between the public and private spheres is maintained and reinforced by the privatised nuclear family.

Beechey (1977) recognises that the:

"interest of capital in keeping down the value of labour power by maintaining the woman's domestic labour within

the home thus creates a tendency towards the maintenance of the nuclear family, which is reflected in and reproduced through a host of social welfare policies." (p.59)

Delphy (1977) goes further than this and argues that under capitalism there are two modes of production - the industrial and the family mode. She says that the:

"first mode of production gives rise to capitalist exploitation. The second gives rise to familial, or more precisely, patriarchal exploitation." (p.13)

However, other writers argue that it is not only under capitalism that the domestic mode of production exists. For example, Meillasoux (1975) considers that the "domestic community" in agrarian societies is vital to the organisation of the society as a whole. In agrarian societies the domestic work of women within the home services the male agricultural workers in a way similar to that whereby the work of women within the nuclear family maintains the wage-labourer under capitalism.

As domestic (unpaid) labour in capitalist production is isolated in the family from the means of production, it will be discussed separately. However, it must be remembered that while domestic production is isolated from social production, it can never be autonomous from it. The isolation is geographical in nature not in terms of an independent domestic economy.

Furthermore, when a group of people migrate from a society which is predominantly agrarian, e.g. rural India, to a capitalist society, e.g. Britain, the patriarchal social relations as expressed in the family organisation of the people in their country of origin may not change drastically upon migration. In fact, the form taken

by patriarchal social relations in a country with vast urban-rural differences such as India may vary from family to family as much within the country depending upon caste and class, as it does when rural villagers migrate to a city in Britain. This point is stressed because of: i) the variation between Indian women of rural and urban origin found in this study, and 2) the changes found in the patriarchal organisation of the family of rural Indian women who migrate to Britain. This latter point will be addressed first.

i) Patriarchal social relations in rural India

In rural India the patriarchal nature of society is overt and explicit. Male domination is best depicted through an analysis of the joint family system; a man and his family have control over his wife and this control is reinforced by the following -

- a) the practice of exogamy. Women are married out of their village (Mamdani, 1972) but they are married into the same caste or sub-caste;
- b) virilocal residence after marriage strengthens the husband's control over his wife, she is a stranger in his home;
- c) marriages are "arranged", often by the village barber (bachola) who selects a mate of a similar social standing from another village. The daughter to be married has little say in the matter;
- d) women must be sexually inexperienced at the time of marriage, and women are married at an early age. For instance, in 1961 in the rural areas of India 22% of the female population in the age group 10-14 were married. (D'Souza, 1972: Narain,

- 1975) On the other hand male pre-marital sexual relationships are permitted;
- e) after marriage women must bear children "to perpetuate the race" (Kapur 1973) Often women are not regarded as properly married until they are pregnant, which is "the first indication that she functioned adequately, that she deserved her place in her husband's family" (Marshall 1973). Barren wives are often returned to their family of origin (Mamdani 1972) and barrenness is the only reason for divorce in rural areas (Marshall 1973);
- f) male children are important as future agricultural workers for the village. It is the male child who lights the parents' funeral pyre (Gordon et al., 1971, p.83). The 1961 Census Report shows that the birth of a male child is still more welcome, and Morpeth (1979) says that village midwives were able to point out men living in the Punjab who "would have had sisters if these girls hadn't been killed at birth." (p.3.) Mamdani (1972) also claims that female infanticide was formerly a common practice amongst Punjabi villagers;
- g) the payment of a dowry from the bride's family to the groom's family reinforces women's dependent status, and also makes daughters a financial liability;
- h) women's position in the family is determined by their husbands and their husbands' family. The mother-in-law plays an important role in the socialisation of the newly married daughter-in-law. (D'Souza 1972; Minturn & Lambert 1964).

These components of the joint family system illustrate the patriarchal organisation of the family in rural India. As Desai (1969) states, the nature of Asian joint families leads to 1) greater homogeneity - the rural family being far more homogeneous and integrated than the urban family; 2) the organisation of work being distributed mainly on lines of age and sex. Since the members of the rural family form a single economic unit and constantly co-operate with one another in agricultural work, the family ties are greater and more embracing; 3) greater discipline and interdependence is found in the joint family. The male head of the rural family exercises almost absolute power over the other members.

D'Souza (1972), Lewis (1965), Luschinsky (1962), Minturn and Lambert (1964), Narain (1975), Wyon and Gordon (1971) also describe the patriarchal nature of the joint family in India and Mandlebaum (1974) recognises the role of the joint family as a means of controlling fertility. The couple living in a joint family have less privacy than if they lived in a nuclear family. This view was also expressed by one of the women studied in this research, she had recently arrived in Britain and since arrival was living in a nuclear household, prior to this she had always lived as part of an extended family. While she was in Pakistan this woman had never used contraceptives, but as all the members of the household slept in one room there was less chance of her having intercourse with her husband. In Britain the woman and her husband have a room to themselves, this extra privacy can mean that intercourse is more frequent.

Other institutions, in addition to the family, reinforce women's subjugation in India. For example, girls are less likely to be educated than boys. The 1971 Indian Census figures show that only 18.4% of women were literate, whilst 39.5% of men were. In rural areas, only 13.2% of women could read. (Lateef, People, 1977) Girls also receive inferior medical care (Minturn and Lambert, 1964, Gordon et al., 1963a). One writer, Vahia (1962), goes as far as to say that it is the joint family system and the lack of emancipation of women which are important factors in the pathogenesis of female hysteria in India. He claims that a woman who cannot adjust to her husband's family "has little or no recourse other than to illness to improve her lot. Hysterical fits gain sympathy and attention, relieve the patient from her duties, and, as such fits are supposed to be the result of supernatural forces, are 'socially acceptable'." This can be likened with the cult of female invalidism, epitomised by hysteria, in upper class women in 19th century Britain and America. Ehrenreich and English (1973) argue "Society has assigned affluent women to a life of confinement and inactivity and medicine had justified this assignment by describing women as innately sick. In the epidemic of hysteria, women were both accepting their inherent 'sickness' and finding a way to rebel against an intolerable social role." (p.46)

The patriarchal joint family system in rural India can be seen to restrict women's life chances in terms of education, health and degree of independence, to mention a few of the areas. Given this pervasiveness, it is interesting to judge the extent to which the patriarchal features of rural Indian society are perpetuated when

women from this background migrate to Britain.

ii) Asian<sup>1</sup> women in Britain

On migration to Britain some of the customs of the patriarchal joint family have become tempered and changed in accordance with English law. As Ballard (1972/73) says:

"in the strictest sense the joint family cannot exist in Britain, since such an institution is not recognised by English law, although jural rights in the property may be felt by the family members to be distributed according to the traditional customary rules." (Ballard, R., 1972/73)

However, the changes in the patriarchal joint family are not solely due to legal re-definition. Urbanisation and proletarianisation are more likely causes of changes towards the nuclear family.

By looking at the features which were present in the Indian joint family and comparing them to the Indian family in Britain, it is possible to gauge the extent to which the form of family has changed.

- a) Asian women in Britain may marry males from their village of origin who live in another town in Britain, but they must still marry within their caste and in most cases their religion. Many Asian youths return to <sup>India or Pakistan</sup> to marry a girl from another village there.
- b) Residence is still virilocal after marriage, but there are an increasing number of nuclear families to be found, i.e. families where the household is composed of the mates and their children.

---

<sup>1</sup> Asian here refers to predominantly Punjabi women.



- c) Marriages are still arranged, but there tends to be greater leniency with photographs being exchanged and some liberal parents allowing their daughters to refuse suitors. Parents still make the choice. (Ballard, C., 1978).
- d) Sexual inexperience for women continues to be highly valued - if a girl is not a virgin she is virtually unmarriageable. With the enforcement of a higher legal age at marriage in this country than in India, it is often more difficult to ensure that a girl remains a virgin and this leads to the greater protection of girls by fathers and brothers in Britain. Often girls are not allowed out unescorted.
- e) A woman's status is enhanced when she gives birth to live children soon after marriage. In Britain, however, although women are still expected to give birth to several children, there is an increasing awareness of the economic liability of having a large family. This is particularly so if the couple live on their own, without the support of the extended family.
- f) The importance of the male child is declining, but the ceremony after the birth of a male child is fervently adhered to and most families aim to have at least one son.
- g) The dowry from the bride's family is still payable in Britain and it is often quite high (Ballard, C., 1978).
- h) The nature of the relationship between the husband and wife in this country is largely determined by the absence or presence of the mother-in-law. A more egalitarian relationship is

likely to develop in a nuclear family, though this is not always the case. In extended families the mother-in-law is responsible for socialising the new wife into her domestic role and if she is living with the newly married couple, the social division of labour within the home is likely to be very similar to that in India. (In cases where the daughter-in-law is in paid employment she may find that she also has a heavy share of the domestic burden - see Wilson, 1978).

The dependency that Asian women have in relation to their men, is reinforced by the law which only permits women's entry into this country as the dependents of men - either their husbands or fathers. They are thus legally defined by the British government as dependents. The British state is here taking an active role in maintaining patriarchal social relations.

This analysis of the law and customs governing the social relations of women and men in India and upon migration to Britain is oversimplified. It takes an example of rural village women (predominantly Punjabi Sikh) and does not fully take into account caste and religious differences. The main group of women migrating to the city studied are from two main castes - Ramgarhia (artisans) and Jats (landowners). The Ramgarhia caste is further divided into sub-castes, such as those of tailors, carpenters, potters, and Jats are divided into sub-castes based on the amount of land they own. Marriages must take place between two people of the same sub-caste. Religious differences between these people are also strong but often not as strong as those of caste and sub-caste. For example, it is possible for a Sikh girl to marry a Hindu boy of the same sub-caste, whereas by tradition she is

not permitted to marry a boy of the same religion but different sub-caste. Sikh girls are not allowed to marry Muslim boys.

The other difference that has been ignored here is the variation between women of a rural and urban background. The situation of urban Hindu women is clearly illustrated by Kapur (1976) in her study Love, Marriage, Sex and the Indian Woman. The educated women interviewed in Kapur's study have little in common with the rural village women who formed the bulk of the Asian respondents in the sample studied.

It is important to make these points because although the patriarchal form of the family does to a certain extent determine the position of women within a particular society, all women are not universally oppressed. The stratification system of a society, whether caste or class based, determines the position of some women relative to others. Thus higher caste/class women are able to oppress and exploit women of lower castes/classes. This is further confounded by the factor of race, in some countries, e.g. South Africa, working class white women are in a position of dominance over some black men and women. (See Rowbotham, 1972, p. 201; 1973, p.124). On migration to Britain Asian people tend to lose status, many of them are employed in jobs which take no account of their Indian qualifications, (cf pages 185-186).

The role of the State in any society is important in determining and maintaining the form of social relations existing in that society, and for this reason it is worth looking at more closely.

#### 4) Role of the State in Britain

The role of the State in advanced capitalist society has been well documented from a Marxist perspective by Miliband (1969), Poulantzas (1972) and various authors in Capital and Class (Nos. 2 and 6). However, these analyses have paid scant attention (if any) to the relationship between the State and women's position in the social formation. There have been several attempts though to relate State intervention to women's involvement in the labour force (see Beechey, 1977; CSE Pamphlet No.2) and also to examine the extent to which women's role has changed since the introduction of the Welfare State. (Land 1976; Wilson 1977). What I want to focus on here is the way in which the State in Britain actively sustains patriarchal social relations in the sphere of human reproduction. Probably the most important interventions by the State into motherhood came at the turn of the century when there were fears about the future generation of citizens. Davin (1978) articulately details the changes that were taking place at this time:

"The relationship between the family and the state was subtly changing. Since parents were bringing up the next generation of citizens the state had an interest in how they did it....To be good mothers they now needed instruction, organised through the various agencies and voluntary societies and local government in the skills of what came to be known as mothercraft, as they were being defined by the medical profession." (p.13)

Two points are of importance here: i) the role of the State in determining what the future generation of citizens should be like and the conditions under which they should be brought up and ii) State intervention into motherhood provided a legitimate reason for

health care professionals to become involved. (This latter point will be developed later in the section about the reproduction of health care). Returning to the first point, it appears that State legislation concerning human reproduction is more likely to be introduced at times of crisis. Particularly in war times when there is concern expressed about the number and quality of children being produced. It is no surprise therefore that further legislation was proposed during the second world war (Beveridge Report 1942).

The Beveridge Report was the first attempt to introduce the idea of planned reproduction. The Report assumed the correctness of the patriarchal family and attempted: 1) to reinforce married women's economic dependence on their husbands and 2) to encourage motherhood, materially and ideologically, as a natural and central part of marriage. (see Bland et al., 1978) Maternity is therefore, according to Beveridge, "the principal object of marriage" (p.50) and "In the national interest it is important that the interruption by childbirth should be as complete as possible, the expectant mother should be under no economic pressure to continue work as long as she can and to return to it as soon as she can." (p.48).

The fact that maternity benefits were introduced when there was national concern about the falling birth rate is significant as it illustrates a possible relationship between the State and population control. Also it is interesting to note that since the post-war baby boom the amount of maternity benefit has not increased significantly, the need to offer financial incentives to encourage reproduction is

no longer seen as important. The maternity grant of £25 is "worth less today, in real terms, than the £1.50 grant first introduced in 1911" (New Society, 29 November 1979). Moreover it was estimated in June 1979 that a grant of £162.40 would be needed to meet current maternity costs.

Although Beveridge in his report implicitly encouraged motherhood, this was only in the context of marriage. He says:

"The interest of the State is not in getting children born, but in getting them born in conditions which secure them the proper domestic environment and care." (p.135)

Thus, unmarried mothers who have not worked are not entitled to Maternity Benefit. This benefit is paid on the basis of the woman's insurance contributions, however if she is married and has not worked then it is based on her husband's contributions. The unmarried woman who has not been in paid employment is discriminated against because she does not have a husband to support her. Each year, 8% of mothers are denied Maternity Benefit because they (or their husbands) have not paid the appropriate contributions (New Society, 29th November 1979).

The other maternity benefit payable is Maternity Allowance, this benefit is only paid if the woman has worked over a certain period of time and has paid the requisite amount of contributions. For both of these allowances, notions of work and marriages are strongly reinforced. The woman who has been in paid employment for a requisite period of time is entitled to benefits in her own right, if the woman has not fulfilled these requirements then benefits are paid based on her husband's contributions. The assumption is that all pregnant women are married.

However, married women are not allowed to claim Unemployment benefit or Supplementary benefit because they are considered to be dependent upon their husbands. Unemployment benefit is paid directly to the man and it is up to him how much of this he gives to his wife (as it is in the case of wages). If the husband does not give his wife enough money to live on then the social worker may be called in to help in the distribution of money. The role of the social worker is very much that of ensuring the continuance of the family at all costs (see Wilson 1977, p.83). In the present study one of the women called the social worker to try and persuade her unemployed husband to give her more money:

"I used to have a terrible time with money with him (husband) when I was expecting Martin (second child). And when I had Martin up to about four months ago you know, that's when I started telling him that I needed more money. Say, he used to get £19, say he'd give me a fiver to get me through the week. But he used to drink you see...Then when I got the social worker, then I started telling him that the social worker says that I was more entitled to the money than he is, and that the social worker's keeping an eye on him you know - even if he wasn't. Just to make sure that I got me money every week, 'cos it was him that was eating as well as us."

(Case No.13B, Parity 2 WC)

This example depicts the interest the State has in maintaining the monogamous nuclear family as a "unit of maintenance." (Hall and Lloyd, 1976, p.16). It is cheaper for couples to be paid supplementary benefit at the married couple rate than for both adults to be paid the single person's rate, which would be the case should the couple separate. (The married couple rate is £25.25 and the single person rate is £15.55 per week).

Women who are unmarried mothers and claiming Supplementary benefit are expected to stay at home full-time, or they can enter into paid employment and thereby lose their benefit. Many of these unmarried mothers do not have professional or technical training and therefore the kind of jobs they qualify for tend to be the lower paid ones. A woman who takes one of these jobs may be worse off financially than when she was receiving benefit, for she now has the extra expense of travel to work and may have the cost of childminding to pay. A contradiction here is that these women are also given preference for their under-school age children to go to State nurseries. These children are viewed as "deprived" coming from one-parent families, their mothers are seen as irresponsible and not suitable to be trusted with the valuable task of child-rearing. The contradiction is most apparent if the child should go to a nursery school, for then the mother is left free during the day, yet cannot obtain a paid job without losing her benefit.

Unmarried mothers receiving Supplement<sup>ary</sup> benefit are also not permitted to have regular sexual relations with men, for "cohabitation" loses them their benefit. The State thus upholds relationships within marriage where women are dependent on men. As Wilson (1977) says:

"The argument used by the SBC to justify the cohabitation ruling was that it would be wrong to treat a woman living with a man but not married to him differently from a married woman, and, since a married woman cannot claim supplementary benefits herself, her husband must do it for both of them, therefore the single woman must be treated as economically dependent on the man with whom she is living. Any other ruling would be a discouragement to marriage." (p.80)



The ideology that all pregnant women should be married is implicit in the Beveridge Report. It is also implicit in the hospital studied and all mothers-to-be were referred to as Mrs. (see chapter on status passage and the role of the hospital social worker, p.270-271).

The judiciary may also play a part in the maintenance of patriarchal social relations. Recently a woman alleges she was sacked from her job because she was pregnant. The case was heard at an industrial tribunal where it was agreed that her sacking did not amount to sex discrimination because there is no male equivalent to a pregnant woman. The law thus only considers women in relation to men. Moreover, Justice Bristow said:

"When she is pregnant a woman is no longer just a woman ... She is 'a woman with child' as the Authorised Version accurately puts it, and there is no masculine equivalent"  
(Guardian, 8th November 1979)

This section has attempted to show the relationship between the State (particularly the Welfare State) and motherhood in an advanced capitalist society. The relationship between motherhood and imperialism at the turn of the century has been clearly spelt out by Davin (1978). Fears about the future of the British race provided the legitimation for health care professionals to become involved in instructing women how to be "good" mothers. Literature was also extensively used as a means of preparing women for motherhood (Davin 1978, p.36). The role of health care professionals in instructing women about motherhood today is referred to in Chapter 9 where the Parentcraft classes are analysed. The literature provided by the clinic is also analysed in this Chapter, while the women's perception of the classes and literature is detailed in Chapter 10.

5) Reproduction of the Labour force

This aspect of reproduction tends to vary with the mode of production and under capitalism there is more of a distinct split between the spheres of production and reproduction than there is in agrarian societies (such as rural Punjab). These societies will therefore be treated separately. Firstly, under capitalism the reproduction of the labour force falls into two parts: a) the servicing of male workers by women in the nuclear family and b) the care and socialisation of future workers, i.e. children, by women.

- a) The servicing of workers and future workers in the home (i.e. what is known as housework) is work that is performed by women without remuneration. Delphy (1977) states that "all contemporary societies, including 'socialist' ones, depend on the unpaid labour of women for domestic services and childrearing." (p.3) However, other writers (Coulson et al., 1975; Dalla Costa and James, 1972; Gardiner, 1975; and Beechey, 1977) argue that it is in capitalist social formations that domestic labour fulfils important economic functions for the capitalist mode of production.

As Beechey (1977) says "the analysis of domestic labour has shown how the woman, labouring in the home without remuneration, and outside the direct domination of capital, produces use values for the reproduction and maintenance of the male labourer and his family." (p.49)

Dalla Costa and James (1972) go further than this and argue that since women's unpaid labour is essential to capitalism and thus to the system of relations within which surplus value is produced, it produces surplus value in its own right. Freeman (n.d.) argues against this claiming that:

"keeping a working husband makes it possible for him to produce surplus value, but it does not itself directly produce it. Woman's unpaid work means that the man can produce more surplus value, for it is his labour power which creates value in the Marxist sense."

Domestic labour therefore contributes to the organisation of the social relations of production, and maintains and reproduces labour power.

The question of whether it is use-value, exchange-value or surplus value that is produced by domestic labour will not be pursued here. What is important at this juncture is the relationship of dependency that is reinforced by paying male workers a family wage with which if married with children they have to use to maintain their family rather than paying women anything for their domestic services. The fact that the family wage is paid to the male worker means that he can dispose of it as he will, it also gives him social power within the family:

"The man's responsibility to maintain his wife and family establishes his power and authority within the family unit, but also imposes restraints upon his political action and militancy. The woman's position of economic dependence and social isolation is the material basis of her conservatism, sexual dependency etc." (Coulson, Red Rag No. 5 ).

It is this latter point that is most important to this discussion of social reproduction because it depicts the relatedness of the different facets of reproduction. It also makes explicit male dominance in the home which means that the wife is financially and emotionally dependent on her husband. Women who go out to work (unless they are in one of the more prestigious professions) tend to be paid lower wages than men and thus their financial dependence on the male "family wage" is reinforced:

"Amongst full-time manual workers the ratio of women's hourly earnings to men's remained at 61% from 1955 to 1971."

(Office of Manpower Economics. Report on Equal Pay HMSO)

b) Care and socialisation of children in the home.

This aspect of the reproduction of the labour force has been separated out because although all married women perform unpaid domestic labour at some time, not all women are responsible for the care of young children. The feminist debate has raised the question of whether there should be wages for housework (James and Dalla Costa argue for wages) but the question of childcare and nursery places (within feminism) has always been seen as the responsibility of the State in locations outside the home. This ideal has not been achieved and since the post-war reduction in the number of nursery places, women in the home are largely responsible for the care of young children unless they can afford private "minders".

Although child care is seen as the responsibility of women, not all women are considered responsible enough to be in charge of young children. Lesbian mothers for example, have recently been denied custody of their children in cases of marital breakdown. Also the children of unmarried mothers are given preference for local authority nursery places. Marriage and heterosexuality are two conditions strongly upheld as favourable for the socialisation of young children. The irony of this situation is that it is women who are responsible for socialising their daughters into the feminine role, thus perpetuating patriarchal social relations. Friday (1977) examines the importance of the mother in determining the daughter's sexual identity. She argues that this sexual identity is formed in the early exclusive mother-daughter relationship.

Rubin (1975) also is concerned with gender identity. She argues that "gender is a socially imposed division of the sexes" (p.179), and that the sexual division of labour exists to reinforce heterosexuality, on which Rubin claims, any kinship system depends. Thus "far from being an expression of natural differences, exclusive gender identity is the suppression of natural similarities. It requires repression...."(p.180). This point is similarly made by Oakley (1974a) when she refers to children whose biological sex was not immediately apparent at birth. It is the gender identity

denoted by the parents and their subsequent enforcement of this gender that made the child into a "boy" or "girl". (p.164)

The existence of a sexual division of labour which in most societies assigns tasks associated with child care to women, also attaches different values to certain tasks. In a capitalist social formation low esteem is accorded to tasks associated with child care and this raises questions about the value of certain tasks within social production. It also raises questions about the way women are seen primarily as mothers, yet two thirds of married women are in paid employment outside the home. Consequently women in the capitalist mode of production have a dual role - as reproducers of labour power and as producers. This gives rise to a tension between women's status as mothers and as workers (these tensions are expressed in the chapter on status passage). Women's status as mothers in Britain has a history of being mediated by their role in production in times of need (e.g. during the second world war). However women's role as producers or reproducers cannot be seen as mutually exclusive for most women who work outside the home are also likely to have been involved in child-rearing at some stage of their life cycle. Thus there is not only a tension between women as producers and reproducers, but there is a further tension between women's role in production and the sexual division of labour. Women who are in paid employment are often solely responsible for all the household tasks. The extent to which the sexual division of labour in household tasks changes when the woman is pregnant is detailed in Chapter 10.

2) In rural India these tensions are not so acute for there is a higher premium on women as reproducers. A woman's prime responsibility on marriage is to produce children and a woman is regarded in low esteem until she has given birth. (see page 19). The different time spans between marriage and birth of the first child for British and Asian women are detailed in the chapter on status passage and show the Asian women's earlier experience of motherhood.

In agrarian societies women are primarily involved in domestic labour and childcare and only tangentially in production outside the home (see pages 268-269). On migration to Britain, Asian women who live in extended families may be expected to engage in paid employment, while the mother-in-law looks after any children. Evidence suggests that these women are still expected to play a substantial role in domestic labour as well (see Wilson, 1978, p.42-43). It is not uncommon for one mother-in-law in Britain to look after several children while her daughters-in-law are out at work. Asian women living in nuclear families in Britain are less likely to work outside the home, and they are more likely to take work in. Women whose husbands work night shift may work outside the home while the sleeping husband is in charge of the children. In the nuclear family situation there is evidence to suggest that men are becoming more involved in childcare and some domestic chores (see Chapter 10 on the role of male partners).

Urban educated women in India do not necessarily find having children is disruptive to their career. There is a plentiful supply of low caste women who help with child care and domestic chores

Kapur, 1976). When these women migrate they tend to find motherhood implies a more radical change to their lifestyle for cheap household help is not so readily available.

#### HUMAN REPRODUCTION

What I have attempted to argue so far is that although human reproduction is a distinctly separate social process from that of social production, it should be looked at in the context of the social totality in order to be understood. The form human reproduction takes in a society is likely to depend on the mode of production and the dominant social relations of the society under study. In most societies men control some aspect of human reproduction. This control is often expressed through cultural practices which limit population growth.

According to Edholm et al., (1977) many demographers since Malthus "assumed that rapid growth in pre-industrial populations was held in check by high mortality levels" (p.112). However, they continue to argue that "the rate of population growth appears to be the result of controlling fertility, though it is not clear whether such control is the result of conscious choice or not." (p.112) Fertility is often controlled through taboos on sexual intercourse, on pregnancy in older women, on multiple births, these fertility controls include abortion and infanticide (see Chapter 5).

These cultural practices are often related to fear of female pollution. Lindenbaum (1972) argues that ideas of female pollution are correlated with population pressure on scarce resources, and



that the greater the need for population control the greater the fear of female pollution. Thus, "fear of pollution is an ideological form of birth control" (p.248) limiting male access to women in societies that need to curtail population growth. Traditionally, anthropologists have regarded "segregation of the sexes, menstrual and post-partum taboos, male initiation ceremonies, and rules regulating the frequency and appropriateness of sexual intercourse (as related) to the concept of female pollution and to the need for men to avoid potentially dangerous contacts with women". (Faithorn, 1975, p.130)

In a study of newly delivered Zulu women by Sibisi (1975) it is claimed that these women are highly polluted, "a condition that is contagious and particularly endangers men's virility, cattle and crops". (p.19) Kitzinger (1978) on the other hand looks at the dichotomy between "women as polluters and creators". "As a non-mother and erotic object she represents the forces of darkness, of animal nature which draws men away from the spiritual, a polluting agency which threatens to emasculate men's vital powers. (p.226).....As mothers, on the other hand, women are the fount of creativity and love, embodiments of charity and sacrifice." (p.227)

The omnipresence of women's ability to pollute men is referred to by Okely (1975). In her study of gypsies she concludes that "Gypsy men are innately pure, almost by pre-destination, whereas the women have to aspire to an elusive purity by good works, whether as virgins or wives. Since in their external role, Gypsy women are more vulnerable to sexual contamination by the non-Gypsy, they must be taught that their ever-present sexuality and fertility are dangerous .....Women's sexuality is always potentially polluting to Gypsy men. The Gypsy women must protect all Gypsies from pollution by

controlling their sexuality: if indiscriminate and casual with Gypsies, they could be so with Gorgios". (p.68)

The relationship between human reproduction and women's pollution potential will be more clearly detailed in Chapters Five and Six). It is clear though that in certain societies male fear of pollution leads men to control women's fertility. As not all societies have the same cultural practices regulating the control of women's fertility, some women may experience particular difficulty when they migrate from one society to another. For example, Kitzinger notes that in Jamaica "the peasant woman does not expect to marry until she has established a long and fertile relationship with a man who provides for her and her offspring." (1978, p.220) However, when these Jamaican women migrate to Britain, their behaviour is deemed promiscuous and their child pronounced "illegitimate". (See Vincent, 1979, who argues that 75% of West Indian babies are illegitimate). Conversely, Asian men are very concerned about the apparent low moral standards in Britain and they fear that their daughters will become corrupted by these. They also feel that their control over their daughters is being eroded by the amount of time girls spend outside of their jurisdiction (for example, at school).

As fertility control in British society is strongly linked with the medical profession, it is impossible to further this discussion without examining the mode of production of health care and health knowledge.

REPRODUCTION OF THE MODE OF PRODUCTION OF HEALTH CARE AND HEALTH KNOWLEDGE

A further aspect of social reproduction as it affects parturient women is the mode of production of health care and the reproduction of <sup>concepts of</sup> health and illness as they relate to pregnancy and childbirth. Before going into detail about pregnancy and childbirth it is necessary to look at how the reproduction of medical knowledge generally affects our perceptions of what constitutes health and illness. There are two broad categories of knowledge which are reproduced in this context: i) lay or folk knowledge ii) medical knowledge. When a person is well these two cosmologies tend to exist side by side without conflict. However when the person is ill there may be a tension between the two forms of knowledge about: a) the cause of the illness and b) the treatment to be followed. Also there is an assumed superiority of medical knowledge among health care professionals and this can be more fully understood if we look at the development of medical knowledge in its social context.

a) Reproduction of knowledge about health care

i) Reproduction of medical knowledge

Medical knowledge is acquired by members of the medical profession through formal training. This knowledge is couched in a particular rational scientific framework and is not easily accessible to lay persons. However, it cannot be assumed that there is only one body of medical knowledge which is unchanging.

The production of medical knowledge has changed over time and in terms of modern medicine the most important changes took place in the early nineteenth century with the development of hospitals. These hospitals were built in an era of industrialisation, urbanisation and developing capitalism. The links between this new kind of scientific medicine and capitalism were very strong as Doyal (1979) remarks:

"capitalist societies are legitimated on the strength of their relationship with science and scientific achievements." (p.43)

In terms of the medical profession, the changes taking place at this time were important in establishing the doctor's superiority over the patient. As Waddington (1973) argues the changes in the structure of medical knowledge in the early nineteenth century were crucial for the "emergence of the doctor as the dominant figure in the doctor-patient relationship". (p.211) (Other writers, e.g. Doyal, 1979 and Waitzkin and Waterman, 1974, would argue this remains the case today). Jewson (1976) looks in more detail at changes which took place in the doctor-patient relationship. He traces the development of three medical cosmologies which dominated western Europe between 1770 and 1970. The first cosmology is one of Bedside medicine - in this cosmology the patient (who was wealthy upper class) dominated the doctor-patient relationship. The doctor was dependent on patronage for his (sic) source of livelihood and was therefore subservient to the patient. This cosmology was superseded with the development of Hospital medicine, this involved a division of labour among health care workers and increasing specialisation. The third cosmology of Laboratory medicine

further divorced the practitioner from the patient, and the cell compound became the focus of attention. With the development of each cosmology, traditional medicine was undermined until a pathological model of medicine was built on the findings of experimental physiology (Jewson, 1976, p.230). This new medical knowledge which was based on science and rationality:

"swiftly dispatched the traditional remedies but offered few alternatives in their place." (Jewson, 1976, p.230)

Thus traditional remedies (often practised by experienced women) were denigrated at the same time as the patient became subordinate to Hospital medicine. The development of Hospital medicine also gave rise to a split between the practitioners of Bedside medicine who viewed the patient as a person, and the hospital clinicians who regarded patients as "cases". This distinction between practitioners and clinicians is still an important one for they both have particular cognitive structures which often come into conflict in the division of labour in health care. Part of this tension reflects the division between the normal and the pathological, or the dominance of the cure model over care. (These tensions are apparent still today and the women studied mentioned them, Chapters 7, 8 and 9).

It must be remembered that Hospital medicine developed at a time when there was growing concern to scientifically control life processes, i.e. those which had previously been seen as natural or normal. This distinction between the normal and the pathological was not confined to medical practice, it was also applied to social phenomena by social scientists. Durkheim (1895) claims that

normal phenomena are those which conform to given standards, while pathological ones "ought" to be different (p.47). A problem with Durkheim's analysis of the normal is that it is biologically determined and located in evolutionary theory. He says:

"A social fact can, then, be called normal for a given social species only in relation to a given phase of its development." (p.57)

Despite this limitation, Durkheim does provide an insight into the way in which the medical profession can gain control through having a definition of "normal" health.

"The state of health, as defined by science, cannot fit exactly any individual subject, since it can be established only with relation to average circumstances, from which everyone deviates more or less; nevertheless, it may serve as a valuable point of reference for regulating our conduct." (p.49)

Thus the clinicians' notion of what is normal in a population of cases contrasts sharply with the individual's conception of what constitutes a deviation from their normal health state (or as I shall argue later in Chapter 7, what constitutes a deviation from health during pregnancy). Durkheim's ideas about normality in health have been developed by more recent sociologists particularly in relation to illness as a deviation (cf Parsons The Social System, 1951) and more specifically in relation to pregnancy (cf McKinlay, 1972).

Durkheim recognises the problem of looking at pregnancy and childbirth in terms of normality, but continues to argue that they are normal events because they are biologically destined and in accordance with nature. The disturbances caused by parturition Durkheim considers normal for -

"the normality of the phenomenon is to be explained by the mere fact that it is bound up with the conditions of existence of the species under consideration." (p. 60).

For women then, one of the "conditions of their existence" is biological reproduction and this is normal according to Durkheim because it is "necessarily implied in the nature of the being". (p.60)

This ideology of pregnant women as natural or in tune with nature need not be restricted only to pregnancy, for there was also a notion that women as a species were equated with nature. Women were seen as irrational and uncontrollable, governed by the laws of Nature. These reasons were used to prevent women entering medicine in the nineteenth century. Men on the other hand, were equated with culture, with being able to act on the world and determine their existence. Ortner (1974) develops this dichotomy in her article 'Is Female to Male as Nature is to Culture?' and argues that connections are made between women's bodily functions and "nature" which are in turn negatively evaluated. In the nineteenth century as Durkheim suggests, the equation of women with nature was couched in terms of human reproduction. Thus there was an ideology of pregnancy as a "natural" process. As Graham (1976a) says in her historical portrayal of nineteenth century manuals:

"pregnancy, the Victorian writers maintained was a 'natural process and NOT a disease.' (Stacpoole). Ill-health, including miscarriage and stillbirth, resulted from self-induced invalidism and the over-indulgence of bodily needs. The achievement of health thus depended, not upon medical intervention as advocated in the nineteenth-century medical obstetric texts, but rather upon a regular and restrained approach to diet, defaecation, fresh air and sex which would bring the woman's daily life into harmony with nature." (p.19)

This predominantly middle-class view was also expressed by one of the more affluent women recorded in the Maternity Letters collection of 1914:

"I have tried to obey the laws of Nature, taking plenty of exercise, good plain food, avoiding constipation - all three very essential things in such cases." (letter number 143)

(This notion of obeying the laws of Nature, particularly in relation to diet, was one expressed by the women in this study (Chapter 7)).

At the same time as there was an ideology of pregnancy as natural, there was a growing move on the part of doctors to define pregnancy as potentially pathological, and there were attempts to control its successful outcome. This move was associated with the growth of obstetrics as a specialty and the erosion of midwifery skills. Therefore, it has been argued that members of the medical profession have placed great emphasis upon the pathological aspects of pregnancy, in order to legitimate their role in the management of pregnancy. (Oakley, 1975; 1976; Shaw, 1974). In a historical context, up until the eighteenth century, male doctors were only called-in to supervise abnormal deliveries of upper middle class women (Donnison, 1977). However, with the professionalisation of medicine and state control over who could practice medicine, an increasing number of male doctors became involved in childbirth.

As Donnison (1977) says:

"In consequence they (male doctors) were now in direct competition with the midwife. This work since time immemorial had been the preserve of women and in particular the resort of women with families to maintain, was gradually being lost to men." (p.21)



The development of the clinical model of medicine, with its locus in the hospital, aided the specialisation of obstetrics and gynaecology as legitimate areas of study. The extension of medical care from childbirth to the ante-natal period came at the end of the nineteenth century with the establishment of the first homes for pregnant women. In France the first such establishment in 1892 took the form of a shelter (or refuge) for abandoned pregnant women. This idea was copied in Edinburgh in 1899 with the opening of the Lauriston prematurity home for pregnant unmarried girls (Browne & Browne 1960). Both of these institutions were seen as a definite attempt to help the needy, whilst at the same time they were concerned with the control of venereal disease.

The involvement of the medical profession in ante-natal care and childbirth led many women in the nineteenth century to believe that pregnancy "was far from natural". (Branca, 1978, p.114).

As part of their preparation for motherhood:

"Women were advised to seek a doctor as soon as they thought they might be pregnant." (Branca, 1978, p.116)

and they were given advice on diet, exercise and clothing. By the twentieth century, Branca argues that:

"blood and urine tests, and blood pressure examinations along with attention to dental care were routine aspects of pre-natal procedure for middle class women." (p.116)

Access to ante-natal care was class-specific as it was based on the ability to pay. The women of the Women's Co-operative Guild were eager to make these services free for all women and actively campaigned "to improve non-existent maternal and infant care." (p.196 Maternity Letters) They also argued for free maternity

benefit (p.209) and for women doctors (p.211). Another example of the class nature of the early maternity services was that it was mainly middle class women who were hospitalised for birth. This was not always to their advantage as in the 1920's and early 1930's the maternal mortality rates increased with the hospitalisation of births because of puerperal sepsis. With higher standards of hygiene and modern drugs, mortality caused by infection is now rare.

Modern medicine therefore attempts to control life processes through scientific application. Although doctors are concerned to control pathology they also recognise the limitations of medical knowledge, and there are areas they themselves do not understand. One such area is the cause and prevention of miscarriage - women in this study were told by their doctors that they did not know what "caused it" (Chapter 8) and it was Nature saying "I haven't done a perfect job" (p.444..). In other areas of medicine what was previously seen as natural has changed, so that we can no longer have a natural birth (or even die of natural causes as Armstrong, 1979 points out).

The result of defining pregnancy as a potentially pathological event is a whole spectrum of health care professionals whose job it is to detect pathology. However, these experts may themselves subscribe to different states of cognitive knowledge and may not all be committed to a pathological definition (see Chapter 9 and the different perspectives of the midwives and doctors). A further point is that women are no longer deemed to know "instinctively" how to be mothers, they now have to be taught and this again is the role of

health care professionals. Women are taught to be dependent on medical experts and not to trust their own experience or the advice given them by their own mothers (see Chapters 8, 9 and 10).

ii) Reproduction of lay knowledge of health and illness

Lay or folk knowledge is that held by every person about health and illness. This knowledge is usually culture specific and is reproduced informally, being passed down through the generations, often from mother to daughter. This knowledge changes slowly over time and may be influenced by current medical thought and practice (though Helman (1978) argues that biomedical treatment reinforces the folk model in the case of colds and fevers). Folk medicines tend to be used widely, particularly for non-life threatening illnesses. The discomforts of pregnancy are non-life threatening and there are many specific folk remedies for them which are learnt about from older women. The extent to which Asian and British women have knowledge of these remedies, and their use of them is detailed in Chapter 7.

Pregnancy as a time of transition and uncertainty is recognised by many writers (Graham 1976b; and Lomas 1966); during pregnancy certain prohibitions and prescriptions are recommended to ensure a successful outcome to the pregnancy (see Chapters 6 and 7). Occasionally the lay knowledge a woman has may come into conflict with medical advice. This may become acute when the pregnant woman is living with her mother or mother-in-law who argues that a certain course of action should be taken which contradicts medical advice. Asian women who live in an extended family may therefore find it difficult to reconcile these differences. (British women may also be exposed to contradictory

advice, but they are less likely to be living in an extended family where the older woman exerts control over them). What must be remembered here is that lay or folk knowledge tends to be more pervasive in societies where medical knowledge is limited. Although in such societies there is usually a formal system of traditional medicine which complements folk medicine. In India, for example, the traditional Hindu system of medicine complements folk beliefs about health and illness. Modern medicine was introduced into India in the early 19th century in the context of imperialism and was used initially among the nobility in urban areas (Homans 1979). Even now, only 30% of the western trained medical practitioners work among the 82% of the population who live in rural areas (Wyon and Gordon, 1971). Most of the rural Asian women who migrate to Britain are unfamiliar with the thought and practice of allopathic medicine.

b) Reproduction of the mode of production of health care

The mode of production of health care is closely related to the reproduction of medical knowledge, therefore I shall argue that the development of modern medicine in Britain has reproduced certain social relations. Firstly, a division of labour based on specialisation has been reproduced. The medical hierarchy has clinicians at the top. This hierarchy is ordered on the grounds of class, sex and race - upper class male doctors dominating lower class nurses. Secondly, there is a distinction between hospital and community care, the primary health care workers being accorded lower status (see discussions in Chapter 9). Finally, in this hierarchy the patient is relatively powerless.

It can be argued these conditions apply to all patients and it is quite true that they do. However I want to argue that in the sphere of reproductive medicine these tensions become more acute because:

- 1) it is debatable whether pregnancy as such is an illness;
- 2) patriarchal social relations are reproduced in close liaison with the medical profession so women have to go to doctors to gain access to resources to control their fertility (e.g. contraception, abortion, sterilisation);
- 3) in the past, medical knowledge has reproduced certain ideas about women. These ideas were used against women who wanted to study medicine and they have also been used to portray women as neurotic and governed by their reproductive organs (see Chapter 5).

#### The implications for pregnant women

This discussion has so far focussed on the nature of patriarchal social relations as they are reproduced in the sphere of human reproduction. It has also attempted to unravel the relationship between human reproduction and the reproduction of medical care. What has not been included is an analysis of the different way pregnancy and childbirth are "managed" in societies with different modes of production. This will be dealt with in the chapter on status passage with specific reference to rural India and Britain.

Recent writers on childbirth in capitalist societies (Donnison 1977; Oakley 1976; Rich 1975) have argued that childbirth which used to be women's business has been taken over by the male dominated medical profession. Callaway (1978), on the other hand, argues that "the control structures of human reproduction (including female care) in most societies, not only today, but throughout history, have been male dominated." (p.174) She argues that we should turn to anthropological literature for an analysis of these male-dominated control structures. A thorough analysis of these structures is essential for the development of the meaning of pregnancy and childbirth to all women, and it is necessary as a guard against reification of the past, or as MacIntyre (1977) says "the myth of the Golden Age" of childbirth.

MacIntyre argues that certain recent writers (Arms 1975; Shaw 1974; Haire 1972; Oakley 1975 and Kitzinger 1971) have been guilty of a romanticisation of the past with respect to childbirth. She claims that these authors have portrayed childbirth prior to the male "take-over" as "a safe, non-alienating, and beautiful experience" (p.18). MacIntyre then turns to anthropological accounts of childbirth to prove that this is not so, and attempts to compare the anthropological data with her own observations in a modern labour ward. The main shortcoming of this analysis is that no account is taken of the "control structures" which Callaway (1978) considers to be so important. These "control structures" which may include religious and traditional beliefs have often been initiated by men. However, it must not be forgotten that some mechanisms of control, such as old wives tales,

have originated amongst older women as a mechanism of control over younger, usually lower status women. In order to understand the control exercised by say, the mother-in-law in the traditional Indian extended family, it is essential to be familiar with the nature of the patriarchal joint family; to be clear about the distinction between the public world of men and the private domestic world of women; to appreciate that a woman only gains authority when she becomes a mother-in-law, and then her authority only extends to the domestic sphere and younger lower status women. The mother-in-law therefore mediates between the male dominated cosmology and the private world of women. The amount of authority the Indian mother-in-law exercises in Britain is detailed in the following chapters which refer to the prohibitions (Chapter 6), prescriptions (Chapter 7) and the division of labour of household tasks (Chapter 10). The mother-in-law exercises most authority over the newly married first-time pregnant woman who is living in an extended household.

Although I have argued there are certain control mechanisms which affect all pregnant women it is important to remember that the ability of women to negotiate or cope with these mechanisms of control depends largely on their own material conditions. It therefore seems important to look at the degree to which women from different social classes are able to determine what happens to them when they are pregnant. In the ante-natal clinic and hospital setting, women with previous pregnancy experience and of higher social class are in a better position to determine what happens to them (see Chapter 8).

Women of low social class who have never been able to determine their existence may resort to fatalistic beliefs when they are pregnant. Fatalism is a <sup>coping</sup> mechanism which is often used by people who have never determined their day-to-day existence.

Carstairs (1955) claims that a high death rate in rural India is accepted through fatalistic beliefs; and Niehoff's study (1959) of factory workers in North India depicts that the workers believed that both the granting of children and the means of providing for them was in the hands of the deities. (p.91) It is usually people in the lower socio-economic groups who are believed to hold fatalistic beliefs.<sup>1</sup> However I would want to extend the notion of fatalism to include the lack of self-determination women experience in their everyday life, and particularly in their attempts to control their fertility. This fatalism is likely to persist until women have the material and ideological means to control their lives. This means women would need to have control over science and technology, and not allow male biological engineers to determine women's reproductive future.<sup>2</sup>

As far as being pregnant is concerned, there appear to be three different states of cognitive knowledge which women subscribe to:

1) pregnancy as natural - it is not an illness condition although there are certain discomforts which are part of pregnancy. This view is most often reinforced by older women and health care professionals working outside the hospital (Chapters 7 and 9); 2) pregnancy as

<sup>1</sup>Niehoff and Charnel Anderson (1966) refer to fatalism amongst peasants, whilst Kollontai (translation 1977) mentions the "passive adjustment of the working class to the unfavourable conditions of their existence." (p.247)

<sup>2</sup>The biological engineering approach to reproduction is discussed by Rose and Hanmer (1976).



potentially pathological - this view is most strongly held by hospital clinicians and the women who are most dependent on the hospital services are most likely to subscribe to this belief. The holders of this state of cognitive knowledge believe that the outcome of pregnancy can be successfully controlled (Chapter 8); 3) there is a belief amongst some women that life processes cannot be controlled - they are pre-determined. This group of women are those who subscribe to fatalism as a means of explaining those events over which they feel they have no control. These views are articulated throughout in terms of "what ever will be, will be".

What I argue in the rest of this thesis (using the empirical data to illustrate these points) is that dominant values are reproduced when women are pregnant. These values relate to women's position in society and their status as mothers, i.e. patriarchal social relations are reproduced. Pregnant women's experience of the maternal health services, I shall argue varies according to the women's social class position, thereby reproducing the class system; and the women's cultural background, thereby reproducing her subordinate position in a white dominated society.

## CHAPTER TWO

### LITERATURE REVIEW

#### Introduction

This chapter provides an overview of the existing literature on pregnancy and childbirth. The overview is not restricted to sociological works as this would deny the overlaps with other disciplines, for example, anthropology, psychology and medicine. The interaction between disciplines is important as shown by the work of Foster (1975) and Olesen (1975) who analyse the relationship between anthropology and sociology in studies of health care. Also included in this review are writings which directly relate to the organisation of the maternal health services, for instance, recommendations made by the World Health Organisation, and literature which has come from various pressure groups campaigning for improvements in the maternal health services. Such pressure groups and recent feminist writings have had a considerable impact on medical practice in obstetrics and these should be taken into account in any review of the subject.

An assumption running throughout the traditional writings from anthropology, psychology, medicine and sociology, is that the pregnant woman is the passive recipient of health care. Many of the writers therefore argue that a particular service provision (which varies according to the discipline) is all that is needed to improve the maternal health services. For instance, psychologists argue for the involvement of psychotherapists and instruction in

psychoprophylaxis in the ante-natal period; members of the medical profession consider that increased medical intervention in pregnancy and at childbirth contribute to lower maternal and perinatal mortality rates; and margarine companies have attributed the disease osteomalacia (the adult form of rickets) commonly found among pregnant Asian women in Britain) to Vitamin D deficiency. They conclude that the addition of margarine to the Asian diet would rectify this problem.

Certain agencies while offering a service also have vested interests in the way the pregnant woman behaves - what she eats, where she has her baby and who attends her. Recent consumer pressure groups coupled with feminist literature and activity, have argued for the woman herself to have a say in determining what happens to her, rather than being manipulated by outside agencies. The pregnant woman's interest is often expressed in terms of giving birth to a healthy baby in a way which involves the minimum of interference and the least possible suffering.

The importance of a literature survey is that it is able to critically examine the existing literature and propose an alternative frame work of study, incorporating some of the more useful analyses and rejecting the others. It also illustrates which areas are under researched and which topics would benefit from further investigation. For example, the health and health care of ethnic minorities in Britain has been grossly under-researched to date, and what research has been done is mainly by members of the medical profession who have encountered problems in their everyday medical

practice with patients who are not of British origin.<sup>1</sup> A fuller understanding of ethnic minorities is facilitated by turning to anthropological accounts of life in their country of origin.

#### ANTHROPOLOGICAL LITERATURE

The subject matter of this thesis - a study of pregnant women, half of whom had originated from another country - made it essential that anthropological works should be considered. It was therefore necessary to look at ethnographic accounts of village life in the rural Punjab, where most of the Asian women originated, for example, Lewis (1965); Luschinsky (1962); Mamdani (1972); Marshall (1973); Morpeth (1979); and Pettigrew (1972). There are also more general works by anthropologists on the position of women in Indian society, and particularly their position in the family - Bhasin (1972); D'Souza (1972); Kapur (1976); Minturn and Lambert (1964); Narain (1975); Ward (1963), and a few studies which look at the concept of caste, Singh (1972).

In the Punjab (one of the most fertile areas of India) concern has been expressed at the exceptionally high mortality rates, particularly among infants and women, Gordon et al., (1963a) and (1963b); Morpeth (1979). The work of Gordon et al., (1971) in the Khanna study is a typical example of the way anthropological techniques have been used by a team of health care workers to analyse villagers perceptions of health, illness and fertility control.

---

<sup>1</sup>Kitzinger (1974) says that for immigrants who carry with them body concepts from their country of origin "a gulf may occur between their ideas and the doctor's as to the nature of their illness." (843).

Gideon (1962) a doctor working in this team has written a very detailed account of the birth of a baby in the Punjab. Other members of the Khanna team have looked at preventive medicine and epidemiology, Gordon et al., (1963b); and medical care in fatal illnesses, Singh et al., (1962). Punjabi villagers' perception of illness and their use of medical care services have been examined by Kakar et al., (1972) and the role of the spirit medium has also been investigated (Kakar, 1972). More generally, there are numerous writings by anthropologists on the indigenous systems of medicine in India, Bannerman et al., (1975); Carstairs (1955); Leslie (1976); Marriott (1955); Opler (1961); Taylor (1973); and Udupa (1975).

Social anthropologists in Britain have looked at the position of Indian migrants. Several studies have looked at family organisation and everyday life, Ballard (1972/73); Ballard and Ballard (1977); Hiro (1969); Desai (1963); Sharma (1971). Particular studies have focussed on the problems facing second generation migrants, Thompson (1970), and the persistence of the traditional system of arranged marriages, Ballard (1978). A few studies have concentrated on the specific problems Indian women in Britain encounter, Dhanjal (1976); and Nath (1970); however, there is no detailed work on Asian women and pregnancy.

Other anthropological studies have looked at pregnancy and childbirth in different societies, for example, the work of Mead and Kitzinger. However, traditional anthropology has tended to be androcentric and ethnocentric and it is worth discussing these points before proceeding any further.

Criticisms of traditional anthropology

Anthropological writings on pregnancy and childbirth (specifically women's issues) have been limited by the over-concentration on male activities and detailed descriptions of inexplicable ritual practices. For instance, Carlebach (1966) talks of "tribal customs associated with pregnancy"; Newton (1975) of "birth rituals" including cutting the vagina just before birth and taboos on food and drink in labour; Ford's (1964) study of 64 primitive societies includes data on dietary restrictions and the people present at the delivery. Paige and Jeffery (1973) detail customary restrictions on sexual intercourse during pregnancy and the prohibition of particular foods and certain items of clothing; Saunders (1954) notices that the pregnant woman observes "a few precautions to prevent harm to herself and the baby"; and finally Thompson (1967) details herbal remedies, folklore and witchcraft and the place they take at the birth event.

The major criticism to be levelled against the above writers is that they treat the pregnant woman as a passive object who has things done to her, or observes certain rituals at appropriate time intervals. A more sensitive account is given by Gideon (1962) (a woman doctor) in her hypothetical account of birth and pregnancy in the Punjab when she discusses the pregnancy in its social setting. However, we still do not have a clear picture of what it is like to be a pregnant woman in rural India. Most of the writers who have a medical training attempt to relate anthropological observances to western medical notions of how things should be done; hence the criticism of ethnocentrism. For example, Gordon, Gideon and Wyon (1965) in their study of midwifery practices in Punjab start with who attends the birth, the duration of

labour, disposal of the placenta, i.e. what anthropologists would traditionally record; then they follow this with a demographic account of maternal and perinatal mortality rates and relate these high rates to the persistence of existing "folk culture". But there is no explanation or account of what constitutes this "folk culture". Likewise in their Khanna study (1971) there is no discussion of pregnancy per se, only reference to the fact that "no woman had systematic ante-natal care" (p.157) Nowhere do they discuss what they consider to be the attributes of ante-natal care, or what benefits it may possess. They merely speak of "pregnancy wastage" - assuming as we tend to in the western world that every pregnancy should result in a live child, an assumption which is not made in rural India. They therefore try and conflate traditional medical views with a meagre anthropological understanding of the society under study.

It thus becomes necessary to identify the cultural context in which pregnancy takes place. This is done succinctly by Nichter (1977) when he discusses what health is and its meaning to South Indian people, before focussing on specific issues such as pregnancy. Health "in a vacuum", as "resistance" and as "equilibrium" are related to the Hindu system of medicine before he attempts to locate the rituals pertaining to pregnancy in the framework of maintaining health as "equilibrium". So although the traditional anthropological observances are made regarding the noting of rituals (i.e. the pregnant woman's dietary prescriptions, who is present at the delivery, who handles the placenta) Nichter situates pregnancy in the spectrum of health and illness. In Hindu medicine this means that pregnancy is seen in terms of the harmony between mind, body and soul. Nichter thus overcomes

the previous criticism of ethnocentrism - he is able to disassociate his western values from his field work and thereby make sense of his data in its cultural context. However we still do not have a very clear idea of what it is like to be a pregnant woman in southern India, for the discussion is pitched at the abstract level of concepts of health within Hindu society, rather than what it is like to experience pregnancy in that society. Here it is worth looking at the criticism of androcentrism within anthropology to see if this provides a more comprehensive picture.

#### Feminist anthropology

In the last few years there have developed criticisms of anthropology from within the discipline. There have been two main points of criticism which are relevant here: 1) that traditional anthropology is androcentric, a criticism voiced in the collections of essays by feminist anthropologists (Rosaldo and Lamphere 1973; Reiter 1975; Raphael 1975; Critique of Anthropology 1977); 2) that traditional anthropology is the science of social administration in the colonies, and to this end has served imperialism. (cf Leeson and Frankenberg 1974). It is the former point I shall direct attention to here (a brief discussion of the second point is contained in the chapter on methodology in the context of using interpreters and informants).

Firstly, androcentrism - Reiter (1975) claims that "a great deal of information on women exists, but it frequently comes from questions asked of men about their wives, daughters and sisters, rather than the women themselves". Thus the information collected



about women is strongly male-oriented, as "men control the significant information in other cultures". (cf Introduction). Rosaldo and Lamphere (1974) also express this view when they claim that "the lack of interest in women in conventional anthropology constitutes a general deficiency, that has led it to distorted theories and impoverished ethnographic accounts." (pv-vi)

An alternative perspective is put forward by Paul (1974) when she looks at the distinctive nature of the female subculture. Paul analyses body concepts relating to women's work and to sex and reproduction in an attempt "to illuminate how women of San Pedro la Laguna see themselves and their world." (p.281)

Feminist anthropologists have thus attempted to overcome the androcentric bias. Raphael (1975), for instance, levels the same criticisms against traditional anthropology as do other feminist anthropologists, but she looks to the tradition and training of anthropologists for the limitations of their research into women. For this reason it is worth quoting her in full:

"The mother, she is represented as an object who sits up or down for delivery, who is warmed by a fire or covered by ashes, who nurses after saying a prayer or before confessing an indiscretion, and who is housebound for an exact number of days in cultures without calendars. Of her activities we find her getting pregnant, performing a rite, preparing a special site, giving birth, nursing hours or days later, and then weaning - on schedule. Within this routine, she either does or doesn't have sexual intercourse ..... Its not hard to understand these errors or superficialities. Most ethnographers come from cultures where marriage is the more dominant rite de passage and motherhood is considered unchanging and dull. Many were trained to look in other directions and do not see where most females are most of their adult lives." (p.65)

Raphael does not leave the discussion here; she suggests her own explanations for the paucity and low quality of data on pregnant women. Moreover, she attempts her own sympathetic analysis by drawing upon the traditional anthropological concept of status passage and updating it to make it specifically relevant to pregnancy. This analysis provides a dynamic picture of the pregnant woman in her transition to matrescence (the time of mother-becoming).

"During this process, this rite de passage, changes occur in a woman's physical state, in her status within the group, in her emotional life, in her focus of daily activity, in her own identity, and in her relationships with all those around her." (p.67)

This dynamic view of the pregnant woman, interacting with other people is reassuring. The pregnant woman is still seen to observe certain rituals, but these rituals are now given some meaning, they are placed within the context of the group. For "ritual interaction must be observed according to the intention of the actor and to the interpretation of the listener as well as to the cultural meaning". (Newman 1969) When placed in this interpretative framework the meanings of the rituals and their significance become more apparent. It is thus worth looking again at some ritual practices which have been noted by women anthropologists and placed in their cultural context.

Kitzinger (1971) notes that pregnant women in peasant societies often fear that the baby will rise up out of the belly into the chest. To prevent this, folk medicines and manipulations by older women are used to ensure that the baby moves down rather than up. Similarly, "Pakistani women in Britain fear that this is about to happen if they vomit during labour, and vomiting is the signal for

the husband's female relatives to lean on the fundus." (p.53, 1971) Luschinsky (1962) discusses the rituals of pregnancy and childbirth and gives a detailed description of the birth. At this time a cloth is placed against the labouring woman's anus to prevent the baby being born through the anus. This gives us an idea of the beliefs some women have of their own bodies, which is substantiated by Kitzinger's work with Jamaican women (1978) and Gideon's on Punjabi women (1962). Moreover, Mead's voluminous writings (for example, 1935; 1971) place pregnancy in a social setting and its cultural context.

The criticism of anthropology as androcentric would appear to be valid, for there has been no literature written by a male ethnographer which gives a sympathetic account of pregnancy. However, simply to replace male field workers with female ones would not necessarily improve the situation. What is needed is a critique of the traditional premises of anthropology which illustrates the elite status of the ethnographer without discarding the more sensitive accounts of women (by women) previously referred to. The feminist anthropologists have attempted in their criticism of traditional anthropology to develop an alternative perspective and these works were incorporated into the discussion on social reproduction in Chapter One.

Anthropological literature which is useful for an analysis of pregnant women who are members of ethnic minority groups

Another area of literature which is useful to the study in hand is the work on pregnant women who are members of ethnic minority groups. The work of Lucille Newman (1964; 1969; 1972; 1975) in

America is particularly important here as she compares two groups of pregnant women, "Negro" and white and looks at specific "cultural influences". These are, she says, the "various forces bearing on reproduction which are not inherent in the social or biological phenomena themselves". (1964, p.22) Newman therefore argues for the contribution of the anthropological perspective in order to be able to understand the pregnant woman's behaviour exhibited in an alien cultural environment. The cultural setting is important according to Newman (1964) for "there are few societies recorded which do not allow some freedom as well as impose some extraordinary restrictions on the pregnant woman." (p.55)

This latter point is important when looking at societies which have two kinds of pregnancy management (the traditional and western) co-existing side by side, e.g. the difference between urban and rural pregnancy management in developing countries. Mueke's paper (1976) on northern Thai <sup>women</sup> attempts to "identify the cultural propositions about social roles and action that underlie the operation of the two health systems, demonstrating that health care systems 1) socialise their agents and clients towards specific attitudes, understanding beliefs and values about society, health and fertility, and 2) act as instruments of social change and indirect education." This point is particularly pertinent to the present research which addresses the problem of women who are pregnant in British society and yet may have experienced pregnancy in their country of origin, i.e. India.

Returning to Newman's thesis (1964), this work is important because it suggests that it is the beliefs, customs, and practices which constitute the behavioural correlates of "cultural influences"

and these influences are found in a particular cultural environment. In America, Newman argues that ante-natal care is the standard accepted practice, but outside of this standard there are customs and beliefs which do not necessarily conform to the ideal - this is the behaviour upheld by the pregnant women which can only be understood by a knowledge of the folk-lore surrounding pregnancy (p.45).

Newman (1964) claims that "folklore is the area of greatest differentiation both socio-economically and racially" (p.171) She demonstrates this in her study of Negro and white clinic and private obstetric patients in California, when she claims that "pregnancy beliefs of a 'superstitious' nature were most prevalent and strongly held among the Negro clinic group. The belief system of the 'back to nature' ethos is almost exclusively held by white private patients." (p.170) Her analysis thus includes aspects of culture, class and race and this is important because these factors are not usually discussed together in anthropological literature; class and race issues being more often assigned to the sociologist.

Numerous other studies of black women in America have been carried out by members of the medical profession and sociologists. These studies are commonly known as "Negro" studies and fall into three main areas:

- i) Literature written by health care workers anxious to have a better understanding of this "alien" group and their culture, so that they can cope with the "problem". Gardiner (1969) says doctors "must have knowledge of the personal and social attitudes and patterns of behaviour of women living in poverty". And Harrison (1967)

recognises differences in personality between Negro and white pregnant women - "There may be a Negro way of reacting to pregnancy and a white way." Watkins (1968) claims that the failure of low income mothers (and here he means "Negroes") to seek pre-natal care is "a major public health problem". Bigham (1964) considers Negro women lack the vocabulary to understand the explanations of their illness, and doctors and nurses therefore need to speak the same language.

- ii) Literature which strongly believes the "Negro" woman to be at fault when she does not seek pre-natal care. Morris (1966) a doctor holds the attitude that mothers whose children received less preventive care were at fault, and among the pregnant, Negroes tended to initiate pre-natal care later than whites. They were "less educated, married to less educated men in the lowest occupational stratum, of high parity, and living further away from the clinic .... They owned fewer automobiles, and listed more difficulties interfering with attendance at the clinic" (p.1240) This work does not isolate the factors which act as a deterrent against women attending the clinic, i.e. the situation of the clinic (on a university campus and out of town) from the socio-economic status of the "Negro" women which may affect their perception of the usefulness of pre-natal care.

iii) Studies which associate "Negroes" with lower socio-economic groups and see them as being subjected to the same conditions, for example, Brown (1976). Most of these studies are by sociologists or use sociological concepts. Thus Baumgartner (1962) views non-whites as socially disadvantaged which may lead to poor nutrition and affect the outcome of their pregnancy. While Winsberg and Greenlick (1967) attempt to determine if cultural differences "result in differential response to pain amongst Negro and white obstetrical patients." Their results indicate that there are no observable Negro-white differences in pain response, but there are associations between pain response and parity and age. The older and higher parity women being more co-operative and stoical. (Cross-cultural responses to pain are referred to again later ( p.77-78)...

Arguing against the work of Harrison (1967) quoted in section i) above, are Pasamanick and Knobloch (1957-58) who hypothesise that "prematurity and pregnancy complication rates increase exponentially below certain socio-economic thresholds." Thus these complications are not to do with innate racial characteristics of Negroes but to their lower socio-economic status.

This last group of writings place more emphasis on social class, age and parity as factors affecting the outcome of pregnancy than racial characteristics or cultural differences. This is probably the case in the United States where non-whites have been for many

generations, but it raises a contradiction, for if the "Negroes" have lost their cultural characteristics through assimilation or integration, how can they still be seen to remain at the bottom of the socio-economic ladder as an "under class"? (Aronowitz (1973); Rex (1973); Boggs (1970); Castles and Kosack (1973)).

This contradiction is understood when one looks at the strong pressures towards integration of the immigrant group into the host society, whilst simultaneously there are equally strong discriminatory measures acting against them. Another debate concerns the question of the persistence of genetic characteristics outside their cultural environment. This will be only briefly referred to here in the context of Curtis' (1959) work on sickle-cell anaemia. This work done in the USA claims that the disease is specific to women of Negroid descent and does in many cases alter the successful outcome of their pregnancy. (Carter (1976) also looks at racial differences between Caucasians and Negroes in CNS malformations and he finds examples in many different environments which lead him to suggest that they are probably genetic in origin).

#### Research into ethnic minority groups in Britain

Much of this literature has been written by members of the medical profession and focusses on the strain which immigrants are seen to place on the N.H.S. (CIBA 1966; Dolton 1966; Galloway 1965; 1967; Skone 1968; Stroud 1965). More specifically, in the 1960's there were numerous works which looked at the strain members of ethnic minority groups placed on the maternal health services. For example,



Schwartz (in CIBA Report 1966) considers that the high birth rate of some immigrants has increased the demand for hospital admission. He refers to the differences in culture and customs which to his mind, precipitate complications of pregnancy. Jones and Smith (1970) likewise take this view, but they place more stress on the "economic impact" - hospital births being more costly in terms of government expenditure, than births occurring at home. To substantiate their claim they quote statistics for 1961 - 85% of immigrant births occurred in hospital whereas 63% of all births took place in hospital. Galloway (1965) also refers to the high number of hospital deliveries amongst immigrant women. But he relates hospital births to bad housing conditions and claims that social grounds were responsible for 65% of the hospital admissions among Commonwealth and Colonial immigrants and for only 21% of admissions among other residents. These remarks were made by Galloway (Medical Officer of Health for Wolverhampton) without taking into account the barriers against "coloured" immigrants obtaining suitable accommodation: for example, initial lack of finance on arrival in this country; discrimination against them by local estate agents and other residents; and the inability of newly arrived migrants to qualify for local authority housing. (cf Rex and Moore 1967) In 1961, for example, only 5.5% of immigrants were in local authority housing compared with 23% of the total population (Jones and Smith 1970).

The political ramifications of Galloway's research were illustrated by Enoch Powell (1969) when speaking in Wolverhampton and it is worth quoting him at length:

"Now that immigrant population, which forms 5 to 13% of the whole, produces no less than 23% of the births; that is, while one in twenty of the population is an immigrant, one in four of the births is an immigrant birth. I am not referring to births in maternity beds - there, the immigrant proportion is higher still, one in three - but to total births; and before any-one calls me a liar, I might mention that the figures are those of the borough Medical Officer of Health and may be found reprinted amongst other places, in the Lancet for 26th October." (p.307-308)

However, the statistics obtained by the Medical Officer of Health had not been "age-related" - the comparison was therefore between the birth rates of Caribbean and Asian women who were in their child-bearing years and had recently joined their husbands in Britain, and the "remaining population" (Lancet, 9th October 1965).

More recent statistics on the birth rates of Asian women suggest that these have now declined (Ilfiffe 1978; Loudis 1978; OPCS, 25th January 1977). However, there is still concern expressed over the perceived high fertility rate of coloured immigrant women (cf Times, 3rd November 1977), although it was recognised that immigrant birth rates in Coventry and Birmingham had not increased, and the rate for Wolverhampton had declined (Times, 3rd November 1977).

This point about immigrant birth rates has been laboured slightly to illustrate the controversy surrounding it. Certainly, the issue of immigrant birth rates has been used as political propaganda to stir up racial prejudice (Powell 1969). Also, members of <sup>the</sup> medical profession have expressed concern about their ability to accommodate an increasing number of women for hospital delivery (Schwartz 1966), or to be able to effectively communicate with them (Dodge 1969 and Dolton 1966).

Research which has been carried out by members of the medical profession into pregnant Asian women tends to focus on the problems the health care workers face when they encounter these women. Most of this literature regards Asian pregnant women as being different from the indigenous population. They tend to be older, shorter and almost always married, they have small-for-dates babies, nutritional deficiencies, higher parity and a higher neo-natal death rate. (Smalley and Bissenden (1977)). They have lighter birth weight babies, a shorter ante-natal supervision period yet a greater post-natal in-patient stay. (Bamford 1971) They tend to make more contacts with their GP during pregnancy for reasons other than the pregnancy. (Ronalds, Vaughan and Sprackling (1977) For dissemination of information and help in times of need they rely upon each other rather than on outside agencies (Candlin 1969-70). Dolton (1960) states that babies born to Asian women have higher still-birth, peri-natal and post neo-natal death rates than those born to UK women. But unlike the previous writers who tended to view these differences as the result of the woman's bad management, Dolton sees them as an indication of the need for first class ante-natal and obstetric care for Asian women. He does not look to social or cultural factors for an explanation of the high mortality rates, but assumes they can be remedied by increased medical intervention.

Yudkin (1970) on the other hand, says it is "no use assuming that immigrant women know about vitamin deficiency" and doctors, health visitors and social workers should have "training in understanding not only each individual cultural group that they work with but the general problems that are involved in immigrant groups coming to a

country". Stroud (1965) claims "every maternity unit should have attached to it a health educator who should preferably be of the same origins as the immigrant people who attend the unit." (p.602)

There are thus two strands of thought running through this literature, firstly, Asian women are a strain upon the maternal health services; and secondly, a very much smaller body of literature which recognises that a cultural understanding of ethnic minorities is necessary to further our knowledge of how they view health, sickness and pregnancy.

A further body of literature looks at nutrition in the Asian population and the relationship between low birth weights and perinatal loss. Wynn and Wynn (1974) state that immigrants are often blamed for the high peri-natal mortality rates, but they argue "The British Commonwealth immigrant population increases peri-natal mortality by about 0.5" which is not particularly significant.

In most of the literature about Asian women and nutrition there is little attention paid to the effect of inadequate diet on the mother's health. Attention is often directed towards the child, as expressed by Cockburn (1976):

"We cannot at this time define the optimum diet for the pregnant woman....(but we) can say that poor maternal nutrition may not only deprive the child of his (sic) physical and mental potential but may also stunt his emotional development." (p.72) (Emphasis added)

Roberts et al., (1973) discuss vegetarian diets among Hindus without taking into account the religious reasons for the adherence to this diet. Their interest is that people "who eat no food of animal origin are liable to develop vitamin B 12 deficiency." Also they

claim Indian women have the smallest babies of all patients (they do not take maternal height into account). However there is no apparent correlation between baby size and vitamin B 12 level.

Hunt (1976) a nutritionalist, has a more sympathetic approach to the dietary habits of the Asian population - she provides a religious explanation for the vegetarian diet of Hindus and also classifies Asian foods according to their heating and cooling properties. She draws on the work of anthropologists to make sense of the diet of these people.

There is little recorded on the extent to which Asian people's diet has changed since they have been in this country. Though it is suspected they have less fresh fruit and vegetables in Britain than they would in India, especially if they come from the fertile Punjab region where produce is cheap and plentiful. Hodgkin et al., (1973) made a comparison of the biochemical evidence of Vitamin D deficiency between Punjabis living in Northern England and in Ludhiana. There was a high incidence of Vitamin D deficiency in the group living in Britain, while only one case was found in the group living in India. One of the reasons for these results is the different climatic conditions of the two countries, and the consequent smaller amount of sunlight in Britain. Another reason is the change in life style of Asian women in Britain, for they are more likely to stay indoors here. In the area of Vitamin D deficiency and osteomalacia (the adult form of rickets) there is a larger body of non-medical literature and this can be attributed to the interest of margarine companies. One of the

preventatives for Vitamin D deficiency is the addition of vegetable oil margarine to the diet. The margarine companies are aware of this fact and have been eager to publish these findings at the same time promoting their products (cf Van den Berghs and Jurgens 1976).

There is a paucity of research into the cultural and social aspects of diet in pregnancy, although there is no conclusive evidence which shows a relationship between poor diet and maternal mortality.

Even more difficult to tease out is the relationship between poor diet and morbidity, because instances of morbidity are not fully recorded. Moreover, it is difficult to isolate poor diet from other variables which affect maternal health, such as bad housing, occupation, high parity (all symptomatic of low social class), though this was done in Baird's (1975) epic study of maternal health in Scotland from 1922-1972. In this study he examined the effect of the depression upon subsequent generations of women and found that they suffered from pelvic deformity and small stature for several generations after the depression. He claims "it is thought that severe and chronic malnutrition due to either low protein alone or low protein and low calories may start to influence foetal weight at the time of implementation of the blastocyst." (p.135)

The importance of social factors, for example, economic depression, poverty, on the outcome of pregnancy are difficult to ignore. Also important is an analysis such as that expressed in the anthropological writings of Mead, Kitzinger, Newman and

Raphael. This literature provides an insight into how the women view their bodies, their relationships within the kin group and a knowledge of the folk-lore surrounding pregnancy. Thus an interpretative feminist approach which takes account of the culture and class of the Asian population is required to be able to make sense of their attitudes towards pregnancy and ante-natal care in this country. This analysis will be discussed and developed later, in conjunction with that of the pregnancy in general as it affects all women in this country. To further this analysis a more detailed look at the literature on pregnancy is needed.

The area in which anthropological and psychological writing on pregnancy overlap is that of pain in labour. Anthropologists discuss cross-cultural responses to pain, while psychologists draw on this and other historical material to teach women to prepare themselves for childbirth. These two perspectives will now be examined in more detail.

#### Pain as discussed in Anthropological literature

Anthropologists have paid considerable attention to the ways people from different societies perceive and respond to pain. Zborowski (1966), for example, looks specifically at labour pain, and says that it is expected as part of childbirth, "but in American culture, it is not accepted, and therefore various means are used to alleviate it, while in Poland, it is not only expected but also accepted, and consequently nothing or little is done to relieve it."

Ablon (1973) discusses the reaction of Samoans to pain when burnt and the stoical attitude they seem to have, while Levi-Strauss (1963) directs attention to the management of pain in cases of difficult childbirth amongst the Cuna Indians. This account includes details of the relationship between the woman and her spiritual world. The shaman encourages the woman to concentrate on her pain and this is experienced as a struggle for her soul.

The painful aspect of childbirth is also recognised by Freedman and Ferguson (1949) when they question the commonly held notion of "painless childbirth" in primitive cultures. They claim that "magical rites or therapeutic procedures" (like the one Levi-Strauss cites):

"may give little indication of how widespread, intense or frequent anxiety or pain may be, but cultures which boast a rich fund of such protective measures and which regularly apply them, at great cost in time and energy, demonstrate that such reaction patterns play an important role in their individual and communal lives.....Pain of childbirth and the ever-present threat of death are usually explained in the animistic and supernaturalist concepts of malicious spirits which are part of the wider mythological structure dominating these societies." (p.365-366)

Beatrice Blackwood's account of birth in the Solomon Islands describes birth as a painful process (cf. Ford 1964), as does Gideon's (1962) account of birth in the Punjab and Ford's evidence on the Thonga of southern Africa. These writings provide a more realistic account of childbirth than some of the more recent feminist writings which have tended to reify childbirth in "primitive" societies as something which is painless (cf. MacIntyre 1977).



PSYCHOLOGICAL LITERATURE

Pain as discussed in Psychological literature

Psychological writing on the fear of death amongst parturient women and the reference to pain associated as it is with anxiety, is a recurrent theme. (Chertok 1973) However, when it comes to defining pain this presents considerable problems, as Chertok (1973) states, "Pain simply seems to be the incarnation of everything 'bad' about childbirth, which thus becomes an event somehow exterior to the parturient woman." (p.41)

The difficulty of measuring "pain" has led to a paucity of research into the amount of pain women experience in childbirth. Davenport-Slack (1973) has tried to evaluate the painfulness of birth and found that 97% of the women in her study said childbirth was the most painful experience they had ever had. She develops her argument to claim that it is not the physiological factors that create the variability in the amount of pain women experience, but the psychological ones - e.g. pregnancy attitude, reliance on drugs and doctors. Thus she considers if a woman has a negative attitude towards pregnancy she is likely to experience pain in labour. Nettlebladt et al., (1976) also relate childbirth pain to a negative attitude towards the pregnancy and attempt to correlate this with low educational levels.

A more positive attitude towards pregnancy was espoused by Grantly Dick-Read (1959) in the 1930s when he realised the psychological importance of childbirth was being overlooked. He related pain sensation to fear and tension - the fear-tension-pain syndrome; and advocated eradicating fear through preparation

for childbirth, hoping thereby to reduce pain. His method teaches prospective mothers to relax, to breathe correctly and to understand the stages of labour and to develop muscular control through exercise. Following from these recommendations increased emphasis has been placed on preparation for labour, for example, the National Childbirth Trust (NCT) in England and the teachings of psychoprophylaxis as developed by Vellay and Lemaze in France.

In Sweden, Bergström-Walan (1963) claims that Swedish education for childbirth resembles that of other countries "in seeking to instill an affirmative attitude towards labour, to reduce labour pains, and to eliminate anxiety." This "education for childbirth mitigated (the woman's) experience of pain during labour. And trained groups reported less pain in their questionnaire responses than did the non-trained groups." (p.132)

Stemming from these theories there has been much psychological literature on the efficacy of education for childbirth - Zax, Sameroff and Farnum (1975); Soichet (1972); Gadalla (1962) Doering and Entwistle (1975); Pilowsky (1972); and Norr et al., (1977) - all of it supporting the benefits to be gained through the use of these methods. Another school of psychological thought looks at pregnancy as a time of "crisis".

#### Pregnancy as "crisis"

Chertok (1972) views pregnancy as a time of "crisis" which implies the revival of past conflicts, for example, that between mother and daughter (p.30); and Doering and Entwistle (1975) consider the "crisis character of childbirth resembles in some

ways the crisis character of surgery." Hoover-Anwar (1972) speaks of "coping with the crisis of pregnancy" and says "pregnancy, especially first pregnancy is considered to be a major life crisis situation for most women, but the exact nature of the crisis varies" (p.86).

Pregnancy as "a state of conflict which diminishes as the pregnancy proceeds" (p.1313) is the way Hanford (1968) perceives the situation -"pregnancy is a state of stress, physiologically and psychologically". (p.1337) While Helper et al., (1968) argue that "life stress before and during pregnancy may interfere with the woman's psychological affiliation with the foetus and thereby jeopardise her ability adequately to mother the baby after birth." (p.183)

This literature about pregnancy tends to view pregnant women as under stress. Scott and Thompson (1956) classify women in their study as "stable" and "unstable". This is a point doctors may recognise when they are dealing with parturient women. If a woman asks questions or refuses treatment, her wishes may be disregarded on the grounds she is under stress and unable to make rational decisions. In some instances, the psychological tradition tends to relate the pregnant woman's attitude towards the unborn child (whether positive or negative) to the kind of pregnancy and delivery she can expect, e.g. Hanford (1968); Doering and Entwistle (1975); Bergström-Walan (1963); Hall and Mohr (1933). It also assumes that in illegitimate pregnancies, the woman has negative feelings towards the baby, for example, Cholmondeley et al.,

(1971) say women with negative attitudes towards the unborn child delay going for ante-natal care and the later the booking, the more likely the baby will be placed for adoption. Tulsky et al., (1972) see "problems surrounding illegitimacy" which require that unwed mothers should be given adequate pre-natal care in order to resolve the conflict between the patient and her pregnancy. These writings and that of Dauids et al., (1961) which claim anxiety is the key factor in pregnancy, do little to show the "normality" of the pregnancy experience (see Chapter 7 for a discussion of pregnancy as health).

Another area of concentration of the psychological literature on pregnant women is the emphasis placed on the oral stage as expressed through vomiting. It is suggested that vomiting in pregnancy reflects ambivalence towards the unborn child. Chertok (1973) claims "the majority of women who vomited had difficulty in accepting the child, and their pregnancy was characterised by alternation between strong desire for the child and equally strong rejections." (p.274) Also concentration upon the oral stage (and the anal stage, as in constipation) tends to reinforce notions about the narcissistic aspects of pregnancy. Thus Chertok (1973), speaks of the pregnant woman in terms of "the narcissistic inflexion of the libido i.e. the libido is withdrawn from either the external world as a whole or from particular areas. The woman turns in upon herself, loving and confusing her body and her foetus, whose anabolism demands all her energies." (p.31-32)

The narcissistic aspects of pregnancy are also referred to by Graham (1976a) a sociologist, when she examines the images of

pregnancy presented in ante-natal literature. The emphasis upon introversion and reflection tends to individualise and isolate pregnant women from the rest of reality, and to assume they are so pre-occupied with their own bodies that they do not have time for other activities or people. Another effect of the theory of oral fixation in pregnancy is that it has been taken up and used by instructors of pregnant women. An example of this which is worth quoting, is given by Claire Rayner (1973) in her discussion of morning sickness:

"It is now known that a woman who is subconsciously afraid of being pregnant, who is unable to face up to the responsibilities it implies, and who has deep and unexpressed fears of resentment about her condition, is more likely to suffer severe sickness than one who is serenely happy. . It is almost as though the sick mother were trying to expel from her body the source of her stress." (p.12)

However, Rayner does not produce any evidence to substantiate this statement and it would appear that she is making certain assumptions which have not been empirically tested. Kitzinger (1971) on the other hand, notes the practices Pakistani women undertake to ensure that the baby is not vomited up.

Medical text books also associate vomiting and anxiety, and the "medical student is taught to believe that many symptoms of illness in pregnancy (excessive nausea, headache) are really a result of her 'fear of pregnancy' rather than any physical condition he need test for." (Weiss 1975)

Conversely, Harvey and Sherfey (1954) claim that a moderate amount of sickness and nausea during the first three months of

pregnancy is common enough to be considered normal; and it is generally accepted as a culturally recognised symbol or a physiologically determined accompaniment of pregnancy. Lennane and Lennane (1973) reinforce this approach when they comment on the widespread occurrence of nausea in pregnancy; they argue that between 75 and 88% of pregnant women experience nausea in the early months of pregnancy (p.289). Given the high incidence of nausea in pregnancy and what the Lennane's call the "scientific evidence" to support the physical nature of the condition, they are intrigued by some of the medical and psychological literature which purports the psychogenic origin of nausea in pregnancy (p.289). Thus they argue the "acceptance of a psychogenic origin has led to an irrational and ineffective approach to their management", i.e. the management of nausea in pregnancy and similar conditions (p.288). Moreover, as these conditions only affect women, Lennane and Lennane (1973) suggest that the "cloudy thinking" may be "due to a form of sexual prejudice" (p.288).

Lennane and Lennane (1973) advocate that we seriously look at the beliefs held by those who support psychogenesis; this approach is considered to be more important than concentrating on the attitudes held by pregnant women, or discussing pregnancy in terms of an event to be "coped with" (Doering and Entwistle 1975; Hoover Anwar 1972) which largely depends on the personality of the pregnant woman. These latter perspectives individualise the pregnancy experience and blame the woman if she has a negative attitude towards her pregnancy (Zax et al 1975). An alternative approach is to look at pregnancy in its wider social context,

in terms of the pregnant woman's social relationships and the social structure which may determine these relationships. However, psychological literature largely overlooks these areas and concentrates on specific issues such as, behaviour in pregnancy.

### "Behaviour" in pregnancy

The "behaviour" a pregnant woman exhibits, unlike the "pain" she experiences is measurable and many tests have been devised to correlate the attitudes a person has with their behaviour. By defining pregnancy as a period of "abnormal" behaviour, the pregnant woman becomes much more interesting to the psychologist. Valabrega (1962) expresses this in its most extreme form - "pregnancy is an illness from which the woman is only delivered by her confinement....it is only after going through such a series of illnesses and according to the pattern imposed by the initiation rite or illness - that the woman is able to adjust to a new stage by a reduction of her libidinal economy." (p.173)

Behaviourist literature on pregnancy is thus couched in terms of how the woman "copes with", "adapts to", "accepts", or her "attitudes" towards her pregnancy. (Doering and Entwistle (1975); Helper (1968); Hall and Mohr (1933). There are "motivational factors and barriers" (Gadalla (1962)) which prevent the woman seeking or utilising ante-natal care. The benefit of ante-natal care to the pregnant woman is accepted by these psychologists. They do not question the medical definition of what constitutes

"good" ante-natal care, they simply investigate the woman's motivation to seeking it as expressed in positive or negative attitudes.

Doty's (1967) analysis is slightly more sophisticated as it takes social factors into consideration - she concludes that maternal attitudes vary considerably with social class and, to a lesser extent, with previous pregnancy experience. Also she argues that attitudes during gestation may be useful predictors of subsequent maternal and offspring behaviour. While Joffe (1969) discusses "pre-natal determinants of behaviour", such as maternal stress, in conjunction with environmental agents, e.g. drugs, smoking, nutrition. And Goshen-Gottstein (1966) draws on functionalist literature when she claims that "the pregnant woman as a patient is not expected to fulfil her customary household duties and, moreover, no blame is attached to her for her condition. She is in fact considered to be in need of help..." (p.87) presumably because of the supposed instability of her pregnant condition.

Finally, some sociologists have looked at women's behaviour during pregnancy. For example, Rosengren (1961) considers the importance of the environment, the social status of women and the view of pregnancy as an illness, for determining the behaviour of women during pregnancy and childbirth. Baric and MacArthur (1977) attempt to develop a method of measuring social expectations (norms) to find out how far women conform in their behaviour to those norms. They claim it is possible "to examine the relationship between norms and behaviour of pregnant



women in a variety of behavioural areas." The areas they discuss are smoking, exercise, diet, alcohol consumption and medication.

The problem with this behaviouristic approach is that it is deterministic - the woman's behaviour is pre-determined and emanates from her psyche. It does not take into account the social relationships the pregnant woman has, either with her family, her doctor or other pregnant women. It also tends to ignore other sociological factors, such as class, religion, race, occupation, and talks purely in individualistic terms. Over and above all this, it is male dominated and oriented, the woman is regarded as the one who is neurotic, unable to cope, narcissistic and potentially pathological. As her behaviour is determined by her pregnant condition there seems to be no alternative but for the woman to repeatedly go through with this "crisis" existence.

Psychology has had an influence on other disciplines, for example, psychology and medicine are similar in the way they both regard pregnancy in terms of the pathological; while one particular branch of sociology (functionalism) overlaps with psychology in its discussion of pregnancy as the adoption of the sick role or illness behaviour.

#### THE MEDICAL DEFINITION OF PREGNANCY AND ANTE-NATAL CARE

Members of the medical profession have been actively involved in the management of pregnancy and childbirth since the 18th Century. Initially ante-natal care was restricted to the wealthy and the very destitute (cf. Browne and Browne 1935), but later its efficacy was advocated for all women. Thus the fifth edition of Queen Charlotte's Text Book of Obstetrics (1939) states:

"The care of the expectant mother during pregnancy is of vital importance if she is to go through her pregnancy and labour safely" (p.79)

and

"there are many diseases of a general nature which are particularly associated with pregnancy, or else are liable to modify, or be altered by, the normal course of pregnancy." (p.210)

At a time of high maternal mortality the medical profession firmly believed that more medical intervention at the time of birth, plus regular ante-natal care would lower the rates. The authors of Queen Charlotte's text book (1939) argued strongly that an analysis:

"of the causes of death serves to show that many of the fatal cases could have been prevented by greater ante-natal care and skill in the management of labour..... Moreover, the loss of the mother of a new born baby, and other young children is not only serious to her family, but by the deprivation of maternal care and training is a source of imperfect citizenship to the State." (p.634)

State intervention in maternity care as expressed in the Maternal and Child Welfare Act of 1918 was largely the result of the Boer and First World War which drew attention to the unhealthy state of the labouring poor, and the fact that many women and babies were dying at birth. It was also influenced by the eugenics argument popular at the time which advocated the need for healthy breeding stock for the future of the nation. Thus there was great pressure upon the obstetricians to reduce the mortality rates and this has continued till the present day.

The aims of ante-natal care as espoused in a recent text book for nurses are as follows: 1) To maintain or improve the general health of the mother during pregnancy. 2) To prevent obstetric abnormality and to treat avoidable complications at an early stage.

3) To give general advice to the mother about pregnancy and to prepare her both for childbirth and for the care of the baby afterwards. (Garland et al., 1976). Moreover, obstetrics is "primarily concerned with the application of scientific knowledge to the physical care of childbearing women and particularly the diagnosis and treatment of the abnormal or pathological." (Walker 1976) Thus a recurrent theme in the medical literature is the notion of pregnancy as a potentially pathological condition.

Hern (1975) says it is useful to regard pregnancy as an illness for which western society has already devised an elaborate system of prevention or treatment. It is defined as potentially pathological and therefore requires regular supervision which doctors claim should ideally be located in the hospital. Great emphasis is placed on the validity of early and regular ante-natal care... "Ante-partum care is an absolute necessity if a substantial number of women are to avoid disaster....(for) pregnancy is a process in which the normal (non-pregnant) physiology is markedly altered for a period of time and which carries a significantly higher risk of morbidity and mortality than non-pregnancy."

(Hern 1971) The use of the word disaster in the above quotation indicates the concern expressed by members of the medical profession that every birth should result in a live healthy baby born to a healthy mother.

The medical argument for more ante-natal care, has been strongly influenced by the work of Butler and Bonham (1963), as expressed in the 1959 Peri-natal Mortality Study: "The importance of early

pre-natal care cannot be over emphasised.....Good pre-natal care requires early and frequent visits by the patient and the careful recording by the clinician of a series of simple observations." Johnston (1964) also claims there has "never been any doubt about the efficacy of pre-natal care insofar as the foetus and mother are concerned." (p.399) And the journal Maternal and Child Care (1967) comments that "in view of its (the first visit to the clinic) importance in the outcome of pregnancy, she (the mother) should obviously be encouraged to attend early, be aware of the need to do so and to be as strongly motivated as possible." (Emphasis added)

The findings of the 1959 Peri-natal Mortality Study which correlated the amount of ante-natal care received with peri-natal mortality, were as follows - the peri-natal mortality (PNM) rate in babies whose mothers had received no ante-natal care at all was five times the average; the rate among babies born to women who received one ante-natal examination was four times the average; and among women having three or four ante-natal attendances was three times the average. Assuming a causal relationship between ante-natal attendance and peri-natal mortality, Butler and Bonham (1963) argue that ante-natal care does prevent some peri-natal deaths. With the reduction in the maternal mortality rates since the beginning of the century, it is interesting to note the change in emphasis from the prevention of the death of the mother (as custodian of future citizens) to the prevention of the death of the baby.

Several studies have been carried out by members of the medical profession to find out which women delay seeking ante-natal care and the reasons for this. Robertson and Carr (1970) find that the few

"pregnant women who are either grand multiparae of low social class, or who are not married are particularly prone to delay seeking ante-natal care." While Schonfield (1962) claims that the time of the first pre-natal visit and the frequency of subsequent ones, is associated with the extent of the mother's formal education, parity and husband's social class. Heward and Clarke (1976) see it as the duty of health care workers to encourage their patients to present at the clinic or their doctors early in pregnancy. While Jolly et al., (1971) recognise the difficulties some women experience in travelling to ante-natal clinics and argue there is a "greater positive acceptance of ante-natal care when received in the local community."

In the medical profession itself there is a debate about the extent to which complications can be prevented through ante-natal screening. Chamberlain (1976) for instance believes that the ante-natal period can be used to prevent and detect handicap. "To reduce handicap further we must apply more widely and more discriminatingly tests that actually tell us what is happening to the foetus." (p.30) This view is backed up by Forster and Davison (1979) when they say that the possibility "of the pre-natal diagnosis of certain chromosomal, biochemical and neural tube disorders adds a critical time factor to the first hospital ante-natal attendance since amniocentesis is a hospital procedure." (p.593) Arguing against this view is Cooper (1969) who says that however carefully pregnant women are examined, "complications of the ante-natal course cannot be anticipated." He therefore argues for the hospitalisation of more births so that these complications can be dealt with.

Hospitalisation of births debate

The Cranbrook Committee (report published 1958) was established to examine the British Maternity Services. This Report highlights the problems encountered with having home and hospital deliveries within a tripartite system of health care. The Committee proposes the unification of maternity services and recommends 70% hospitalisation of all births. The later Peel Report (1970) argues that the Perinatal Mortality Survey (1963) demonstrates that women were being booked for home confinements who might reasonably be expected to experience complications in labour, and as a result were having to be transferred to hospital at a late stage with enhanced risk to mother and child. The Report therefore advocated 100% hospital confinement.

The Butler and Bonham Report (1963) was quite explicit in correlating the increased rate of hospital deliveries with the reduction in peri-natal mortality. However as Cochrane (1972) points out, because the decrease in PNM rate co-varied with the increase in hospitalisation of births, it does not mean that they are causally connected because the improvement in standards of living and nutrition must also be taken into account.

Outside the medical profession, Ashford and Fryer (1970) argue that it is by:

"no means certain that the trend towards increasing hospital confinement apparent since 1963 is the best policy. It could be that better general conditions and standards of medical care during pregnancy might do more to reduce mortality" (p.149, emphasis in original)

This argument is supported by Cooper (1969) who shows that the peri-natal mortality rate doubles from social class I to V.

More recently, concern over Britain's peri-natal mortality rate in comparison with other Western European countries, has led some members of the medical profession to question the relationship between high incidence of hospitalisation of births and low peri-natal mortality. In Holland for example, most deliveries take place at home (Huygen 1976) and the peri-natal mortality rate is lower (Maxwell 1974). Articles in The Place of Birth (ed. Kitzinger and Davis 1978) provide convincing arguments which question the assumption that hospital deliveries are safer (e.g. Richards, Tew, Huntingford).

Criticisms of obstetrics from within the medical profession

The hospitalisation of births debate has led to dissent among members of the medical profession. Kerr (1975), questions the appropriateness of judging the standard of maternity care in terms of peri-natal mortality (p.2).

Another area which has caused considerable controversy is that of induction of labour. Richards, a psychologist, (1975) argues that induction techniques carry some iatrogenic risks and do not seem to have very clear advantages for either doctors or their patients. (p.595) Professor Huntingford (1975) also questions the use of induction and doctors' attitudes towards their patients: "I get very angry about my profession and my colleagues, because I feel that they are more concerned about their own image and their own satisfaction than the job they are meant to be doing." Also he thinks that the time has come to "question every piece of medical advice that is given."

Huntingford is regarded as a rebel within the profession and is often at loggerheads with the medical profession.

In April 1974 Nursing Times, Kathleen Clayton, a midwife wrote an article 'Daylight Midwifery' which was an attack on the induction of labour. This evoked much correspondence in the medical journals and ended with doctors being cautioned (in the BMJ) from appearing on television programmes. This shows the power of the medical profession in being able to restrict controversial subjects being discussed publicly.

Out of all this debate there comes the message that the medical services and obstetrics in particular should be "humanised". Professor Nixon (1975) for instance described many of Britain's hospitals as "inhuman to mothers." While Chalmers (1977) notes a "positive association between peri-natal mortality rates and the provision of all types of doctors" (p.13) although doubts that doctors are causing death.

There is a considerable pressure to "humanise" obstetric practice, and this pressure continues at one level in the ongoing "Human Relations in Obstetric Practice" Seminars,<sup>1</sup> and at a much wider level there have been the recommendations of the World Health Organisation.

#### The WHO ideals

The WHO makes recommendations about the standards of health care through<sup>out</sup> the world. These suggestions are seen as "ideals" to be strived for and are far removed from the actual practices involved in the organisation and delivery of health care. On the

---

<sup>1</sup> These seminars brought together social scientists and obstetricians to discuss the sociological and psychological aspects of childbirth in an attempt to establish a dialogue.



subject of maternity care the WHO has written several reports which specifically state how the maternity services should be organised. In 1952, for example, the WHO drew up their definition of maternity care which is much broader based than the medical definition and stresses the normative aspect of childbearing:

"The object of maternity care is to ensure that every expectant and nursing mother maintains good health, learns the art of child care, has a normal delivery, and bears healthy children. Maternity care in the narrower sense consists in the care of the pregnant woman, her safe delivery, her post-natal examination, the care of her newly born infant, and the maintenance of lactation. In the wider sense it begins much earlier in measures aimed to promote the health and well-being of young people who are potentially parents, and to help them develop the right approach to family life and to the place of the family in the community. It should also include guidance in parent-craft and in problems associated with infertility and family planning."

(Technical Report Series No.51, p.3)

This Report also considers abnormalities "can often be prevented or minimised by adequate pre-natal supervision". The ante-natal period thus "offers a good opportunity for the integration of curative and preventive medicine." The Report also argues that instruction and/or birth should necessarily take place in the hospital, while at the same time recognising the hospital environment as a contributing factor to long labour.

Another Report (No.31) discusses pregnancy in terms of its "emotional significance" and sees the need for the pregnant woman to establish a relationship with one nurse or doctor. All mothers should have the Maternal and Child Health services made available to them (No.115) and unmarried mothers should be given particular attention because of the higher infant death rate among their children (No.51). There is a whole Report devoted to "The Midwife in Maternity Care" and this provides a very sensitive account of

the importance of traditional birth attendants in many countries - "These persons may be illiterate and mostly have no training at all in midwifery, but they are usually well versed in folklore relating to maternal and infant care and are likely to be among the most highly respected members of their communities." (No.331) The recommendation is that these traditional attendants are given instruction so they can play their part in the health service structure. In most countries though it is becoming increasingly difficult to receive continuity of care from one midwife, and the midwife has to some extent become "a member of a team" working more closely with the doctor. Despite this, the midwife is seen as having special responsibilities and these are "to establish an understanding relationship with the expectant mother and to gain her confidence. She should encourage her to attend the clinic regularly for pre-natal care throughout pregnancy, advising and where possible, ensuring, that the expectant mother receives medical examinations." (No.331).

The WHO Reports set out the ideals to be attained in maternity care. The type of care suggested is comprehensive and tends to view the pregnant woman in terms of a whole person, not look solely at her pregnancy. Moreover, the WHO views pregnancy in a normative sense, rather than in the medical model which considers it to be a potentially pathological condition.

#### Differences in medical practice

The reference to midwifery in the WHO Report suggests that childbirth may be viewed differently by midwives and doctors. This

assertion is examined by Walker (1976) in her study of perceptions of midwives and obstetricians of the role of the midwife. Walker looks at accepted definitions of the midwife which suggest "that she is a woman trained to care for other women during the normal childbirth process; a complementary role to that of the obstetrician who is concerned primarily with the application of scientific knowledge to ensure as far as possible the physical well-being of mother and infant." (p.129) However, as most midwives have had previous training as nurses "they are more likely to accept an "illness model" of childbirth and continue to behave as nurses working within the obstetrical field rather than as midwives primarily concerned with the normal". The move towards hospitalisation of birth and the resultant involvement of more midwives within the hospital setting has tended to strengthen "nursing" rather than "midwifery" behaviour.

In Walker's (1976) study she tries to ascertain if doctors and midwives agree as to what midwifery is. Respondents were asked to define midwifery and were then asked if midwifery is the same as obstetrics. The majority of the midwives (81%) thought midwifery different from obstetrics, the majority of doctors (64%) did not distinguish between the two words. "Those who distinguished between the two thought of obstetrics as the work of doctors who are more scientific, and concerned with techniques and with the abnormal; midwifery as the work of midwives in normal maternity care and involving greater contact with mothers, and the wider aspects such as health education." (p.135) This difference between the perceptions of midwives and obstetricians to their roles is important and will be referred to later in the research

findings in the context of the division of labour between maternal health staff (Chapter Nine). Another study which draws out the different attitudes between maternal health workers is that of Comaroff (1976b) when she examines the treatment received from physiotherapists and contrasts it with that received from midwives.

The Association of Radical Midwives (ARM) was set up in January 1977 with the aim of restoring the role of the midwife for the benefit of childbearing women and their babies. The work of this group has indicated a move on the part of a number of midwives to have their skills recognised.

#### CONSUMER OR PRESSURE GROUP VIEWS

Community Health Councils were established in 1974 with the intention of representing the patient's point of view. Certain Community Health Councils have been eager to look at the organisation of the maternal health services. For example, South Tyneside CHC carried out an investigation of patient satisfaction with maternity care (1976) and Northumberland CHC argued in 1975 that there was no conclusive evidence in favour of total hospital confinement. Locally, Coventry CHC undertook its own survey into the conditions at the ante-natal clinic in 1977. These findings were reported in the local press (Coventry Evening Telegraph, 24 February 1977).

Pressure groups have drawn on research findings to strengthen their arguments. The work of Goldthorp and Richman (1974) which recounts the effects of the 1973 hospital strike on maternity patients, has been widely used to question the policy of 100% hospital

confinements.

The pressure groups which have been most active in campaigning for improvements in women's childbearing experiences are the National Childbirth Trust (NCT), the Association for Improvements in the Maternity Services (AIMS), the Society to Support Home Confinements (SSHC), and the Patients Association. The NCT was founded in 1956 and this group is most widely known for advocating the psychoprophylactic technique of preparation for childbirth. The NCT also provides literature on pregnancy and childbirth and a breast feeding support group for mothers after the birth of the baby. In 1960, AIMS was established, this group produces a quarterly news-letter to keep its members informed of the current debates and practices in the maternity services. Later, in 1974 the Society to Support Home Confinements was established specifically to take up the issue of the location of birth. The Society considers that home deliveries (with the appropriate back-up services) can be as "safe" as hospital ones, and moreover, that patient preferences in this matter should be taken into account (see Russell and Clayton; no date). In addition to the special interests of these groups, the Patient's Association has received considerable correspondence from women about unpleasant pregnancy and childbirth experiences and this led to publicity being focussed on these issues.

Women's groups have also looked at the treatment of women in ante-natal clinics and during labour, and have made recommendations for the kind of treatment they would like to receive (cf. Swansea Women and Health Group, 1974). The work of all these groups is important because they have created a forum for women to discuss their pregnancy and childbirth experiences and to suggest alternatives.

THE SOCIOLOGICAL VIEW OF PREGNANCY AND ANTE-NATAL CARE

The sociological literature on pregnancy and ante-natal care is very far-ranging and has been influenced by other disciplines and perspectives. Sociological writings on pregnancy are numerous - they look at how pregnancy affects the normative ordering of society by asking if pregnancy is an illness condition (Rosengren 1961-62; McKinlay 1972a). The more recent feminist writings look at pregnancy from the woman's perspective - what does the pregnancy experience mean to her. To introduce this widely disparate literature it seems sensible to return to psychology and note the influence this had in defining pregnancy as an illness; this will then be followed with a discussion of the medical influence upon sociologists; and finally the more critical sociological works (including the feminist approach) will be examined.

Pregnancy as "illness" or the adoption of the "sick role"

This area of literature links very closely with aspects of the psychological literature previously discussed, and it views pregnancy in terms of illness. Before plunging straight into this discussion there needs to be reference to the work of Parsons (1951) for he developed a theory which labelled illness in general as "deviance", and considered the ill person to "adopt the sick role". Parsons claims that ill health has dysfunctional consequences for society because it incapacitates members of society from performing their individual social roles. This theory was in part derived from Freudian psychoanalysis which explicates the role of the unconscious in illness causation; it thus claims that illness is

partly controllable by the individual. Moreover, by being ill, a person is able to avoid social responsibilities, and following from this, the adoption of the sick role is seen to be a form of deviation. Parsons outlines four aspects of the institutionalised expectations of the sick role: 1) exemption from normal social role responsibilities - this is largely legitimated by the physician; 2) the exemption of the individual for responsibility for their ill health; 3) individuals must want to return to health - they are obliged to fulfil this demand; 4) individuals have an obligation to seek medical help and accept treatment.

Although this functionalist definition of the sick role is intended to further our understanding of ill health, it has limitations in that it places too much emphasis on social stability, and the co-operation between patient and doctor. Also it lacks an explanation of the way in which illness is perceived differently in other societies.

There have been attempts to apply the notion of "sick role" to pregnancy. McKinlay (1972a) attempts to do this using Parsons' four categories, but finds that they do not strictly apply. For instance : 1) the pregnant woman often suffers from "role overload" and thus cannot be seen to be exempted from normal social role responsibility; 2) women often make a conscious decision to have a child, so they cannot be exempted from responsibility for their condition; 3) pregnancy is not necessarily a time when women feel unwell, so there is often no question of them wanting to return to health; 4) McKinlay says "There is no real obligation to seek professional help." However, McKinlay (1972a) fails to point to

the extra strain placed on some pregnant women who may be expected to carry on as normal with household duties, and continue working outside the home until they are seven months pregnant. (These points will be dealt with in more detail in Chapter Ten).

Moreover, McKinlay says the pregnant woman is under no obligation to seek professional help. In Britain, there is particular emphasis on pregnant women to keep ante-natal clinic appointments, if they fail to do so they are visited at home by a domiciliary midwife. Finally, there are very strong social pressures on the pregnant woman not to "default" for to do this, members of the medical profession argue, is to jeopardise her own health and that of the baby.

Although McKinlay argues that pregnancy does not fulfil the criteria of the Parsonian analysis of the sick role, he does accept the medical definition of pregnancy as a condition requiring constant supervision and monitoring (1970). He therefore concentrates on the way in which pregnant women "utilise" the service. A discussion of this study follows, but there is one further reference which is useful to the debate in hand - McKinlay argues that women of low socio-economic status (class IV and V) are more fatalistic and less socially mobile and therefore tend to be less inclined than higher socio-economic groups to adopt the sick role. However, he does not explain why this may be so, the working class women having more children, less help in the home and therefore being less able to adopt the sick role.

Rosengren (1961-62) also discusses pregnancy in terms of the sick role. He constructs a hypothesis that women who expect to



enact the sick role during pregnancy will be characterised by general social instability. And he sees the function of the sick role is to offer "an opportunity to enact a sanctioned role for those who may be unwilling to continue their usual social roles". He attempts to equate the adoption of the sick role with the woman's social class values. He therefore argues that women who expressed combinations of lower and middle class values tend to be more inclined to adopt the sick role during pregnancy than were women who expressed either all middle or lower class values. The problem with this analysis is that he does not isolate the social factors which determine the composition of class values, he sees these values deriving from the attitudes of the women themselves.

The point was already mentioned that a sick role analysis attempts to explain the temporary deviance of the person from their social obligations. This analysis concentrates on the return to "normal" by the deviant as soon as possible. Or more succinctly, as Waitzkin and Waterman (1974) express it "the sick role as a conservative mechanism fostering social stability".

Also there are difficulties inherent in adopting the sick role, the person has to learn what it means to be a patient. As Davis and Horobin (1977) state, the "patient has to learn to perform his patient-role adequately ....'role' of 'patient' is by no means a simple well-defined set of rights and obligations applicable to all." Thus the adoption of the sick role may in itself present problems leading to role conflict; it cannot be seen only as an exemption from normal role responsibilities, for it implies that other role responsibilities are taken up and it does not provide a sanctuary from conflict.

This is in contrast to the way pregnancy is viewed in common every day language. Women consider they "fall" pregnant, or they get "caught", also pregnancy can be seen as contagious "every one is getting pregnant now, I hope I don't catch it." From this it would appear that there is a whole area of popular mythology which does not see women in any way responsible for their pregnant condition. It is something that happened to them.

Sociological literature which adopts medical definitions

Some sociologists researching into pregnancy and ante-natal care have accepted the medical belief of the usefulness of ante-natal care. This does not happen only in the field of pregnancy, it has occurred throughout medical sociology generally as explicated by Gold (1977) in her article 'A Crisis of Identity: The Case of Medical Sociology'. Here she notes the extent to which medical sociology articles contain "implicit and explicit medical value assumptions" and the tendency for "medical bias" in research "in which the sociologist is wholly or partly dependent upon medical sponsorship and definition of the research situation". This is similar to the points made by Straus (1957) when he highlights the differences between sociology of medicine and sociology in medicine.

In the literature on pregnancy, both McKinlay (1970) and Illsley (1956) from the Medical Research Council Unit at Aberdeen have in the past accepted medical definitions of the efficacy of ante-natal care. This may have been determined by their close association with local medical institutions, or they may themselves

have believed in the benefits to be gained from attending ante-natal clinics. For instance, McKinlay (1970) discusses utilisation of the ante-natal services in detail, but in the summing up of his work he mentions that ante-natal care may be "merely an elaborate ritual of Western society without any real pay off in terms of obstetric performance." However, his whole study to that point concentrates upon utilisation behaviour without really questioning whether the service provided is of any benefit to the women involved.

Moreover, McKinlay considers that "need is the primary determinant of utilisation" and "no matter how much a service may be disliked it will be used if the need to do so is urgent enough." (Emphasis added, p.384). Although need is considered central to the thesis there is little reference to what is meant by need, and elsewhere it is argued, there has not been any successful attempt to quantify need nor is there any conception of an overall need (Manson and Taylor, 1976). However, Matthew (1971) a social economist, recommends that "the need for medical care must be distinguished from the 'demand' for care and from the use of services or 'utilisation'." By isolating "need", "demand" and "utilisation" Matthew is able to say that utilisation occurs when an individual actually receives care. Thus "Need is not necessarily expressed as demand, and demand is not necessarily followed by utilisation, while on the other hand, there can be demand and utilisation without real underlying need for the particular service used." (Emphasis added) And this is the very point that McKinlay seems to have overlooked.

McKinlay seems to have accepted the medical definition as expressed by Donabedian (1961) "Need occurs whenever, in the light of

current medical knowledge, medical care would prevent illness, disability or death, would shorten or ameliorate the effects of illness or injury or would restore function when, because of illness, injury or congenital defect, capacity is reduced below the maximum achievable by the patient." As it is difficult for the medical profession to measure need in terms of the morbidity rates, it is usually determined in relation to mortality; a very crude index. Thus the "need" for ante-natal care is seen by members of the medical profession in terms of lowering the maternal and neo-natal mortality rates. In this definition no account is taken of the amount of non-life threatening suffering pregnant and labouring women undergo; their needs as women for information and support are ignored.

MacKinlay (1970) claims it is the amount of ante-natal care which is important in determining need - "In the area of obstetrics, it is possible to define the amount of ante-natal care as the number of weeks between the date of a mother's first attendance and the date of delivery of the child." (p.16) Though he recognises this approach has "the weakness that frequency of ante-natal attendance is usually influenced by the mother's state of health." (p.16) What he does not take into consideration is that it is not only the amount of ante-natal visits that is important, but also the content of them. And nowhere in his thesis does MacKinlay discuss what constitutes the ante-natal visit - he merely discusses the number made. He therefore is able to claim that "the lower class value system prevents patients from receiving adequate care" without considering that the services may be offered in such a way, or situated in a location, which makes them unacceptable and inaccessible to lower class women.

To determine differences between women who attend the clinic and those who do not, <sup>and McKinlay</sup> McKinlay (1972b) labels them "utilisers" and "underutilisers". Women who present at the central ante-natal clinic during or before the seventeenth week of gestation are considered to be "utilisers"; all those coming to the clinic on or after the twenty-eighth week of pregnancy are considered as "underutilisers". McKinlay is thus accepting the medical model which says women should attend ante-natal clinics in the belief that maternal and peri-natal mortality will be reduced, and those who do not attend are seen as defaulters, Porter (1971) or underutilisers.

Another sociologist who has in the past accepted the medical arguments for the efficacy of ante-natal care is Illsley. In his earlier work in particular (1956) he states that "late attendance is most common in those groups known to have most complications, i.e. the unmarried, the lower social classes and the higher parities." Thus he is tempted to "advise that every effort should be made to secure earlier attendance." But he does recognise that "mere association between late attendance and high morbidity and mortality rates.....is not enough, since the one may not result directly from the other" (p.111).

Elsewhere, Illsley (1966) uses peri-natal mortality rates to argue for "improved distribution of maternity services based on peri-natal risk rates, by a system of selection for hospital care based on obstetric criteria, and, most difficult of all, by persuasion of the at-risk groups to accept hospital care." (p.2) But hospital care in itself is not likely to remedy the situation, for the research shows that there are correlations between region

of residence; maternal height; social class; and perinatal mortality which will still persist even if there is hospitalisation of care. Moreover, there are considerable differences between hospitals; voluntary teaching or private institutions having greater access to high technology medicine than municipal or non-teaching hospitals.

Although Illsley has worked closely with members of the medical profession he is also critical of certain medical practices. For example, he does recognise that "apart from its technical content, obstetrics and gynaecology fulfilled another function - that of social control, of preserving established institutions and normative sexual behaviour" (p.240, 1974). And although sexual and reproductive behaviour have become "medicalised" and begun to absorb social and psychological perspectives, in some areas "the change is as yet barely discernible." (p.241)

The sociological importance of Illsley's work is the attempt he makes to isolate several variables for study in relation to perinatal mortality. He thus does not fall into the same trap that Butler and Bonham (1963) did. Moreover, Illsley (1966) notes that despite improvements in obstetric techniques, the medical services and living standards generally, the differential between social class perinatal mortality rates did not alter, which suggests the need for detailed studies over time of social class and the maternal health services (e.g. Baird 1975).

#### Ante-natal care and "social class"

McKinlay (1970; 1972a and 1972b) discusses ante-natal utilisation in terms of social class. He says that "In Britain the lower working class, because of among other things, occupational and residential

instability, economic precariousness, a generally impoverished milieu and diminished life chances is alienated from a predominantly middle class system." Moreover, numerically it is the working class that dominate, but it is the middle class who have ideological control and access to "superior" knowledge and material wealth.

In relation to pre-natal care Milio (1975) succinctly draws out the differences between the value system of the medical profession and that of lower class patients - "middle class women were found to adhere most closely to the 'ideal' pre-natal regime recommended by their medical practitioners. However, although lower-class women were less likely to follow the 'ideal' regime, their pregnancies were relatively uneventful and they had healthy babies." This suggests that the medical profession's "ideal" pattern of pre-natal activities is influenced by dominant middle class beliefs, "rather than physiologically-based requirements." (p.49)

Fish (1966) also refers to significant differences between manual and non-manual women in terms of "their patterns of expectations and attitudes towards pregnancy, labour, hospital and attending staff." He divides the patients into "ideal types" primary (manual) and instrumental (non-manual), and notes that conflict and dissatisfaction are more likely to occur among the "instrumental" than the "primary" patients. Doty's (1967) study found maternal attitudes to vary considerably with social class. While Hoover-Anwar (1972) examines the lay referral system of patients and found that lower class patients relied more on lay consultants than did the upper middle class.

McKinlay (1970) considers it is the woman's subculture which determines her pattern of utilisation of maternity and child welfare services, and her subculture is determined by the woman's social class. The ante-natal environment is particularly important and as Dubos (1970) says:

"Pre-natal and early post-natal influences can affect almost every characteristic from nutritional needs and morphological appearance to learning ability and emotional attitudes.....nutritional deficiencies, exposure to toxic substances, and many other forms of stress experienced by the mother during the early stages of pregnancy so commonly cause birth defects and other abnormalities that become manifest only later in life."  
(p.57-58)

Smith (1970) follows up this point about the importance of the ante-natal environment on the outcome of pregnancy and states that "the social class of the mother accounts for a larger part of the variance in peri-natal mortality than any other identifiable attribute of the pregnancy or delivery" (p.16) Following on from this Milio (1975) claims that if lower class patients are to receive treatment relevant to their condition, a clear explication of the lower class value system is required. And conversely, if sociologists want to understand the organisation of the maternity services and the way in which women are treated, then it can be argued that a clearer explication of middle class values are needed, particularly those of the medical profession.

The way in which sociologists have accepted some of the medical arguments about the importance of medical intervention in pregnancy and childbirth has already been noted. Other areas deemed to be of sociological importance are "legitimacy" and "planned" parenthood.



Pregnancy as "legitimate"

The normative value that pregnancy must be legitimate is very strong, but in many cases it is assumed that all births are legitimate and no reference is made to unmarried mothers, or they are ignored because they are seen to be "atypical". (Despite the fact that 8.8% of births were "illegitimate" in 1974: OPCS 1974). Thus the birth should be "legitimate" and pregnancy to an unmarried women constitutes deviance (Lomas 1966), as does high parity (particularly among the unmarried or immigrant groups). This is a different argument from that which sees pregnancy itself as deviance or illness, which prevents the woman from carrying out her normal role responsibilities; (Parsons 1951) Rosengren (1961); for in this argument pregnancy is regarded as normal and desirable if it occurs in the right woman at the right time, that is, to all married women of a certain age and parity. (McKinlay 1972a; MacIntyre 1975).

Like the women who do not attend for ante-natal care, the pregnant unmarried teenagers are also seen as defaulters or deviant, for they are seen to attend late for ante-natal care; (Illsley; 1956; Gill et al., 1970; McKinlay 1972b) or they attempt to conceal their pregnancy (Gill et al., say close to 10% of unmarried women managed to conceal their pregnancies until the onset of labour). They are also deemed responsible for high peri-natal mortality rates, 42.5 per 1000 births according to Gill et al., 1970; and Weeks 1976). (OPCS DH3 No.2 1975 does not show the peri-natal mortality rates for illegitimate births, but it does give the figures for infant deaths, i.e. those under one year, per 1000 illegitimate live births and for 1975 this was 22.52, as opposed to 15.77 for all live births). It is very difficult to make any conclusive statements about the peri-natal mortality rate of.

babies born to unmarried women without first controlling for social class, age and parity of the mother.

American studies suggest that some members of the medical profession consider illegitimate pregnancies more likely to result in complications and that delivery of such births should take place in "a setting which provides skilled obstetrical attention and adequate facilities". (Tulsky et al., 1972). They argue that these women tend to have "hostile attitudes to the delivery and the refusal to co-operate with the obstetrician in a certain number of unwanted pregnancies." (Husar-Doder et al., 1972).

The values that are implicit here further delineate the contradictions inherent in the pregnant condition. For pregnancy may be evaluated as a symbol of high prestige and role status, or it may be seen as the consequence of promiscuous or shameful activity (Hoover-Anwar 1972).

This literature indicates that a sociological approach is needed which takes into account the unmarried woman's fear of being "discovered" or "discredited" (see Pearson's 1973 account of the social and psychological aspects of extra-marital first conceptions). Busfield (1974) also notes the pressure on unmarried mothers to give up their child for adoption which encourages them to conceal the pregnancy. MacIntyre's (1975) thesis on pre-marital conceptions follows unmarried women through their pregnancy career and their encounters with general practitioners to provide an analysis of the way decisions are made about whether the pregnancy should continue or not. It is the GPs who act as gate-keepers to the services women may wish to use, for example, pregnancy testing, ante-natal care or

termination facilities. Thus the woman's previous relationship with the GP may influence whether or not she goes to him/her for advice. There are very valid reasons why unmarried pregnant teenagers present late, or not at all, for ante-natal care and these need to be investigated more thoroughly rather than simply blaming the women for non-attendance.

Some health workers have attempted to make their ante-natal classes more acceptable to unmarried women, but this is the exception rather than the rule. Wade (1972) a midwife, attempts to encourage unmarried women through the use of first names and an informal atmosphere; "information can replace old wives tales, and sex education and family planning information can be given alongside instruction in breathing and relaxation techniques for labour." Although more of the ante-natal classes are sympathetic to the special needs of the unmarried mother, not many women attend these classes.

In addition to the legitimacy of the birth (which is usually only seen as a problem when the woman is not married) the pregnancy should also be planned. Medical opinion is fairly consensual on the number of children a woman should have and at what time intervals. (See MacIntyre 1976b). Also early motherhood is linked to marital dissolution and truncated education (Bacon 1973-74) and women having unwanted births tend to leave school early and not to be fully prepared for motherhood (Brennan 1974). Therefore, some members of the medical profession see it as their responsibility to advise pregnant women on family planning, including sterilisation; this is particularly noticeable in the case of unmarried mothers, those of high parity and immigrant groups.

Location of sociological research into pregnancy

Sociological research into pregnancy which is located in the hospital setting has to guard against accepting medical definitions of pregnancy and an overconcentration on the clinical encounter. Attention should also be paid to the social network of the pregnant woman concerned - the role of other family members, what kind of advice and support they provide. One reason for the preponderance of research in the hospital setting is the ease with which a sample can be drawn from a clinic population, provided access has been approved.

Rosengren and de Vault (1972) discuss time and space in an obstetrical hospital. They look at the way: 1) persons are "used" by the setting; 2) the environment is "used" by the persons acting in it and 3) they consider that neither is personal conduct changed substantially because of the setting, nor is the setting and its existing limits circumvented to any great extent by the participants. MacIntyre (1976a) observes the management of ante-natal consultations by obstetricians. She claims that in an "ante-natal clinic women felt that they lacked the power to negotiate over whether they had problems, or what these problems might be, because of the reliance placed by the obstetrician on objective physical signs rather than on subjective symptomatology." (p.12) She defines three types of consultant management of patient: 1) sticking to the absolute minimum necessary procedures, in order to save the consultants and the women time; 2) some obstetricians use the opportunity of routine consultations to engage in preventive medicine and consideration of general health procedures, not generally relevant to the current pregnancy; 3) use of consultations to "humanise" the

experience of pregnancy. The consultant informed patients of test results and explained their implications; asked about family, employment, side effects. The routinisation and medicalisation of the ante-natal procedure can also be seen as a form of social iatrogenesis "in making women increasingly dependent, such that increasing care acts to increase the need for care." (p.30)

Comaroff (1976b) also locates her study in the hospital ante-natal clinic, but in this instance she is also pregnant - therefore she is not merely observing but also participating. This approach is very insightful as it shows what it is like to be one particular patient in the clinic environment. It tells of the clinic procedures, conversations with other women and those with staff, the encounter with the doctor, and the paucity of information that is given to expectant women about their pregnancy. But it also has the limitations of such an approach.

Hart (1977) relates her own personal experiences as a pregnant woman, and discusses the "authority crisis in modern maternity hospitals." These subjective accounts by women sociologists give a very clear idea of what specific individual women feel during pregnancy and how they react to the hospital ante-natal clinic. However the accounts they give may differ from those that would be obtained from say a working class woman with four children, and for this reason they cannot be regarded as typical or representative of all women. This does not mean that they are not valid in their own right, they indicate the need for research into the experiences of women from different social classes and ethnic groups.

Another area of research closely associated with the location of the hospital clinic, is that of internal examinations. Although

of course the woman does not necessarily have to be pregnant to be subjected to one as Emerson (1972) makes clear in her paper on "behaviour in private places". In the writings on pregnancy the internal examination is often not referred to at all and this can be related to the sexual connotations of the examination and the difficulty in gaining access for observational studies. Other writers who refer to the examination do so in terms of what is said, or in relation to the rituals surrounding it. Richman and Goldthorp (1976) provide an account of doctor-patient interaction; they see the consultation as being "heavily compartmentalised...each segment hinged with appropriate speech behaviour," (p.164) and they speak of the "sacredness" of the occasion.

Oakley and Graham (1977) refer to the doctor's perception of the patient's status which is revealed by the way he refers to the vaginal examination. For middle class women the term "vaginal examination" is used, but for working class women they are told "I'm going to examine you down below." (p.28) Comaroff's (1976b) account of her ante-natal experiences does not add much to the literature on how women react to the internal examination, and this is probably due to the fact that to express her feelings and reaction to the examination would lay bare an area which is not normally discussed. She speaks of the examination involving "intimate bodily procedures", (p.26) and the examination room as "the location in which medical personnel make contact with the woman's body." (p.27) The presence of the midwife is seen as an "attempt to counteract the patient's potential feelings of embarrassment or invasion of privacy." Emerson (1972) sees the importance of the presence of the nurse as a

"chaperone" during the examination, and draws out the contradiction confronting the staff "In the medical world the pelvic area is like any other part of the body; its private and sexual connotations are left behind when you enter the hospital."

Henslin and Biggs' (1971) study of women undergoing vaginal examinations over a fourteen year period, gives detailed accounts of what these situations mean to a large number of women. They say that "the vaginal examination can become so threatening that for many women it not only represents a threat to their feelings of modesty but also threatens their person and their feelings of who they are. Because of the threatening aspect of the structured genital exposure of the vaginal examination, some women keep putting off vaginal examinations, and it is not uncommon for women to wait until they are in the last trimester of pregnancy before coming in for their first pre-natal examination." This provides an alternative argument to why women delay in seeking ante-natal care and is particularly relevant to unmarried teenagers and Asian women who traditionally are not supposed to let any man (other than their husband) see their body.

The apparent insensitivity of some doctors towards women's attitudes concerning vaginals increases the woman's fear of the examination. One doctor (Rhodes 1972) writes - "by the intimate nature of the physical examination he establishes a rapport with the patient, based on contact, which is denied to other practitioners. He also has a chance to 'listen' to non-verbal communication such as the racing pulse, the tender abdomen, the tender pelvis and above all the reaction to the vaginal examination with its obvious sexual

overtones." (p.386) He does not consider that the racing pulse may be the result of the woman's fear of being examined; for as Moyes (1977) states "an internal examination for pregnant women can be both painful and humiliating." If the doctor is young then it may be even more humiliating as it "is more difficult for the woman to accept them professionally." Internal examinations are often made by male doctors on female patients, a point clearly expressed by Frankfort (1973).

Many of the studies of pregnancy and ante-natal care have been based in the hospital setting where the pregnant woman is examined alone. It is not surprising therefore that scant attention has been paid to the father at the time of birth (Pawson and Morris 1972; Richman and Goldthorp 1978). There has been recent interest in the role of fathers once the baby is born (see McKee 1979; Cleary and Shepperdson 1979). Moreover insufficient attention has been paid to the effect that pregnancy has on other family members, for example, young children, parents and parents-in-law. The reason for this being that pregnancy is not looked at in its social context but in terms of its medical definition, i.e. as a potentially pathological event. It is around this issue that feminist literature has directed itself, and this literature will be looked at now.

#### FEMINIST LITERATURE ON PREGNANCY AND ANTE-NATAL CARE

Probably the earliest piece of feminist literature on women's role in reproduction is L. Davies, Maternity: Letters from Working Women. Davies (1914) says "we claim for these letters that for the



first time are presented in them the real problems of Maternity seen through the women's own account of their lives." (p.2)  
(p.2) But what is really interesting about this book is that it presents this information in terms of a class analysis:

"The roots of the evil lie in the conditions of life which our industrial system forces upon the wage-earners. It is useful to consider the different conditions under which the middle-class and the working-class woman becomes a mother. The middle-class wife from the first moment is within reach of medical advice which can alleviate distressing illness and confinements and often prevent future ill-health or death. During the months of pregnancy she is not called upon to work; she is wellfed; she is able to take the necessary rest and exercise. At the time of the birth she will have the constant attendance of doctor and nurse, and she will remain in bed until she is well enough to get up. For a woman in the middle-class to be deprived of any of these things would be considered an outrage. Now a working-class woman is habitually deprived of them all....." (p.4)

The feminist literature of the present moment tends to ignore a class analysis and the continued class variations in outcome of pregnancy and directs its energy into an attack on male professional dominance. This situation has evolved because of the change in nature and extent of provision of health care. At the beginning of the century access to health care was a privilege for those who could pay, now however the health service is supposed to be universal and comprehensive, entitling all to "free" health care. In recent years there has been greater specialisation in the hospital services with less attention directed to the domiciliary services. The increased hospitalisation of births has led to greater medical intervention and the pregnant woman is often treated "'as if' she were ill" (Oakley 1975).

Many women feel they have been robbed of "autonomy and authority" (Oakley 1976) and have argued for control over their bodies. The Boston Women's Health Collective (1971) want:

"to improve maternity care for ourselves and all women calling into question the present care we receive. This care interferes with the rhythm of our lives. It turns us into objects. We want to be able to choose where and how to have our babies. We want adequate flexible medical institutions that correspond to our needs." (p.157)

Rankin (n.d.) says women want to feel that they give birth, rather than the child being born through medical intervention. Beels (1974) says "the medical profession takes over and dominates our bodies and feelings for nine months plus; controlling and putting us down while we're in their hospitals" (p.8)

These women thus want to break away from the medical monopoly on childbirth, reliance on technology (Shaw 1974) and make pregnancy and childbirth a more worthwhile experience (Kitzinger 1972; Graham 1976b; Boston Women's Health Collective (1971; 1978); Haire 1972; Lang 1972) which a women can go through with dignity (Cartwright 1977; Kitzinger 1972; Emerson 1972; Lubic 1972). Furthermore, women would like to take a "mediator" with them to help maintain control over their medical encounter (Shaw 1974; Swansea Women and Health Collective 1974) and they should be able to choose the location of the delivery (Society to Support Home Confinements 1974; AIMS; Beels 1974) and Linck (1973) advocates the legislation of a woman's right to choose.

Pregnant women's body images are looked at by Graham (1976b); Kitzinger (1972); Rosser (1978) and Pines (1972). Graham (1976b) discusses pregnancy in terms of spirit possession, the woman's body

being taken over by an alien being; while Kitzinger (1972) says that "fundamental to each individual's body image are concepts about cleanliness and defilement and those parts of the body which are generally considered 'dirty' and to be kept hidden...Lower part has traditionally been considered shameful...women often find it difficult to talk about their bodies with doctors, even when they get the opportunity and may feel that it is improper to do so." (p.124) A woman's body image and the extent to which she feels de-sexualised or de-humanised during the pregnancy can have a profound effect on the doctor-patient relationship. If the woman sees the internal examination, for instance, as a sexual assault then she may not return for future clinic appointments.

Also important is the image presented of pregnancy in the media; thus Graham (1976a) looks at "images of pregnancy in ante-natal literature" and draws out themes - "about the importance of psychology v physiology, about health v sickness and self v medical care - which appear as a historical dialogue in the development of ante-natal literature". (p.17) Also, in conjunction with McKee, Graham (1978) looks at the "Ideologies of Motherhood and Medicine on Radio and Television" and here they examine the ideological function of the media - "its role in portraying and sustaining a particular cultural consensus about medicine and motherhood". Programmes on pregnancy stress the importance of the mother's obedience to the doctor and compliance to medical procedures for the well-being of the child in utero. (p.10) As Busfield (1974) says "Ideologies play an important part in social control, they constrain individuals by presenting them with a set of expectations for their behaviour and appropriate rationales that support the expectations.

These relate to accepted values within the society." (p.33)

The accepted values surrounding pregnancy are that the woman is married, that she wanted the child and that she is prepared to look after it once it is born.

To date the feminist literature on pregnancy has tended to ignore the different social class positions of women. So while we have insightful accounts about personal experiences, these accounts are by articulate middle class women. This is not to deny the validity of these accounts, but it must be remembered that they only portray what it is like to be pregnant if you are white, middle class and married. They also tend to isolate the pregnancy from its social context, and ignore the support and information received from family and friends. There are obvious reasons why the pregnancy has been divorced from its social context, the main one being that most of the unpleasant aspects of pregnancy are located in the clinical setting - it is here that the woman feels she has lost control over her body, it has been appropriated by the medical profession for their scrutiny and intervention. But there does need to be an account of the woman's social class and ethnic background if we are going to understand what it means for different women to be pregnant at a specific point in time, and their response to the management of pregnancy.

CHAPTER THREE

METHODOLOGY

Introduction

The methodology employed in this research was tailored by the need to separate the specific experiences of Asian and British pregnant women from those experiences which are common to all pregnant women. There was an inevitable tension between a comparative method, which attempts to tease out the differences between women of distinct social backgrounds, and a general study of the similarity of experiences of all women during pregnancy.

A further comparative dimension of the study is the distinction between medical and lay beliefs about pregnancy. In the previous chapter I argue there has been an over-concentration on the medical (or pathological) aspects of pregnancy and a paucity of material about pregnancy as a social event. To redress this balance and place pregnancy in its social context it was necessary to collect data on the social meaning of pregnancy. The inclusion of folk beliefs about pregnancy provided data which could then be compared with the information women received from members of the medical profession. The research is therefore, comparative in two senses, one, a comparison between two groups of women and secondly, a comparison between two states of cognitive knowledge.

An observational study of the interaction between pregnant women and health care staff may have revealed some of the tensions between lay and medical knowledge and indicated a differential system of treatment based on the social class and cultural background of the woman. However, such observations do not tell us what the woman (or the staff for that matter) experienced. Moreover, such a study would need to be confined to the clinical setting and thus would overlook the social aspects of pregnancy. To overcome these problems the women in the study were interviewed twice, once in the consultant antenatal clinic using a structured questionnaire, and once in their own home where an in-depth semi-structured approach was used. Details of these two sets of interviews and the practical problems encountered (both in setting-up and carrying-out the interviews) are developed more fully later.

Particular problems which were recognised at the outset of the research were i) the researcher had little knowledge of half the population to be studied (i.e. the Asian women) and needed to learn more about the population using first informants and later an interpreter. A large body of comparative literature was drawn on and used by the researcher to inform and substantiate the informants' and respondents' statements; ii) the language difference between the Asian women and the researcher was recognised at the outset and an interpreter used to overcome this problem. The justification for using an interpreter and the practicalities of doing so are discussed in some depth later,

as are the limitations of this approach.

The following account is an elaboration of these points, a detailed explanation for the methods used, how these methods were implemented and the nature of the problems encountered. The practical problems experienced by researchers often substantially modify the research process and for this reason attention should be paid to them. As MacIntyre (1979) says:

"practical experiences may affect and determine the extent to which a theoretically appropriate research design may actually be put into successful operation". (p.769)

#### RESEARCH TOPIC

The initial impetus for the choice of research was political, it stemmed from an awareness that Asian women's pregnancy experiences were different from those of the indigenous population. A fundamental concern of the researcher was whether these women received a different service, or used the health services in a dissimilar manner.

My attention was drawn to the differential experiences of Asian women in the ante-natal clinic when I spoke to a consultant obstetrician (12th October 1976) who complained of his inability to communicate with pregnant Asian women and expressed concern that school aged children were being used as interpreters. This consultant saw the language difference between him and the Asian women as the main problem, he did not consider that culture or social class might be contributing factors. Another member of the medical profession, this time an Asian GP, voiced his concern at the

factors preventing Asian women keeping their ante-natal appointments. He was quoted in the local press as saying:

"Many pregnant Asian women may have lost their babies because they are too shy to let male doctors examine them". (Coventry Evening Telegraph, 1976)

This doctor explained the problem in terms of "belief and tradition" (unlike the consultant who only saw language as a problem). Although both doctors had different theories about the behaviour of Asian women, they were alike in that they saw Asian women as radically different from the indigenous population in their use of the maternal health services. To judge the extent to which the Asian women differed from British women and whether any differences could be explained in terms of cultural background, it was necessary to conduct a comparative study. This research approach permits an exploration of the similarities and differences between two groups of women passing through the maternal health services and provides the basis for an analysis which looks at the way women use different aspects of the maternal health service, for example, clinics, GPs and Parentcraft classes.

#### THE COMPARATIVE METHOD

The comparison of one or more social group with another is not a new research technique. Sociologists in the past have looked at different social classes in relation to education (Halsey et al., 1956), family structure (Young and Willmott, 1960), social mobility (Glass 1954; Goldthorpe and Lockwood, 1963) - to name but a few examples. Anthropologists on the other hand, have



used the comparative method to examine the universality of certain phenomena, as Mair (1972) says, they are looking for "regularities independent of time or place" (p.49). In this tradition, Ford (1964) conducted a comparative study of human reproduction in sixty-four "primitive societies", while Murdoch classified one hundred and seventy five societies according to hunting and gathering (see Gough, 1975).

The comparative method is distinct from those social anthropological works which look at the society in its totality. These studies are usually small-scale, in-depth studies which use participant observation as the main means of data collection. It would have been possible to conduct an in-depth study of pregnant Asian women, but this would not have satisfied the researcher's initial question which was to examine how Asian women fared in comparison with indigenous women. An in-depth, participant observation study is best suited to a detailed analysis of one particular social group (cf. Saifullah Khan 1974) and it is difficult to use this methodology outside the home environment of the social group. It is therefore easier to study an ethnic minority group within its own community rather than in an institutional setting such as a hospital.

#### KNOWLEDGE OF POPULATION TO BE STUDIED

At the outset, the researcher was familiar with literature on the problems facing Asian migrants to Britain (for example,

immigration policy, Rose 1969; Jones 1970; housing, Rex and Moore 1967; education, Crishna 1975; employment, Lomas and Monck 1977, Islam 1976) but the researcher had no immediate knowledge of the Asian community.

It was essential that this theoretical knowledge of ethnic minority groups was supplemented with a practical insight into the Asian community in Coventry. To this end, the researcher involved herself with many of the community activities, visited the gurdwara (Sikh Temple), attended and participated in the English language teaching classes. Local informants introduced the researcher to many English-speaking women who had been pregnant and later the interpreter introduced non-English speaking women to the researcher. The informants used and the visits made are detailed in Appendix A together with details of relevant media (pages 1 - 9).

The information collected in the initial exploratory period necessitated a further study of secondary literature on traditional and folk medicine in India. These works were useful background knowledge and helped the researcher to make sense of some of the informal conversations. (This literature is summarised in chapter two).

As the researcher gained more knowledge of the Asian community, she became aware of the diversity among the population. Most of the Asian migrants to Coventry were from the northern area of India, the Punjab (about 75% of Asian migrants came from this area). These people are either Sikh or Hindu by

religion, but most of them are Sikh. According to a Report on Ethnic Minorities in Coventry, the Community Relations Council estimates that 67% of the total Asian community are Punjabi speaking Sikhs (1974, p.2). After partition in 1947 when northern India was divided into West Pakistan and India (the Punjab) many Muslims who had been residing in India returned to Pakistan. These people are now found amongst the migrants to Coventry and they constitute about 13% of the Asian population. Some of the Muslims speak Punjabi as well as Urdu because they or their parents at one time lived in northern India. Other Indian migrants are from Gujerat (about 15%) and a substantial number of Gujeratis have come to Britain via East Africa. The final group of migrants, about 5% of the Asian population, are Muslims from Bengal.

Given these differences among the Asian population, the researcher had to decide whether to draw a sample representative of the total Asian population, or to concentrate on one specific group, for example, Punjabi Sikhs. Without much knowledge of the implications of the differences (for example, the importance of religion, language, caste, area of origin, rural or urban background) it was difficult to select which variables were most significant and which should be controlled for. Moreover, the researcher was attempting to isolate the factors<sup>which</sup> had a bearing on the way the woman viewed her pregnancy. Conversations with the clinic staff illustrated that they did not view the differences

in religion, area of origin and so forth, as significant and tended to treat all Asian women the same. As the clinic staff were not differentiating between the Asian women it seemed important to select samples from the clinic which were representative of the total Asian and British clinic population. The problem with this approach is that small sub-samples of, say, Muslim women are obtained and it would be dangerous to make generalisations about these women from a sub-sample of four (the number attained in this study). On the other hand, the researcher did not want to attach too much importance to religion without being fully aware of the extent to which it is an important factor. When the data was analysed it became clear that religion on its own was not an important factor, but combined with rural background it was. Therefore, Muslim women from rural villages were amongst the most "traditional" of women interviewed, while a Muslim woman who had an urban background and college education was one of the least "traditional" women. To avoid attaching too much importance to unknown variables, the samples were only controlled for by place of origin (Asia or Britain) and parity (the details about the samples in chapter 4 show how representative of the total clinic population the samples were).

An advantage of studying women of various social and cultural backgrounds is that the similarities between the women become more apparent, whereas a study of two specific groups of women, for example, Punjabi Sikh and British working class would tend to make the differences between the two groups of women more

marked. Conversely, a more in-depth study of one group could have provided an analysis of the meaning of the pregnancy to the woman, in terms of an explanation of their concepts of the body and the effects on the body due to certain forms of treatment. These elements are missing from the research and it is one of the limitations of using the comparative method. On the other hand, for the researcher to understand in depth the meaning of certain phenomena to a specific group of people she would need to be familiar with all aspects of their culture and moreover would need to speak the language. As the initial impetus for the research was an understanding of the way women used the maternal health service and who they consulted if they had any worries, a detailed analysis of belief systems did not seem immediately relevant. However, to interview non-English speaking people did present certain problems and it is worth discussing them in some detail.

#### INTERVIEWING NON-ENGLISH SPEAKING PEOPLE

##### Extent of the problem

To judge the extent of the language problem the Community Relations Office (now Commission for Racial Equality) in Coventry was consulted. They provided information of a Planning department study which showed that 12% of households studied in the Asian area contained at least one person with "little or no English" (Foleshill District Plan 1977). Moreover, this study found that

59.5% of Asian women do not speak English and most of these women were in the age-range 25-54 years (i.e. largely the childbearing years). (Section 2:3 of study). (The extent to which the Asian women in this study did not speak English is detailed in chapter 4).

To date there has been little written on the language problems facing research workers studying non-English speaking people in Britain. Phillips (1960) looks at the problems of using interpreters and informants in anthropological field-work; while the work of Dodge (1969) recognises that "the main difficulty in dealing with immigrant communities will be found in the language barrier" (p.149). The lack of information on interviewing non-English speaking people led the researcher to turn to social anthropological studies to see if the way they approached the language problem was relevant to the research in hand.

#### The social anthropological approach

Social anthropologists almost unanimously argue that field-workers should learn the language of the people under study. Bohannan (1954) for instance, argues that to fully understand a culture one must understand the language, and from this learn the distinctions people make between concepts. Hoebel and Frost (1976) recognise that anthropologists who learn the language become aware of "new avenues of perception". Language to them

"not only underlies culture but offers a series of ways of penetrating culture and cultures." (p.363).

For anthropologists the emphasis is thus on learning the language. In the British tradition Malinowski has been an important figure, though as Henson (1974) says, he "was not the first anthropologist to base his theories on ethnographic research which he himself had carried out in the field, nor was he the first to employ the local language during his research." (p.40). However, the task of learning the native language was not a difficult one for Malinowski, he "naturally acquired a thorough knowledge of the language" (1922, p.vii) and considered that "language is the ethnographer's most important tool" (1935, cf. Henson, 1974, p.58). Likewise Elkin (1941) sees language as just as:

"integral, formative and expressive an element in a culture as the social organisation, religion or economics with which it is interrelated" (p.89)

Although learning the language is seen as all important and interpreters should be avoided at all costs (Malinowski 1922; Westermarck 1936) very few studies contain any information about how the language is learnt. It appears that for many field-workers they are plunged into the native society and faced with a "sink or swim" situation. Not all anthropologists are able to "naturally acquire" languages as easily as Malinowski, for instance it took Beals (1970) two years to be able to converse, and Henson (1974) says that in order for the anthropologist to gain any benefit from learning the language he/she would:

"have to know it better than any ordinary member of the community under observation, because he would have to know all the different social, occupational and geographical varieties of the language. If one could even begin to assess how long this would take, also taking into consideration the extent to which the language differed from that of the anthropologist, one would have to allow at least three years for nothing but learning the language" (p.94)

In instances where the anthropologist does not have a full grasp of the language of the population under study, she/he may use informants to help with data collection. Many traditional anthropologists question the use of informants as a valid means of collecting data, although most anthropologists do use informants at some stage of their research. The criticism levelled against informants is that they are often unreliable sources of information, though this is seen to largely depend on their personal qualities:

"The personal qualities of the informant, his intelligence and character, are equally relevant to his usefulness and reliability.....The native informant may tend to overstate the case, stressing similarities or differences which are not really to be found, in order to prove that his culture is the same as that of the anthropologist, or of another tribe, or that it is fundamentally different from these." (Nadel 1961, p.321)

Informant unreliability is one of the reasons anthropologists in the past have been adamant it is essential to learn the language. As Henson (1974) says "in the introduction to every monograph it became obligatory to state one's linguistic achievements, in order to prove that the material in the rest of the book was trustworthy" (p.91) However, careful choice of informant can to a large extent eliminate potential mistakes, and it is possible to check the information given by using several informants. In some cases the



careful selection of informants can save the field-worker much time and prove to be invaluable sources not only of collecting information, but also of verifying the data obtained.

Nadel (1961) has argued it is possible to administer a questionnaire using trained informants (p.324) and this has been done in the past where the questionnaire consists of either pre-coded questions or "closed" questions. The informant cannot be legitimately used where the questions are phrased in such a way that they lead to some form of unstructured interview. There is also a danger as Nadel points out "that the informant may too readily adopt the investigator's point of view and categories, or what he believes these to be." (p.321) Informants are often leaders in the community and not necessarily representative of the rest of the group. As Whyte (1960) says:

"Special informants are frequently found at key positions in the communication structure, often as formal or informal leaders in the organisation". (p.365)

However, the reliability of the informant can be checked and Whyte advocates comparing "an informant's account with accounts given by other informants" (p.363) and cross-checking the accounts by discrepancies.

Whyte tends to place more importance on the use of informants than other social anthropologists and this is perhaps because his study was of an English-speaking group, which he called the "street corner society" (1973). As Whyte did not know much about this sub-culture he was dependent on informants as an introduction into the group and also as a basic source of information. The aim of

Whyte in his study was to become one of the group and to be accepted as such by the group. The technique employed, participant observation, is widely used by anthropologists though it is to be questioned whether researchers are ever fully accepted by the researched.

The differences, cultural, social and racial, between the anthropologist and the population under study tend to bar the full acceptance of the stranger to the native group - there is probably a tolerance of the researcher which may to some extent depend on what they can offer to the group. In many instances anthropologists have been tolerated because they possess superior skills which are of benefit to the people being studied. It is not insignificant that much ethnographic work has been conducted by doctors cum anthropologists, for example, Maclean (1971) in Nigeria; Gordon, Gideon and Wyon (1965; 1971) in the Punjab.

In terms of this study, the researcher did not have any particular skills to offer to the women being studied, nor was it feasible to become a participant observer. My domestic commitments did not permit me to live among the Asian community "au naturel", and furthermore given that the study is a comparative one, this behaviour would raise certain methodological questions. For example, should I spend a similar period of time living in a British community I was not so familiar with? It was possible and in fact highly likely that I was going to encounter British women whose ways I was not totally "au fait" with. Moreover, there are certain basic problems involved in the use of participant observation as a research technique among ethnic groups and these can be related to the anthropological tradition.

Methods used to solve the language problem

The first contacts with non-English speaking Asian women were made through bilingual informants. These informants were carefully selected and were contacted through community workers. Women who were introduced informally, often as friends or neighbours of Asian informants, were very important to the research as they tended to present the rural (often uneducated) woman's point of view, which counteracted the picture portrayed by the Asian women prominent in the community hierarchy. It was crucial that women were contacted informally, rather than through the official channels to avoid falling into the trap of being dependent on informants selected by partisan individuals.<sup>1</sup>

The variety of opinions presented by these informants gave a comprehensive picture of what the Asian women themselves thought. Occasionally in an English Language class or in a woman's home, a woman with a reasonable working knowledge of English would translate for those unable to express themselves. Some of the best sources of background information into women's attitudes to childbirth, both in this country and in the Punjab, were the informal meetings held in women's homes or the English Language class. In the company of other women some of the less articulate lost their shyness and contributed to the discussion in their own language. What had been said was then translated to the researcher by one of the English-speaking women.

<sup>1</sup> Many anthropologists in the past have been dependent on informants selected for them. For example, Henry (1940) says "Generally missionaries or government officials will be kind enough to direct the ethnologist to a good informant." (p.633).

The shyness of Indian women in talking about pregnancy and childbirth led me to exclude men as informants as far as possible. Therefore, when a worker in the Community Relations Office suggested some of the Indian political organisations might be of assistance, this lead was not followed up. These organisations tend to be male dominated and it did not seem appropriate to study pregnancy through men's eyes. Later on in the research, informal contact was made with Asian males (usually husbands of informants) and political matters, for example, the women's sweat shop strike were discussed along with general conversations about life in India or the problems encountered by Asian migrants to Britain. The husbands of key informants were particularly helpful, and the different behaviour of a woman in her husband's presence was illuminating.

Before the formal interviewing of women in the sample took place there had been numerous informal conversations which provided an insight into Asian culture and also indicated the type of question it was permissible to ask Asian women. In terms of designing the questionnaire, equal attention was paid to acceptability of the questions to the British sample. Therefore, the advice of Blanc (1956) was heeded:

"Relevant information on the cultures concerned ought to be on hand before building the questionnaire".  
(p.209)

Choosing an interpreter .

The research was designed so that comparable data would be obtained from all the women interviewed. The methodology of the study, combining informal and formal techniques, aimed to control for bias as far as possible. Therefore, it was recognised that the introduction of an interpreter to the study was a possible source of distortion and certain measures were taken to minimise this.

Careful selection of the interpreter is the first step towards eliminating bias. An example of a study where this is not done, is Candlin's study (1969-70) of Asian ante-natal patients in Lancaster. She uses a male interpreter who was a mature student of her husband. The use of a male interpreter in a study of pregnancy is highly problematic and the limitations are revealed in the research. It transpires that most of the questions resemble those asked by hospital staff when booking patients for hospital confinement. Candlin's study thus tends to be limited by dependence on existing medical data and the responses are confined to those acceptable for an Asian woman to disclose to an Asian male interpreter. However, the study was more concerned with communication between Asian patients and hospital staff than with pregnancy per se and from this point of view some of the recommendations are valid.

Other health care workers (Candlin was a Health Visitor) have recognised the benefits to be gained from using interpreters.

For instance, Dodge (1969) refers to the use of interpreters in a V.D. clinic:

"An interpreter must have some knowledge of what the contact tracing procedure involves, a basic knowledge of the technical terms involved so that the translation will be meaningful in both directions. The interpreter must also have the right personality, and must practice the 'professional' secrecy which is so vital. The selection of the right person must therefore be approached with great care; the ability to speak the languages required being only one of the qualifications." (p.149)

This example defines what the "right" characteristics are from a medical point of view and they therefore differ from my criteria of what constitutes a "good" interpreter. What Dodge's study does show is some of the benefits to be gained from having an interpreter, provided the interpreter has the "right personality". However there is no advice given on the qualities one should look for and avoid. Before actively selecting an interpreter it was necessary to draw up a list of the criteria needed and the possible hazards involved in choosing an interpreter. The problem areas can be listed as follows:

- a) the interpreter may have originated from a different geographical area in Asia than the respondent and may not speak the same language;
- b) differences in religion should be remembered, this particularly applies where Muslim women are concerned as they tend to be more secluded from the rest of society;
- c) the interpreter may be of a higher caste or class than the respondents and this may lead to lack of communication

between the two women and distort the information obtained. The lower caste woman may be reluctant to discuss certain issues with a woman of higher caste;

- d) the interpreter may have resided for a longer period of time in this country than the respondents and therefore may be more "integrated" into British society, for example, dress, behaviour;
- e) in some cases the interpreter may be protective towards the Asian community and therefore alter the wording of the questions to save embarrassment to the respondent;
- f) the interpreter may be eager to impress the researcher with the standards of the Asian community and may therefore alter the responses to fit in with their pre-conceptions of what they think the researcher wants to find out.

Taking these hazards into account it was possible to think positively about the criteria for selecting an interpreter and draw up a list of essential qualities:-

- 1) the interpreter should be female, married and have children;
- 2) she would need Punjabi as her native tongue, but also be able to speak Hindu, Urdu and Gujerati;

- 3) she should be fluent in English so that communication between herself and the researcher is unproblematic;
- 4) she should have the ability to converse readily with other women, for example, some of the women would be more "traditional" than others. Also as some of the questions are of a sensitive nature she should be prepared to ask them and not be too embarrassed herself;
- 5) it is essential that the interpreter wears traditional dress when interviewing - either a sari or salwar kameez (pyjama-type trousers and tunic top). This would make her more acceptable to the respondents;
- 6) it must be possible for the researcher to brief the interpreter on the purpose of the research. To be able to explain that women's opinions are needed, and the researcher is interested in all aspects of Asian culture, especially as it relates to general health and pregnancy in particular. (It was important for me as a researcher to stress that Asian culture was not seen as strange and incomprehensible, but as interesting and illuminating, giving a valuable insight into a different life style);
- 7) the interpreter needed to be unemployed, or only working part-time, as the interviews in the clinic would take place in the afternoons. The home interviews would be at times suitable to the respondent, so they could be at any time of the day.



These conditions severely limited the choice of interpreter and I was reluctant to go through formal channels, for example, the employment exchange, to search for one. Thus the researcher became closely involved with Asian women, hoping that a potential interpreter would turn up. There were several offers of help from Asian women, but these came from women who were already employed in community work, and although some of them could have been given absence from work for the period of interviewing they were unsuitable for other reasons. For instance, one woman who offered her services and who initially appeared to be a likely candidate turned out to be unsatisfactory on further questioning. Her initial attractions were that she spoke fluent English and it was very easy for me to communicate with her; she had past nursing experience and had in fact started her midwifery training - therefore she knew something about the subject under study. However, it later transpired she was a Kenyan Asian and came from a high class family; she was married to an Englishman; wore "western" dress, i.e. tight fitting clothes; and her nursing training, far from making her more sympathetic to the needs of Asian women, tended to align her with the medical profession. Finally, and perhaps most important of all, this woman was childless (and wanted to remain so). This may have led to some respondents being reluctant to talk about pregnancy and childbirth to a woman with no experience of her own. Despite the unsuitableness of this person as an interpreter, she was a useful informant and helped to crystallise the qualities needed in an interpreter.

Visits were made to English language classes for Asian women, to the gurdwara (Sikh temple) and to women's homes. After about two months a suitable interpreter was found. This period of time was also used for drawing up an initial draft of the questionnaire and for applying for funds to pay the interpreter, so no time was lost). The person who was eventually employed as interpreter spoke four Asian languages and had been involved in voluntary work at her local school. She helped run the play-group which her youngest daughter attended and also interpreted for the school staff as and when needed. Any literature sent home to the Asian parents was translated by her and she was also trying to involve some of the mothers in the school's activities, for instance, she had started an Indian dance class at the school which also served to enlighten the staff about Punjabi culture. She was very warm and pleasant and popular with staff and parents alike, and because of her contact with the school she knew most of the Asian people in the area and introduced me to many of them. She had given birth to three children in Britain and therefore had first hand experience of pregnancy and childbirth in a foreign country. By birth she was a member of the Jat caste (Sikh landowners) which was the largest caste group in the study (see pages 209). Despite her belonging to the Jat caste she attended the gurdwara (temple) for the Ramgarhia caste (skilled artisans) and her caste position did not visibly affect her relationship with lower caste women.

The decision was made to employ her as an interpreter. Over the following months we worked together closely agreeing on the

acceptability of the questionnaire to Asian women and finally translating it into Punjabi. An original draft of the questionnaire was tried out upon a group of women at an English language class. At the same time, pregnant or previously pregnant British friends were subjected to "mock" interviews.

#### Translation problems

The intention was that the questionnaire administered to the British and Asian sample should be the same. This posed certain problems in terms of the words used and the meaning of these words in a cross-cultural context. For example, in Punjabi there are three possible translations for the word "pregnancy";<sup>1</sup> Umidwari is used by rural people and means "to carry a baby"; Garbhwati meaning "a lady" (wati) who "is expecting" (garbh) and Bacha Hon Vala meaning "becoming with child" are terms used by more educated urban people. The question arose as to which translation we should use in the questionnaire. After some discussion it was decided that Umidwari was the most appropriate as most of the women to be interviewed would originate from the rural areas. If a highly educated woman was interviewed it would be possible to interchange the words and use the term most appropriate to her.

---

<sup>1</sup>Also in English there are several terms used for pregnancy - "to be expecting", "to carry", "to have a bun in the oven", are a few of the variations.

Another observation was that some words relating to pregnancy and childbirth are referred to by Asian women in their English form. An explanation for this is that Asian women do not talk freely about matters relating to sexuality and it is possible to save them some embarrassment by referring to the English equivalent, for example, "relations with husband", "monthlies" or periods, miscarriage. There are other words which we have in the English language which do not have an equivalent in Punjabi. These differences are cultural - for instance in Indian languages the words "please" and "thank you" are used only for special favours. In certain instances this has led English people to think that Asians are rude, the case of a woman in hospital was quoted who said to the nurse "Give me some water" and the nurse was very offended at being spoken to in this demanding manner (see also Wilson 1978, p.151). Therefore, the interpreter and researcher had some lengthy sessions discussing the meaning of the questions in English and the appropriate translation in Punjabi.

After translating the questionnaire it was checked by another Punjabi woman (an undergraduate sociologist) to see if it read fluently. Then the questionnaire was translated back into English to check that the original content was the same. This technique is referred to by Phillips (1960) as "back translating" (p.302).

Problems encountered when using an interpreter

Although most of the problems encountered were anticipated and compensated for, there were one or two minor frustrations when using the interpreter in the clinic setting. Firstly, it transpired the interpreter knew many of the women attending the clinic and therefore the interview was not the ten to fifteen minute encounter anticipated. It was often frustrating to watch the interpreter and respondent enter into a lengthy dialogue which could not be understood, and which did not appear to be associated with the questionnaire because it was not being referred to. At the end of the interview it would transpire that the two women knew each other from years ago, or were vaguely related. It was therefore obligatory for the interpreter to observe the traditional Asian social convention of inquiring after family members. Most of the Asian population in Coventry live within a well-defined area and many of these people come from the same villages in India, it was therefore inevitable that the interpreter would meet people she knew. In the British sample only one person was known to the researcher and she came from the University.

Another unanticipated consequence of using an interpreter in the hospital clinic was that the hospital staff became aware of how useful it was to have a multi-lingual person around. And although Dodge (1969) says "there is much more to communication than hiring an interpreter" it was apparent from my observations that the hospital staff really experienced difficulty in trying to

communicate with the Asian patients. The Asian women also were often unable to communicate fully with the staff. The inability of the staff to communicate essential facts to Asian patients was highlighted by the research interpreter being asked on numerous occasions to interpret for them. The first request came from the consultant via the midwife in charge, the patient was unable to speak English and communication between consultant and patient was thus impossible. In another instance the midwife was unable to explain to an Asian women that she was to be admitted to hospital as she was expecting twins and was anaemic. A further woman who had been interviewed the previous week approached us at her next clinic visit because she could not understand what the staff were saying to her. They were concerned that the baby was small-for-dates and they wanted her to go to the Maternity hospital and have an ultra-sonic scan; without the interpreter the staff were unable to explain these facts to the women.

Towards the end of our period of interviewing in the clinic, the interpreter was asked if she would work there on a voluntary basis. This offer was declined by the interpreter as she had been engaged in voluntary work for some years and was now looking for paid employment. This example is interesting because it shows how our presence in the clinic gave the staff a taste of what changes could be made and the advantages to be gained from having an interpreter.

This discussion of how the language problem was dealt with has preceded the more detailed account of the research process. The reason for this is that the language problem was recognised in the early stages of the research and its outcome affected the subsequent methodology. In the absence of a suitable interpreter the research would certainly have followed a difficult course. The remaining methodological issues are as follows.

#### POPULATION STUDIED

The population studied was pregnant women in Coventry at their first attendance at the consultant ante-natal clinic. This population differs from the total population of all pregnant women in Coventry, for it excludes those women who 1) conceal their pregnancy; 2) do not keep their hospital ante-natal appointments; 3) have a home delivery; 4) are booked for delivery in the GP Unit. Although these four categories of pregnant women are excluded from the sample, it is possible to find out various facts about them; for instance, about 70% of all births are booked in the consultant unit (Regional Health Authority Statistics, 1976-1979, Table I ) yet about 80% of all babies are delivered in the consultant unit (Coventry Maternity Hospital Statistics 1966-1976). In 1976 there were only 40 home births in the city of Coventry and this number is still decreasing.

The women who receive consultant care are more likely to be medically defined as "at risk" than those booked in the GP Unit. They are also less likely to have a GP who uses the GP Unit, for instance, the GP may not be on the Obstetrics List. (In 1977 out of 159 GP's, 146 were on the Obstetric List, despite this only about 40 GP's used the GP Unit on a regular basis). The criteria for defining a pregnant woman as medically "at risk" in Coventry, are as follows:

- 1) primiparae, and either under sixteen or over twenty-eight years old;
- 2) over age thirty-five, any parity;
- 3) the woman's fourth or subsequent pregnancy;
- 4) women of small stature, i.e. under five foot tall;
- 5) to have a medical history which indicates complications of pregnancy;
- 6) to have had a complication in a previous pregnancy, for example, Caesarian section or difficult vaginal delivery;
- 7) to be expecting twins (or a multiple birth anticipated).

The women in this research were in medical terms more likely to be "at risk" than those omitted from the sample who were receiving GP care.

Women attending the consultant clinic also visited their GP through a system of "shared" care. This meant the women had experiences of GP and consultant care in this pregnancy.

Women who were not born in either the British Isles or Asia were excluded from the study. This was done to make the comparison between the two groups much clearer.



PRELIMINARY STUDY

A preliminary period of time was spent in the consultant clinic looking at the attendance records. Before a final sample size could be determined it was necessary to know how many Asian and British women passed through the clinic on a daily, monthly and annual basis. The daily lists showed the number of "new" cases, i.e. first-time attenders; the number of "old" cases and the number of "emergency" cases, i.e. those with no appointment. It was only possible to find out the number of Asian women by surname, the lists being recorded by name. (The monthly statistics were in number form only). A sample of Asian women was drawn from the daily list and their hospital records looked at to see if they in any significant way varied from the other attenders. This practice was essential as it indicated the length of time it would take to draw up a sample (it also showed that it would not be possible to concentrate solely on primigravidae as this sample would take months to draw up).

Also as the records were held at the clinic for the women attending that day it enabled me to familiarise myself with the staff and surroundings. The organisation of the clinic was noted and informal talks held with some members of the staff (see chapter 8 on clinic organisation and chapter 9 for details of the division of labour amongst the staff). The details contained in the hospital records are outlined in Appendix A, (p.x-xiii).

DRAWING UP THE SAMPLE

It took five weeks to draw a total sample of ninety Asian and British women. The number of first-time attenders at any clinic session varied from four to fifteen (the larger numbers tending to be on a Tuesday when there were two consultants in attendance). The number of Asian first-time attenders in an afternoon varied between none and five and it was possible to isolate them from the other women by their surname. Given the small numbers of Asian women attending it was feasible to interview all of these women (with the aid of the interpreter) together with a comparable number of British women (also chosen by surname). In busy clinic sessions, the primiparae were selected (using the hospital records) and these women were all interviewed. A comparable number of British women from all of those attending the clinic at that session were selected by the time of their appointment. For example, three or four women would be given appointments for the same time at fifteen minute intervals - (block-booking) the woman whose name appeared at the top of the list for each of the quarterly hour periods was selected and if her surname did not sound British the next name down the list would be taken using the same criteria.

To choose the sample in this manner the full co-operation of the clinic staff was needed. Firstly, the help of the receptionists was essential in granting access to the daily attendance lists from which the women were selected for interview. It was also necessary to look at the hospital records to see how

many of the women attending the clinic were first pregnancies (as the women's obstetric histories had not been taken at this stage, this was done by looking through the notes for any mention of a previous pregnancy). Having selected which women were to be interviewed their records were marked to indicate to the clinic staff that they were part of the sample and needed to be interviewed after they had been "booked-in". The Sister-in-Charge assisted in this by bringing the women to be interviewed.

Determining a persons' nationality (particularly a woman's) by their surname is problematic. This was highlighted in the clinic when a woman with a British-sounding surname was selected for the sample, but at the time of the interview it was discovered she was married to a British man yet had not been born in Britain herself. In this case the woman was excluded from the sample as her attitude towards pregnancy and childbirth might be significantly different from the rest of the women in the British sample and thus blurr any distinctions between the two samples under study. Likewise with the Asian sample it was not always possible to judge a woman's country of origin by her surname, and several women were excluded from the sample because they had Muslim surnames but did not originate from India or Pakistan. Moreover the Sister-in-Charge seemed to equate being "coloured" with coming from Asia and some women were brought to us for interview who were not Asian.

At the end of five weeks, ninety women had been interviewed, there being equal numbers of Asian and British women in each sample. Out of this initial sample it was intended to obtain a

final sample of fifty-two women (evenly divided between Asian and British women) was considered appropriate in view of the allocated time. The larger first sample was drawn to account for women who may later refuse to be re-interviewed, those who miscarried or had a still birth before they were eight months pregnant (the time they were to be re-interviewed), and those who moved or were untraceable at the time of the second interview.

#### QUESTIONNAIRE DESIGN

The women in the sample were to be interviewed twice in order to obtain all the information needed, and also to establish a relationship with the women for the second interview. The original intention was to interview the women at the consultant clinic at their first attendance (using a formal structured questionnaire) and then to interview the women in their own home at eight months pregnant (this interview would be in-depth and less rigidly structured).

The questions to be asked at each interview were divided into two - those that could be asked in the clinic setting, using a questionnaire, i.e. mainly factual questions relating to the woman's pregnancy experience at her first clinic attendance; and secondly, those requiring more time and covering the whole of the pregnancy. Most of the questions to be included in the questionnaire were situational, i.e. relating to the hospital ante-natal clinic, and the woman's experiences of the clinic on that particular occasion. It was hoped to determine how much knowledge the women had of pregnancy and ante-natal care at the

beginning of their pregnancy and where they had obtained this knowledge from. As the women were going to be interviewed later there seemed to be a case for keeping the questionnaire as short as possible in order not to offend the respondents and deter them from agreeing to be interviewed again. As Moser and Kalton (1972) say:

"Lengthy, rambling questionnaires are as demoralising for the interviewer as for the respondent, and the questionnaire should be no longer than absolutely necessary for the purposes." (p.309)

Time was also an important constraint because the interviews were to be held in the ante-natal clinic where the women would wait on average two hours at their first visit. They might not therefore have welcomed having to answer a questionnaire on top of their "official" visit. Initially it was thought all the questions would be asked after the women had been through all the clinic procedures, i.e. booking, weighing, having blood pressure taken, seeing the doctor and so forth. However, given the women had a lengthy wait after being "booked" and before seeing the doctor, it seemed a good idea to use this time period to interview them. The time problem was solved by dividing the questionnaire into two parts; the first part to be asked while the woman was waiting to be seen by the doctor, these questions related to the woman's knowledge of pregnancy, GP visits and previous pregnancies; and the second shorter part, referring to what had actually happened at the clinic on that day, to be asked after the woman had seen the doctor and just before she left the clinic.

Access to the women's hospital records<sup>1</sup> meant it was possible to avoid duplicating questions asked when the woman "booked" her hospital bed. In the first interview there was no need to ask the woman personal details, for example, marital status, occupation, which would already have been asked that day and which the woman may find embarrassing, or even impertinent.

The problems of time constraint and format of the questionnaire could have been overcome by sending a postal questionnaire to a sample of ante-natal clinic attenders. But by doing this a very biased sample would result, only those able to write (and read) and being sufficiently motivated replying. Moreover, postal questionnaires have a notoriously high non-response rate, Shipman (1972) places it at 70%, and it would thus take a long time to draw up the initial sample. Additionally, it was hoped that the first interviews in the clinic would enable me to introduce myself to the women while at the same time combining the interviewing with observation of what went on in the clinic.

Conducting interviews in the clinic meant it was necessary to take account of the extent to which the environment may have affected the answers given. This was an important factor to be remembered when designing the questionnaire and it was necessary to stress to the women that I was not in any way associated with the clinic. Questions the women may have felt inhibited answering in the clinic were omitted from the questionnaire and asked at the later "home" visit. This procedure effectively

---

<sup>1</sup>The accuracy of the hospital records is discussed in Appendix A (p 11).

avoided the problems faced by Fairhurst and Lightup (1979) in their research into the climateric. These researchers did not recognise the "sensitive" nature of their research and initially approached their sample by letter. They were then very surprised when they had a very high non-response rate.

The questionnaire was also designed with a view to analysing the data obtained by hand rather than using a computer programme. (See Appendix A, p.14) Although the women's actual responses were wanted, some of the answers could be anticipated and where this was the case a selection of possible answers were listed (with provision for alternatives) in an attempt to cut down on the completion time. The anticipated answers were selected from the most popular responses given in the pilot study.

In this study a draft questionnaire was used to judge the acceptability of the content of the questions; the appropriateness of the vocabulary used for all respondents; and the comprehensibility of the questions and the responses they evoked. Through this procedure leading questions and ambiguous words, or words that the women did not understand, were eradicated from the questionnaire. The particular problems with the Asian translations and the need for cross-checking have already been discussed.

The aim of the questionnaire was that it would be understood by all women and for this reason technical jargon was avoided as far as possible, and only words which the women would have encountered beforehand in everyday life were used. Moser and Kalton (1972) also make this point when they say "With surveys of the general population, the first principles in wording are that the questions should use the simplest words that will convey the exact meaning, and that the phrasing should be as simple and as informal as possible." (p.223) Certain words have a variety of meanings to different people and it is necessary to spell out exactly what is meant, for example, the question "Have you read any books on pregnancy and ante-natal care?" does not account for the fact that the word "book" means different things to certain people. It can mean anything written to some people, whereas it has to have a hard-back cover for others. There thus needs to be a distinction made between leaflets, magazines, and text books.

Easier administration of the questionnaire was facilitated by dividing it into sections so that unnecessary questions were not asked. For example, questions about previous pregnancies were situated at the beginning of the questionnaire where they could be easily avoided if the woman had not been pregnant before. Also the Asian women were asked about their knowledge of the English language and these questions were only put in the Asian translations.



At the end of the interview the women were given a letter thanking them for their co-operation and re-affirming the second interview in their own home at eight months pregnant. Also the women were asked to keep a note of the number of ante-natal appointments they had kept between the first and second interview (copy of letter in Appendix A). These appointments were also noted on their records.

#### RESPONSE RATE

The response rate in the clinic was extremely high and no-one refused to answer the first part of the interview schedule, possibly because they associated the interview in some way with the clinic as they were introduced to me by the Sister-in-Charge. Once the Sister had left, the women were clearly told that the research was not associated with the hospital, but by this time they may have felt it impolite to refuse. However not all of the women returned for the last part of the questionnaire.

On the second day of interviewing two of the women did not return to answer the last part of the questionnaire. The women's name, address and telephone number (if there was one) was recorded on the interview schedule and it was therefore possible to contact these women at home and determine their explanation for not completing the interview. One of the women was contactable by telephone and was most apologetic for not returning - she had to collect her child from school and had been at the clinic for two and a half hours and could not wait any longer.

However, she did agree to answer the rest of the questions over the telephone and confirmed she was still willing to participate in the study. The other woman was not on the telephone so the last part of the questionnaire was sent to her through the post with a stamped addressed envelope. A few days later this was returned duly completed with apologies for having forgotten to complete the interview at the clinic. This procedure was followed for all the women who did not complete their interview and eventually all interview schedules (bar one) were completed.

To guard against women leaving the clinic without completing the last part of the questionnaire, the receptionist's help was enlisted. As every woman left the clinic they needed to make their next appointment with the receptionist. By informing the receptionists of the women included in the study they were able to check if these women had returned for the final part of the questionnaire before leaving the clinic. However, if the woman did not want to be re-interviewed there was nothing anyone could do.

Over the course of interviewing three women out of ninety refused to be re-interviewed and also did not want to be interviewed in their own home later on.

#### EXCLUDED FROM FINAL SAMPLE

A further nine Asian and British women were excluded from the final sample because they did not fulfil the criteria previously stated. Four British and two Asian women actually lived outside the city boundary. As the study relates to ante-natal care in Coventry and is concerned with the information and "care" women

receive from their GPs and local Parentcraft class, it is important to confine the sample to those women residing in Coventry and having a GP within the city boundary. The women who came to the consultant clinic from outside the city were those with particularly bad obstetric records.

The other British woman who was excluded had been booked for a home birth but developed slight oedema at term and was referred to the clinic by her GP to confirm she could still have a home delivery.

Out of the Asian sample, one woman was not followed up as she was transferred to another hospital for her ante-natal care, this hospital being easier to travel to from where she lived. Another woman had recently moved to Coventry and was only three weeks away from her expected delivery date, and there was no time to re-interview her at home.

Non-attenders at the clinic or DNA's (Do Not Attend)

Women who concealed their pregnancy and those who failed to keep their hospital appointments were excluded from the sample. During the period of interviewing twenty-three out of about one hundred and fifty Asian and British women did not keep their hospital appointment (this refers solely to first-time attenders). It was possible to determine the non-attenders by checking the attendance list at the end of the clinic. Every woman given an appointment has her hospital records sent to the clinic for completion at her ante-natal visit. If she does not attend, her records remain with the receptionist at the end of

the day. These records contain the woman's full name and address, so it was possible to write to the women and find out why they failed to keep their clinic appointment. The clinic staff did not send reminders to first-time attenders who failed to keep appointments. The reason for this is that the woman may have miscarried and be upset by receiving notification of another ante-natal appointment. Women who have already attended the clinic once and fail to turn up for future appointments are automatically sent another appointment from the clinic and if they fail to attend this the community midwife is notified and requested to visit them.

Since one of the reasons why first-time attenders do not keep their appointment, is that they have miscarried, it was necessary to word the letter carefully so it was not offensive. This was done by pre-selecting most of the possible reasons for non-attendance, leaving a space for other reasons not included. All the woman had to do then was tick the appropriate answer or add her own reply. A stamped addressed envelope was included to facilitate return. The letters sent to Asian women were translated into the appropriate language. Despite these measures only nine replies were received from the twenty-two letters sent. One woman telephoned the clinic to change her appointment date, so no letter was sent to her.

Of the twenty-three DNA's, seven of them were Asian, and out of the sixteen in the British sample, seven of them replied; two of the seven Asians replied. The responses given to the letter and a copy of the letter sent are detailed in Appendix A p. 27-29.

### Concealed Pregnancies

The only way to find out about concealed pregnancies is retrospectively, i.e. after the birth. The hospital records show the total number of hospital ante-natal attendances a woman has kept and therefore indicates which women have not received any ante-natal care at all; these women being emergency booked at time of labour or the baby being born before arrival at the hospital (BBA). By going through all the hospital records of women who delivered in a one month period, i.e. about 350 records, it would be possible to determine the number of women who did not receive any ante-natal care at all. The records also show the country of birth, marital status, age and parity of the woman.

The Regional Health Authority statistics show that about 1% of births are not previously booked-in at the maternity hospital - these are the women who conceal their pregnancies and do not receive any ante-natal care at all. (Table I ).

Using the hospital records it would be possible to isolate the women who give birth without receiving any ante-natal care at all and see if they fare any worse (in terms of successful outcome of pregnancy) than the women who have had regular ante-natal care.

### IN-DEPTH INTERVIEWING

After the period spent in the ante-natal clinic drawing-up the sample and administering the questionnaire it was necessary to analyse the data obtained before conducting the second interviews.

This analysis was important as it helped to clarify which questions still needed to be asked. The second interviews were to be unstructured and therefore a check list was needed which was comprehensible to both the researcher and interpreter. Once the check list had been agreed upon by both of us it was pre-translated into Punjabi and checked by the same Punjabi student. The aim of the check list was that it could be referred to at the end of the interview to ensure all the questions had been asked, it was not intended as a rigid guide to question ordering. (See Appendix A, p.30 ).

Informal interview techniques were used for the second interview so that data could be obtained which was not readily accessible through the use of a formal questionnaire. This information related to the woman's own opinions and attitudes towards the hospital clinic and the other maternal health services they had experienced; it was also concerned with the women's attitudes towards their bodies and their pregnant condition. It was thus an area which needed careful handling and the formal structured techniques were therefore inappropriate. As Moser and Kalton (1972) say:

"Where the survey subject is highly complex or emotional, it may be that the greater flexibility of the informal approach succeeds better than set questions in getting to the heart of the respondent's opinion." (p.297)

Before re-interviewing the women, their hospital records were looked at again and details relating to the progress of their pregnancy noted. In particular the number of attendances and any non-attendances were noted, as were periods of hospitalisation. When the woman was interviewed again her answers

were checked against the hospital records.

The women were notified (either by letter or phone) the week before my anticipated visit. This meant all the women knew they were going to be interviewed and would be asked questions about their ante-natal care to date. In this way the women were prepared for me, which they were not at the first interview. Also some women saved up questions they wanted to ask about the organisation of ante-natal care, their entitlements and so forth. Some of them wanted more precise details of the research and the effect it might have on the maternal health services in Coventry. Thus, in the second interview there was more interaction and this can be related to the fact the interview was conducted in the woman's home and she was expecting the visit. However, the informal interviews did require more skill than the structured questionnaire; trying to keep a conversation flowing despite interruptions from children or visitors, is not always an easy task. Questions the women seem reluctant to answer were gently probed or tried in a different context later on, the flexibility of the informal approach permitting this. With the Asian women in particular, questions which were embarrassing for both the woman and the interpreter (for example, those about menstruation, where babies came from and so on) were managed by the interpreter saying she needed to ask these questions because the researcher (myself) did not know anything about the Asian way of life. Normally, questions of this nature would not be asked of a stranger and some of the women, especially the first-time pregnant women were very shy.

The presence of children and interruptions from visitors tended to disrupt the flow of the interview. Also the presence of other adults, for example, mothers, mothers-in-law, and husbands was sometimes inhibiting. However, it was not possible to exclude these people from the interview, particularly if the woman lived with her husband's family or if the husband was not at work at the time of the interview. Two Asian husbands sat through part of their wife's interviews and it may be significant they were both Gujarati, it is possible they were more wary of our visit than the Punjabi women who readily accepted us. Other husbands (or male partners in the case of some of the British sample) who were at home at the time of the interview made themselves scarce and sometimes were not even seen. Where the women were living in some-one else's household then it was likely the mother or mother-in-law would sit in on at least part of the interview. This applied to the British sample as well, and one mother listened in to the whole of her unmarried sixteen year old daughter's interview and towards the end could not resist adding her own contribution, recounting her own pregnancy and childbirth experiences. Visitors also sat through interviews, adding their comments over a cup of tea later. Some children were more demanding than others wanting their mother's attention, asking for drinks and toys!

All the women (apart from one who had been out when I first arranged to call) knew in advance of my visit and some of them had made arrangements for another person to look after the child/children



during the interview. If the woman was on the telephone she was more likely to arrange to be visited when no-one else was around; however, if she was contacted by letter then the time would be largely pre-determined by the researcher's (and interpreter's) other commitments, this might not be the most suitable time of day for the woman but none of the sample asked for an alternative date or time.

These are some of the problems encountered while conducting in-depth interviews in the respondent's home. None of these problems were insurmountable and the benefits to be gained from conducting the interviews on "home" territory where the woman is relaxed are many. To keep the relaxed and informal atmosphere of the interview it was imperative on my part that questions should be inoffensive to the respondent. Unstructured interviewing is more demanding for the interviewer, requiring her/him to recall what has previously been said and follow-up interesting leads. In-depth interviewing also raises the problem of how to record the data. It is not possible to write down verbatim what the respondent is saying and at the same time fully comprehend the content of what is being said. Also, by writing while someone is speaking one is unable to observe the expression on the respondent's face and any gesticulations. Additionally it is impossible to write down everything said and the tendency would be either to paraphrase or to omit comments which at that moment do not appear to be significant. However, it is not until all the data has been collected that any analysis

of what is significant can justifiably be made. For all these reasons there appeared to be no alternative but to use a tape-recorder and the usefulness of doing this is discussed below.

But before moving on, it must be said that the value of interviewing the women in their own homes cannot be underestimated. Observing the women in their own environment was a rich source of information and provided information about the women that did not come out in the questions. The clothes the women wore, particularly the Asian women, indicated much about their life-style. If an Asian women wore a sari or shalwar-kameez she was more likely to be "traditional" than a woman wearing western dress. An unmarried mum on Social Security is less likely to have maternity clothes than a married woman living on a new housing estate. These observations can be incorporated into the rest of the data to give a comprehensive picture of the woman and her social background.

Before consulting with the interpreter it had been intended to ask questions relating to the number of people in the household. However, the interpreter said that if these questions were asked many Asians would be upset by them and may refuse to complete the interview. The reason for this was that in the past there have been numerous accounts in the press of Asian households being overcrowded, and some households harbouring lodgers without declaring this to the local authority. With the recent hostility to the Asian community which has been re-emphasised by the National Front many Asian people feel insecure in this country and are

frightened by the prospects of deportation. Also with the British women, questions which were not, in their mind, directly related to pregnancy and ante-natal care were viewed with suspicion. This opinion was expressed by women when they remarked on the irrelevance of some of the questions asked by the clinic staff upon booking. For example, some women were upset at being asked whether or not they were married, and the occupation of their husband or partner. In fact most of this information was obtained from the second interview without directly asking questions. The size of the house and the number of rooms was determined by asking to use the toilet and thus gaining access to another part of the house other than the front room (where most interviews were conducted). The number of people in the house could be estimated by asking the woman questions about help with household tasks, whether or not her children were still living with her, and where her parents or parents-in-law live. The women in most instances referred to either their husband or partner spontaneously, what they objected to was the searching questions asked at the ante-natal clinic, particularly if they were not married. For instance, unmarried women were asked if they intend marrying the putative father, and if not they may be referred to the Medical Social Worker.

In the home situation, the marital status of the woman and whether or not she lives with any-one was determined by asking what assistance the woman received with domestic chores and childminding. Also in the woman's home the period before and

after the formal part of the interview was useful as it enabled the researcher to chat to the woman over a cup of tea or coffee. In these circumstances the interviewer has to be prepared to volunteer information about herself, where she lives, is she married, has she any children?, but it does establish some sort of reciprocity between interviewer and respondent and the interviewer is not seen in the context of some-one who is prying into the respondent's personal life. In the home situation the respondent may be more prepared to volunteer information about herself because she has the opportunity to ask questions of the researcher.

#### Using a Tape-recorder

The advantage of using a tape-recorder has already been alluded to, and it appears to be the most popular method of data collection used by social scientists employing the in-depth interview technique. Moser and Kalton (1972) recognise this when they say "In the less formal methods of interviewing, tape-recorders may be particularly useful for recording what the respondent has to say" (p.279). They advise the use of tape-recorders for open and intensive interviews "The interviewer is then free to concentrate on the interview" (p.281). But they also argue that the tape-recorder may also lower the response rate, particularly in "surveys on sensitive subjects". (p.281). In this particular study there was no refusal on the grounds of the tape-recorder being used, but there were several instances where we had to explain to the women the reasons for using the machine.

The only resistance to the tape-recorder came from Asian women. The first objection arose at the very first interview which was with a young Punjabi woman who had only migrated to Britain six weeks previously. The respondent had never used a tape-recorder before and was very shy. Also the mother-in-law was reluctant for the interview to be tape-recorded as she thought the tape could be used against her newly arrived daughter-in-law. It took ten minutes and the intervention of the sister-in-law who demonstrated how the machine worked before the respondent agreed to be recorded. In all cases confidentiality was stressed and all the women were told that the cassettes would be destroyed on completion of the research.

The second strong objection came from a Muslim woman who also had not been in this country very long. She had never seen a tape-recorder before and was intrigued to see it work. After listening to her voice on the tape she agreed to be interviewed, but tried to insist the cassette was handed to her at the end. There followed another period of negotiation before we could depart with the cassette, having agreed it would be returned to her after transcription. Other objections were raised to the tape-recorder but they were only slight and once the interpreter had explained it would be very tiring and time consuming for her to hand-write the responses, which would then have to be translated for me to understand, everyone agreed.

The researcher was present at all the Asian interviews yet was unable to participate if the woman did not speak English,

in these instances the interpreter gave a brief synopsis in English of what had transpired and this was also taped. From this resume it was possible for the researcher (through the interpreter) to follow-up some of the questions and clarify certain issues. Later on when the tapes were translated and transcribed by an independent agency the accuracy of the interpreter's synopsis was checked.

Another problem associated with using a tape-recorder was that it would not record clearly for the whole of the interview by using batteries. This meant it had to be connected to the mains and a screw-driver and spare plug were carried around in case the house was wired differently. Plugging-in the recorder sometimes meant it was a distance from where the respondent was sitting and often furniture had to be arranged accordingly. Storm-Clark (1978) recognises the problems associated with having to re-arrange furniture so that both respondent and researcher are close enough to a single microphone, yet sitting comfortably. His solution to this problem is to use a more expensive recording machine with a dual or multi-directional microphone. However with limited funds a cassette recorder with single microphone was all that was available.

Despite the unsophisticated recording equipment and the need to re-arrange furniture to compensate for this, there were no objections from the respondents. Once the recorder had been "installed" the respondents relaxed and forgot it was on. This

was shown by the way some women noticeably jumped when the cassette came to the end of the first side and clicked loudly.

There were often interruptions during the interview and this occasionally affected the clarity of the recording, particularly if it was young children making the disturbance. Some of the tapes have background noises of children chattering and playing with toys, one even has the sound of a child sitting on her potty! Often the sounds are not merely "background" and in houses near to main roads the noise of passing lorries drowned the conversation. For these reasons it was essential to transcribe the tapes as soon as possible and certainly no later than the same evening if background noises were detected. This was only possible for the British sample, or English-speaking Asians, but the Asian interviews did contain a synopsis<sup>1</sup> of what was said and this was transcribed immediately.

Another hazard with young children being present was that they found the recorder a particularly attractive toy. Many of them wanted to, and did, pull at the microphone and alter the dials. In this situation the only solution was to distract the child or remove the machine to a place out of the child's reach.

If these problems are taken into account there are considerable benefits to be gained by having the interview on tape so that it can be referred to at any time. When the tape is transcribed there is a verbatim account of what was actually said. Also, through repeated listening to the tape, the significance of

---

<sup>1</sup>The synopsis provided a brief summary of the interview translated into English for the researcher's benefit. Using this, the researcher was able to ask supplementary questions and clarify certain points.

pauses, giggles and lengthy silences can be interpreted and made sense of. This in conjunction with the recorded observations, provides a holistic picture of the interview and what actually happened. It was therefore essential for this research which wanted to capture the respondent's accounts of their experiences in a detailed and descriptive way.

#### Non-Response for the In-Depth Interview

Two British women were unwilling to be interviewed a second time and seemed reluctant to be visited at home. In both instances it was the husband who spoke for the woman and it may have been his decision rather than the woman's. In the first case a letter was written to woman notifying her of the intended visit. Yet she was not at home at the appointed time. A note was left asking the woman to contact the researcher and inform her of a convenient time for the interview. Later the same day the woman's husband 'phoned saying "We don't want you around the house. My wife doesn't mind answering your questions or seeing you at the clinic, but we don't want you around the house". The researcher explained that the woman had previously agreed to be interviewed at home and had specifically asked for an afternoon visit. He then said his wife was in hospital, and it was agreed she would be visited there. However, when the researcher called at the hospital three days later the woman had already given birth (twenty-four days early).



Another British husband did not want his wife to "be bothered". A further British women was hospitalised antenatally and although quite willing to be interviewed in hospital, delivered before an interview could be arranged. An Asian women who had a still-birth prematurely was not re-interviewed and two women (one British and one Asian) moved from Coventry in the middle of the study and were therefore excluded.

#### TRANSCRIPTION OF TAPES

The tapes varied in length from 60-135 minutes and took an average of 6 to 8 hours to transcribe. Asian tapes were transcribed as far as possible by the researcher and then sent away to be translated and transcribed by an independent agency.

#### DATA ANALYSIS

The data obtained from the in-depth interviews was transferred onto index cards and filed in categories such as kin; previous pregnancy experiences; old wives tales. Initially, these categories were kept as broad as possible, after numerous shufflings the cards were organised under more specific headings and cross-references made wherever needed.

The organisation of the data by hand was time consuming and at times tedious, but it was an excellent way for the researcher to familiarise herself with the data and watch the conceptual patterns emerge.

The data obtained on the questionnaire was more factual and there was less of it, so it was more easily managed. The questionnaire responses were transferred onto index cards and the responses aggregated.

CHAPTER FOUR

THE SAMPLE

Introduction

Before presenting the data pertaining to the women's pregnancy it is essential to understand the background of the samples studied and gauge how representative these samples are of the total population. In deriving the significant similarities and differences between the samples, the analysis attempts to avoid conventional assumptions about the women studied, the most commonplace being the assumed dependence of all women on men. The problem of making assumptions about women is confounded when we look at women from another country who have migrated to Britain, for it is easy to make incorrect assumptions about an unknown population.

In an attempt to overcome these problems, this chapter sets out to 1) detail the total population and the relationship of the Asian population to the indigenous population; 2) provide an overview of the distribution of the maternal health services in the geographical area studied; 3) specify detailed information about the women selected for study, for example, parity, length of education and so forth; 4) attempt a classification of the women into social groups; and 5) to compare the outcome of pregnancy for both samples studied.

1) RELATIONSHIP OF ASIAN POPULATION TO INDIGENOUS POPULATION

a) General population

Coventry is an industrial city in the midlands, composed of areas with heavy concentrations of engineering factories interspersed with residential areas. The car industry and the General Electrical Company (GEC) employ large numbers of skilled and unskilled manual workers. A shortage of workers in these industries in the 1950's attracted workers from overseas and at the time of the 1971 Census 3.5% of the population of Coventry were of South Asian origin. Since 1971 the number of Asian migrants has continued to grow, but there are no up to date statistics on the size of the present population.

Statistics which are available show that in 1976, 11% of all births in Coventry were to women born in India, Pakistan or Bangladesh (Table II). This can be compared with the percentage of births to women from South Asia in the rest of the United Kingdom (2.8% in 1971 to 2.2% in 1975 - see Table III).

In Coventry there is an inner city area of older terraced houses. This area lies between three railway lines and is commonly known as the "railway triangle". It is here that the bulk of the Asian population resides. (Seventeen - 65% of the Asian women studied lived in this area). The indigenous population is more widely dispersed throughout the city although there are large concentrations of people in the high-rise council flats of Wood-End.

b) Asian population

Before looking in detail at the Asian sample studied a brief overview of the reasons for migration and the results of this process will help to place in context the presence of Asian women in Coventry.

Large scale migration from India and Pakistan to Coventry began in the 1950's. Initially it was the young Asian males who migrated, wives and families following later after the men folk had established themselves. The reason for migration to Coventry can be analysed in terms of "push" and "pull" factors. The "push" factors are related to the conditions in the country of origin which make it desirable to migrate from that country, and the "pull" factors are the attractive conditions in the receiving country. The attraction of migrants to Coventry in the 1950's was the shortage of labour needed in the engineering industries.

According to the 1971 Census figures, out of 10,130 Asian migrants to Coventry, 8,560 were from India, and of these about 80% came from the Punjab (Northern India). According to Deakin (1970, p.35) Punjabi Sikhs form four fifths of Indian migration to Britain, originating from two districts in Eastern Punjab - Jullunder and Hoshiapur. The Sikhs are well known for their travelling and are viewed as "frontiersmen and pioneers" by Aurora (1967). However, wanderlust is not on its own a significant explanation of migration from the Punjab to Britain. The political, economic and social factors operating in the Punjab and simultaneously in Britain need to be scrutinised.

First, the political factors - the partition of the Punjab in 1947 forced an estimated three million Punjabi Sikhs into the eastern area of the Punjab. The displaced people either took over small holdings or, because of the shortage of farmland, began to look elsewhere for employment and housing. Later in 1960 the building of the Mangla dam further displaced significant numbers of Pakistani people near to the Punjab border, providing an additional group of people from the same region with an impetus to look abroad for work. Positive measures were taken by the British government to encourage migrants from the New Commonwealth and after the 1962 Immigration Act Saifullah Khan (1974) says "there is no doubt that there were special facilities for displaced people who wished to go to England".

Travel agents and the advent of cheap charter flights greatly aided Asian migration and this was particularly important in the years 1961 and 1962 (Deakin, 1970).

The "pull" factors which drew Punjabi Sikhs to Britain can be seen primarily in economic terms. The early migrants of the 1930's who were mainly peddlars, found that by the late 1940's with the expansion of British industry they were able to gain employment in factories located in the Midlands and London. The news of availability of jobs reached fellow kinsmen in India and acted as an incentive to "displaced" men to look to Britain for employment. The economic boom in Britain in the 1950's meant there was a scarcity of unskilled labour and plentiful employment for the new migrants.

In terms of control over immigration the British Government changed its policy depending upon the needs of British industry. In 1955 the Home Office reached the decision that no control over the number of immigrants was necessary - needless to say this was at a time when there was a serious labour shortage. However, with the influx of a large number of non-English speaking migrants (unlike the previous English-speaking West Indian immigrants), the British Government negotiated agreement between the Indian and Pakistani Governments, who agreed to try and curb migration in 1958. This agreement failed to be effective and by 1960 claims were made that passports were being forged. A Standing Committee report advocated a system of immigration control based on the availability of employment and checking immigrants' health standards and criminal records. In 1962 the Ministry of Labour (as it then was) introduced a system of work vouchers which intended to control the number of unskilled immigrants, while those with specific skills to offer, particularly doctors were made more welcome.

So far migration has been discussed purely in the context of wage labourers, and as stated beforehand, in the initial period of migration it was only the men who were involved. This situation was aided by the social structure of the Indian family, and its joint nature (see Chapter One). Deakin (1970) says it was:

"common for a husband to remain abroad for many years, returning occasionally to his wife....This pattern began to be broken when control of immigration was seen to be imminent in Britain, and it was thus from 1958 onwards that the Sikhs began to bring their wives and families to this country" (p.36)

The migration of women to Britain reflected a more permanent settlement of families in Britain, which was partly precipitated by the change in immigration laws. For instance, the 1962 Immigration Act permitted the dependants of persons already resident in Britain to enter freely, but imposed entry restrictions on people looking for employment. The 1962 Act defines dependants as "wives, children under 18, and elderly parents". However, by 1968 the Commonwealth Immigration Act made the further specification that all dependants are required to obtain an Entry Certificate from a British High Commission in their country of origin. The most pertinent point that all this raises is in relation to women, and their dependence on men - whether their husbands or fathers. As S. Khan (1975) says "all first generation Asian women migrants to Britain, have come as dependants, that is their actual and legal status". (p.310)

The arrival of Asian women migrants had two effects 1) it made what was previously seen as temporary migration, more permanent in status, and 2) it re-united families. Despite the permanent nature of migration to Britain, there persist sharp differences between the Asian and indigenous population. These differences will now be examined with specific reference to Coventry.

c) Result of migration

In studies of race relations there are various theories which attempt to explain the status of the migrant group in the host society. Pluralists, such as Park (1950) argue that immigrants will eventually become integrated into the host society, while the "conflict" theorists argue there is little evidence to suggest that ethnic minorities



are becoming assimilated. On the contrary, they argue "coloured" immigrants tend to remain as an "underclass" in the host society and are never fully integrated into it (Aronwitz 1973; Boggs 1970; Castles and Kosack 1973; Rex 1973).

It is beyond the scope of this thesis to engage in an analysis of the degree of "integration" of Asian people in Coventry yet when the data is analysed by 1) area of residence, 2) type of housing and 3) employment, some interesting patterns emerge which suggest that an "underclass" theory is the most descriptive of the present situation.

i) Area of residence. The factors leading to the over-concentration of the Asian population in one geographical area are: 1) the lack of funds the migrants possessed when they first moved to Britain; 2) their inability to qualify for council housing in the first instance and 3) discrimination on the part of landlords, estate agents and local residents. (Daniel 1971 in his book based on the PEP report 'Racial Discrimination in Britain' details the discrimination coloured people faced when they applied for privately rented housing, council housing and house purchase - see pages 151-196).

Although some Asian families have been living in Coventry a considerable time, there is little evidence to suggest a widespread dispersal of the Asian population throughout Coventry is imminent. Seventeen (65%) Asian women studied lived in the inner city area inside the "railway triangle" (the equivalent of the "twilight zone" described by Rex and Moore 1967). A further six (23%) lived less than half a mile outside this area in similar terraced housing.

Two (8%) lived within a mile of the "railway triangle" and only one woman lived over a mile away - she lived with her in-laws in a modern semi-detached house in a pleasant residential area. None of the British women lived in the "railway triangle", but eight (31%) women lived on council estates. One of these estates, Wood End, is reknowned for the high rate of vandalism, so much so that it is difficult to attract tenants to live there and in some areas about a third of the flats are unoccupied. Four (15%) of the British women interviewed lived in this area and this was the largest concentration of the British sample in any one geographical area.

Most of the Asian women studied had lived in Coventry for relatively short periods of time, seventeen (65%) women had lived in Coventry for less than six years, but it must be remembered that most of these women were marrying into families which were well-established in Coventry. Seventeen (65.5%) women came to Coventry on marriage, ten (38%) of these women came straight from Asia while seven (27%) were already living in another city in Britain (see Table IV). A further four (15%) women came to Coventry to join their husband after several years of separation, only two (8%) women came to Coventry with their husbands and three (11.5%) moved with their parents. (Table V shows that since 1971 the number of births to women from the New Commonwealth and Pakistan has remained at 13-15% - about 3% of these births were to women born outside India, Pakistan, Bangladesh).

ii) Type of housing. Nineteen (73%) Asian women lived in terraced housing compared with eight (31%) British women. Four (15.5%) British women lived in newer terraced council properties and the other four

British women lived in terraced houses outside the inner city area. (See Table VI). Six (23%) Asian and eight (31%) British women lived in semi-detached houses; one (4%) Asian and seven (27%) British women lived in flats (four (15.5%) British women lived in council flats); and three (11%) British women lived in detached houses.

The majority (54%) of the British women lived in owner-occupied homes, the tenure of property for the Asian women is not known as the interpreter considered it insensitive to ask this question. However, none of the Asian women lived in council housing, while eight (31%) British women did. (See Table VIb). When the first Asian migrants moved to Coventry they were ineligible to qualify for council housing as they did not have the appropriate residence requirements, however, most of the Asian families in Coventry would now fulfil these requirements yet do not apply for council housing. They prefer to live with or near to family and friends in the Asian community, unlike the West Indian population which has accepted council housing on estates outside the inner city area. The Asian population therefore still occupy the lowest strata in the housing classes outlined by Rex and Moore (1967).

iii) Employment. The majority of Asian male migrants to Coventry have no professional qualifications, they originated from rural areas and their skills were agricultural. Most of these migrants became employed in light engineering and unskilled manual jobs; some find employment with the Midland Red Bus Company as drivers and conductors. The migrants who trained for a profession in India or Pakistan often

find their qualifications are not recognised in Britain and they either have to re-train or to accept a lower status job. (One of the Asian women said her husband was a qualified teacher in India, but was unable to teach in Britain and now worked as a storeman for British Leyland).

Table VII shows the occupations of the male partners of the women interviewed. There is a pre-ponderance of British men in professional and skilled jobs, whereas most of the Asian men were in skilled and unskilled manual jobs (almost half of them being in unskilled jobs). The number of men unemployed was the same for both sub-samples.

It is highly unlikely that the differences in type of occupation held by Asian and British men will alter with respect to first generation Asian men. It is to be hoped that second generation Asian boys who are educated in Britain will proceed to have the same employment prospects as white school leavers.

It is even more difficult to be optimistic about the employment opportunities of Asian women in Britain. Table VIII shows that of the women studied, sixteen (61%) Asian women compared to two (8%) British women had never been in paid employment. The Asian women who had been in paid employment mainly took manual jobs and the largest group of women, six (23%) were employed as machinists. Compared to this, half of the British women were employed in the service occupations - clerical and secretarial being the most popular occupation, seven (27%) British women fell into this category, while six (23%) were employed in manual work.

The type of employment Asian women are permitted to engage in reflects their position within patriarchal society - they are employed in jobs which have a total female labour-force.

2) DISTRIBUTION OF MATERNAL HEALTH SERVICES IN COVENTRY

i) Domiciliary or community services. It is known that GP list sizes vary from area to area and while the list sizes of individual GPs is a closely guarded secret it is possible to find out which areas are underdoctored. The Family Practitioner Committee in Coventry keeps a record of the number of patients each GP has and a financial incentive is offered to doctors to work in underdoctored areas (i.e. those with 3,500 patients per doctor). At the time of this study it was recognised that the large council estate, Wood End, to the North East of the city was underdoctored. (Meeting with Family Practitioner Committee member, 28th October, 1977).

The building of a new health centre in the centre of town, housing twelve doctors from four practices has meant that the inner city area does not appear to be underdoctored (although without the individual list sizes of the GP's this is difficult to determine). Although the "railway triangle" area appears to have sufficient doctors per head of population, the doctors practising in this area are different from those practising in other parts of the city. 18% of GPs in Coventry are Asian (analysis of the Medical List of Coventry Family Practitioner Committee by surname of GP) and the majority of these doctors practise in the Asian "area". It is not surprising, therefore, that of the thirty-nine Asian women studied in the initial

sample, 77% of them had an Asian GP (and 72% of the twenty-six Asian women in the final sample). Compared with this, six (15%) of the thirty-nine British women in the initial sample had an Asian GP (the same percentage of British women in the final sample had an Asian GP). See Table X.

The concentration of Asian women in one area results in them using fewer GPs than the British women who were dispersed throughout the city. In the initial sample (thirty-nine Asian and thirty-nine British women) the Asian women used a total of nineteen different individual GPs, whereas the British women used a total of thirty-two different GPs. Twelve (31%) Asian women attended one general practice compared with the largest number of British women attending one practice - four (10%). Five individual GPs were used by both the Asian and British women studied and three group practices were used by Asian and British women. (There was no difference in the number of Asian and British women having a woman doctor - Table IX).

It would also appear that Asian and British women use their GP differently (see Chapters Seven, Eight and Nine). There was a variation between the two samples in the maturity of the pregnancy when the woman first attended her GP; the British women tending to present earlier (Tables XI and XII). An analysis of total number of hospital births 1976 to 1978 also substantiates this point (Table XIII). However, it must be remembered that some Asian women migrate to Britain when they are already pregnant and their late attendance at the GP and consultant clinic tends to skew the rest of the figures. Two (8%) Asian women in the final sample migrated to Britain at five and seven and a half months pregnant respectively.

There is also reason to believe that the GPs referral patterns to the consultant clinic differ considerably. The Asian women tend to be referred to the consultant clinic later in their pregnancy than the British women (Table XIV). It is difficult to make any statements about referral practice without a detailed study of this, but it could be that Asian GPs do not consider early referral to the consultant clinic to be important. For instance, more Asian women than British were referred to the consultant clinic in the last trimester of pregnancy.

The GPs have autonomy over how they organise their ante-natal services and there is considerable variation from practice to practice. Some GPs have midwives in attendance, others do not; some have separate ante-natal sessions while others include pregnant women with their other patients. Thirty group practices had a midwife present at their ante-natal sessions compared with twenty-two group practices which did not involve the domiciliary midwife. (One GP held private ante-natal sessions for his patients). The variations between GPs and how the women studied perceived these differences are detailed in Chapter Nine.

The Parentcraft classes in operation at the time of the study were held at fourteen different clinics throughout the city. However, these clinics were not evenly dispersed and there were some large residential areas which did not have classes in the immediate vicinity (for example, Earlsdon, Allesley, Holbrooks, Longford and Wyken). Moreover, during the course of the research two of the classes were discontinued through lack of support. One class was held at the Teachers Training College because there were no other suitable premises in the area, however, no women turned up at this class and it was closed. To expect

pregnant women to attend a College which was not easily accessible by bus was perhaps ambitious on the part of the organisers of the classes. Lack of foresight also caused the classes in the Asian "area" to close. These classes were provided without recognising the language problem and taking measures to overcome it. (Eleven, 42%, Asian women studied said they did not attend Parentcraft classes because of the language problem - see Chapter Ten).

The number of women studied who attended Parentcraft classes in current or previous pregnancy is detailed in Table XV.

TABLE XV                      NUMBER OF RESPONDENTS WHO ATTENDED PARENTCRAFT CLASSES IN CURRENT OR PREVIOUS PREGNANCY

Attended Parentcraft classes	Asian		British		Total	
	No.	%	No.	%	No.	%
a)						
<u>Final sample</u> N = 26						
Current pregnancy	3	11	6	23	9	17
Previous pregnancy	1	4	5	19	6	12
<u>Attended NCT classes</u>						
Current pregnancy			1	4	1	2
Previous pregnancy			3	12	3	6
	<hr/>		<hr/>		<hr/>	
<u>Total attending classes</u>	4	15	15	58	19	37
b) <u>Primipara</u>						
<u>Final sample</u> N = 9						
Attended classes	3		6		9	
Did not attend	6		3		9	
	<hr/>		<hr/>		<hr/>	
<u>Total</u>	9		9		18	
	<hr/>		<hr/>		<hr/>	



ii) Hospital based maternal health services. The consultant ante-natal clinic is situated in the centre of the city near the bus station and is therefore most accessible for those women living in the inner city area. Consequently, the Asian women spent slightly less time in travelling to the clinic than the British women - it took nineteen (73%) Asian and fourteen (54%) British women less than twenty minutes to travel to the clinic (see Table XVI).

TABLE XVI      TIME TAKEN TRAVELLING TO CONSULTANT CLINIC

Final sample	Asian		British		Total	
	No.	%	No.	%	No.	%
5 minutes						
- 9 minutes	3	11	2	8	5	9.5
10-14 minutes	8	31	7	27	15	29
15-19 minutes	8	31	5	19	13	25
20-24 minutes	2	8	3	11	5	9.5
25-29 minutes			1	4	1	2
30 minutes	5	19	8	31	13	25
	<hr/>		<hr/>		<hr/>	
	<u>Total</u>	26    100	26    100		26    100	

The mode of travel to the clinic was different for both groups of women. Over half (54%) of the British women travelled by car, while the majority of Asian women (69%) came by bus (see Table XVII). None of the British women lived within walking distance of the clinic.

TABLE XVII      MODE OF TRAVEL TO CONSULTANT CLINIC

Final sample	Asian		British		Total	
	No.	%	No.	%	No.	%
Bus	18	69	12	46	30	57.7
Car	3	12	14	54	17	32.7
Walk	5	19			5	9.6
	<hr/>		<hr/>		<hr/>	
<u>Total</u>	26	100	26	100	52	100
	<hr/>		<hr/>		<hr/>	

None of the Asian women were able to drive, the three (12%) women who travelled to the clinic by car were driven by their husbands. All of the British women (54%) who had travelled to the clinic by car had driven themselves.

The consultant clinic was open every afternoon from 1330 hours until about 1700 hours (the clinic tended to finish earlier on a Tuesday when there were two consultants in attendance). Although the number of women passing through the clinic varied from day to day, there does appear to be a strong correlation with the numbers attending and the consultant on duty. One consultant Z was more popular than the other two and this is reflected in the attendance figures. The GPs tended to refer to a particular consultant, but if a women wanted she could ask to see the consultant of her choice (see Chapter Nine).

TABLE XVIII      TOTAL NUMBER OF WOMEN ATTENDING THE CONSULTANT CLINIC DURING THE FIVE WEEKS OF INTERVIEWING - ANALYSED BY CONSULTANT IN ATTENDANCE

Consultant on duty		Week 1	Week 2	Week 3	Week 4	Week 5
Monday	Y	81 <sup>1</sup>	62	79	57	83
Tuesday	(Z	(39	(58	(33	(34	(34
	(X	(49	(-	(43	(51	(60 <sup>1</sup>
Wednesday	Z	107	111	110	94	104
Thursday	Y	86	78	75	93	81
Friday	X	75	78	77	89	77
<u>Total</u>		<u>437</u>	<u>387</u>	<u>417</u>	<u>418</u>	<u>434</u>

<sup>1</sup>At these two sessions W - a locum, stood in for consultants Y and X.

The figures show that the largest number of women attended the Wednesday afternoon clinic of consultant Z. An analysis of the women studied shows that more British women had Z as their consultant than consultants X and Y; whereas more Asian women had Y as their consultant X and Z. Consultant X had the least number of patients.

TABLE XIX      CONSULTANT OF WOMEN INTERVIEWED

Initial sample	Asian		British		Total	
	No.	%	No.	%	No.	%
X	7	18	9	23	16	21
Y	18	46	12	31	30	38
Z	14	36	18	46	32	41
<u>Total</u>	<u>39</u>	<u>100</u>	<u>39</u>	<u>100</u>	<u>78</u>	<u>100</u>

In addition to having larger clinic sessions, consultant Z also routinely performed cervical smears on his patients, whereas the other two consultants did not. During the interviewing, the clinics on a Wednesday afternoon consistently took longer, which is interesting because although more British women had Z as their consultant, British women on average had slightly shorter waits at the clinic than the Asian women.

TABLE XX                      LENGTH OF TIME RESPONDENTS SPENT AT CLINIC

Final sample	Asian		British		Total	
	No.	%	No.	%	No.	%
Up to $\frac{1}{2}$ hour						
Over $\frac{1}{2}$ hour - 1 hour			1	2.5	1	1.3
Over 1 hour - $1\frac{1}{2}$ hours	11	28	14	36	25	32
Over $1\frac{1}{2}$ hours - 2 hours	20	51	17	44	37	47
Over 2 hours - $2\frac{1}{2}$ hours	5	13	4	10	9	12
Over $2\frac{1}{2}$ hours - 3 hours	3	8	2	5	5	6.4
Don't know			1	2.5	1	1.3
	<hr/>		<hr/>		<hr/>	
	<u>Total</u>	39    100	39    100		78    100	
	<hr/>		<hr/>		<hr/>	

It is difficult to determine the reason why Asian would spend longer at the consultant clinic, especially as they are less likely to attend a session with the most popular consultant. There are, however, other factors which influence the length of wait, such as, the time of appointment and staffing levels, and without controlling for these variables it would be difficult to conclude that Asian women are discriminated against in this respect. What was observed

though was the way in which some privileged white women were given preferential treatment. A doctor, a nurse and a member of the National Childbirth Trust were all seen to be hurried through the clinic in less than an hour, while none of the Asian and other white women were. These "privileged" women were not included in the study and it would be interesting to know if they were consistently given preferential treatment.

Another difference between the Asian and British samples was that the Asian women were more likely to bring someone with them to the clinic than were the British women. Sixteen (61.5%) Asian women were accompanied at their first clinic visit compared with five (19%) British women. The Asian women were most likely to take someone with them to act as an interpreter for them. However, the clinic staff did not approve of patients being accompanied and on days when the clinic was very crowded the Sister-in-charge would ask anyone who was "not a patient" to wait outside "As I will not have any of my ante-natal patients standing". After this announcement anyone who was not pregnant would be obliged to leave (with the exception of children); so that the women who had brought friends/husbands with them for company, or to interpret in the case of many of the Asian women, were left on their own in the waiting room.

During the course of the pregnancy, British women tended on average to make more visits to the ante-natal clinic than Asian women. The average number of visits made by British women was 7.4 compared to 6.7 visits for Asian women. It is difficult to judge if this difference is meaningful as the women who have the most visits are usually those who are seen to be more at risk. Also, the

figures for the Asian women are skewed by the Asian women who migrated to Britain in the later stages of their pregnancy - they thus received fewer consultant clinic appointments. Throughout the whole of their pregnancy four (15%) Asian women had missed one of their ante-natal appointments and three (11.5%) British women. The women had missed these appointments because of domestic reasons, sickness in the family or difficulty with transport. (Fuller details contained in Appendix A).

At the first interview the respondents were asked about their preference for the location of ante-natal care. Half of all the women in the initial sample and 58% of the women in the final sample said they would prefer to receive all their ante-natal care from their general practitioner. (See Table XXI). The reasons given to support their preference for general practitioner care were 1) that he/she was nearer; 2) they did not have to wait so long; 3) it was more convenient to take their other children; 4) he/she carried out the same procedure as the clinic anyway; and 5) for some of the Asian women the language problem was eased through having an Asian GP. At the second interview at eight months pregnant, only 25% of all the women in the final sample said they would prefer all their ante-natal care from their GP. (See Table XXI). An explanation for this change in attitude is provided in Chapter Nine.

3) DETAILS OF THE WOMEN STUDIED

Age

i) Age at first interview. The age distribution of all women in the initial and final samples is shown in Table XXII. Forty seven (66%) of all the women interviewed in the initial sample were in the 21 to 30 age range. In the initial Asian sample the largest concentration of women, thirteen (33%) were in the 21 to 25 age range. In the initial British sample, the largest concentration of women, seventeen (44%) were in the 26 to 30 age range. The figures obtained in the final sample are comparable and show that the Asian respondents tend to be younger than the British respondents.

ii) Age of respondents at first pregnancy. The age of respondents at their first pregnancy shows a marked difference between the two samples. (See Table XXIII). For instance, in the final sample, twice as many Asian women (sixteen - 61%) as British (eight - 31%) were pregnant before age twenty-one. The British women were most likely to become pregnant for the first time in the age range 26 to 30. Ten (38%) British women were in this age range at the time of their first pregnancy compared to two (8%) Asian women.

Twenty-three (88%) Asian women had become pregnant before age twenty-five, compared to fourteen (54%) British women. One of the reasons for the earlier age of first pregnancy among the Asian women is the earlier age of marriage. Ideally in Asian tradition early marriage is followed by the birth of the first child (Marshall, 1973).

iii) Age of respondents at first marriage. Twenty (77%) Asian women in the final sample were married by the time they were aged twenty; whereas eight (31%) British women were (Table XXIV). All the Asian women in the final sample were married compared to twenty-two (85%) British women. Four (15%) British women had never been married and one British woman was married twice.

#### Parity

Parity was the only factor controlled for when drawing up the samples. The aim was to have the same number of Asian and British women in the final sample facing their first viable birth. Women who had already given birth were not controlled for parity.

Parity was therefore defined according to the number of previous viable births the woman had experienced, i.e. the number of births which occur after the twenty-eighth week of pregnancy. A primipara is therefore a woman facing her first viable birth (she may have previously miscarried but this does not count as a viable birth); a multipara is a woman who has experienced a viable birth at least once before (in this category are included women who have given birth to a still born baby of over twenty-eight weeks gestation). A woman who has previously given birth to one viable baby is referred to as parity one; a woman who has given birth to two viable babies is referred to as parity two, and so on.

In the initial sample there were fourteen (36%) primiparous Asian women and thirteen (33.5%) primiparous British women. The



majority of British women (sixteen - 41%) were parity one while equal numbers of Asian women (eight - 20.5%) were parity one and three. (See Table XXV). The Asian women were of higher parity than the British women having experienced nineteen more viable births. The Asian women also experienced more non-viable births - in the initial sample twelve Asian women had a total of fifteen non-viable births compared with eight British women who had a total of eleven non-viable births. The figures for the final sample are comparable - nine Asian women had a total of twelve non-viable births and five British women had a total of seven non-viable births. In the initial sample there were the same number of stillbirths and neo-natal deaths for both Asian and British respondents and in the final sample there were three stillbirths to Asian women compared with one stillbirth and one neo-natal death for British women. (See Table XXVI). When the number of non-viable pregnancies and pregnancies not resulting in a live baby are taken as a percentage of the total number of pregnancies, there is no significant difference between the Asian and British samples. The higher parity of the Asian women cancelling out the higher rate of non-viable births. (Table XXVII)

#### Marital Status of Respondents

Thirty-eight (97%) Asian women and twenty-eight (72%) British women in the initial sample were married. (Table XXVIII). Three British women married between the first and second interview, two for the first time and one woman remarried.

Marital status does not indicate whether or not the woman is supported or self-sufficient. For example, of the two British women in the final sample who were still "officially" married but separated from their husbands, one was living with her mother and claiming supplementary benefit and the other was living on her own, in her own home and in full time employment. Two of the British women who had never married were living with the father of the child they were expecting, one was living with a male partner (not the father of the child) and one was living with her parents. None of the three women living with male partners were in paid employment, while the unmarried woman living with her parents was.

#### Social network of respondents

i) Family network. Eleven (42%) Asian women were living in an extended family at the time of the second interview. Two (8%) Asian women were staying with their in-laws for the duration of the pregnancy and returning to their own home after the birth and lying-in period (forty days). Three (11.5%) British women were living in an extended family; one young unmarried woman was still living with her parents; another woman and her husband were living at her parents home until they emigrated to Australia after the birth; and one woman was separated from her husband in the early months of pregnancy and moved back to Coventry to live with her widowed mother.

Seventeen (66%) Asian women and twenty four (92%) British women had relatives living in Coventry; so although the Asian respondents were more likely to be living with relatives, they were less likely

to have relatives outside the household living in the same city. (Table XXIX). The seventeen (66%) Asian women who had relatives living in Coventry saw these relatives more than once a week; in most cases if the woman was not living with relatives, she lived in an adjoining house or house in the same street. Daily contact with female relatives was often the norm for these women.

The British women were less likely to see female relatives on a daily basis, four (15%) British women saw their mother or mothers-in-law daily. Fifteen (58%) British women saw their mother or mother-in-law at least once a week and this visit was likely to be routinised either as weekend visit (usually involving a meal) or a regular child minding arrangement. The British working class women were more likely to live in the same area of the city as their relatives than the British middle-class women who tended to live in the new housing developments on the periphery of the city.

TABLE XXIX      FAMILY NETWORK OF RESPONDENTS AT TIME OF SECOND INTERVIEW

Final sample	Asian		British		Total	
	No.	%	No.	%	No.	%
Lives with parents/parents-in-law <sup>1</sup>	11	42	3	11.5	12	23
Relatives live in Coventry	6	24	21	80.8	29	66
Relatives elsewhere in Britain	5	19	2	7.7	7	13
No relatives in Britain	4	15			4	8
	<hr/>		<hr/>		<hr/>	
<u>Total</u>	26	100	26	100	52	100

<sup>1</sup>Two Asian women were staying with their parents-in-law for the duration of their pregnancy, after the birth and traditional lying-in period they intended returning to their own home.

Twenty (77%) Asian women mentioned female relatives as a source of advice on pregnancy and childbirth, particularly in terms of the behaviour to be followed. Eighteen (69%) British women mentioned female relatives as a source of advice and support, the working class women more often consulted their relative about problems of pregnancy, while the middle-class British women were more likely to use their mother or mother-in-law to help with child care. (See Chapters Six, Seven and Ten for a discussion of the role of female relatives in pregnancy).

The British women were more likely to draw on their husband (or male partner) for support in pregnancy than the Asian women. Eight (31%) British women mentioned their male partner as a source of support compared to four (15%) Asian women. The kind of support they provided is detailed in Chapter Ten.

ii) Friends. Ten (38.5%) British respondents (particularly the middle-class women) quoted friends as a source of advice and information in pregnancy compared with four (15%) Asian women who were all living in nuclear families. The women who had the least contact with female relatives were most likely to be dependent on friends and professional sources of advice and support. Generally speaking, the British middle-class women were most dependent on non-familial sources of advice and the Asian women with no female relatives at hand were more likely to be dependent on friends for support and advice.

The extent to which the women studied consulted their social network about discomforts in pregnancy is outlined in Chapter Seven.

Clashes between lay and professional advice are detailed in Chapters Nine and Ten.

### Length of Education

There were significant differences between the Asian women and British women in the length of education received. This can in part be explained by differences in educational provision in Britain and India. In Britain, education is compulsory and the school leaving age has been fixed at age sixteen since 1971; in rural India, on the other hand, (where the majority of Asian respondents originated from) education is compulsory between the ages of five and twelve years. In some villages lack of resources means that some children do not start school until age six or seven (personal communication 1979). In addition to the differences in educational resources between Britain and India, there are also significant differences in India of access to education on the grounds of sex. In the past it was only sons who were educated and although education is now supposedly compulsory, it is not unusual to find young village women who have not attended school. Table XXX shows that six (23%) Asian women had no formal education at all and a further seven (27%) women had a maximum of five years education. In total, half of the Asian women studied had five years education or less. The women who had not received any formal education were three (11.5%) Muslim women from rural villages; two (8%) Sikh women from rural villages; and one Hindu woman who came from a village in Gujerat who joined her husband in Tanzania before finally setting in Britain.

TABLE XXX      RESPONDENTS' LENGTH OF EDUCATION

Final sample	Asian		British		Total	
	No.	%	No.	%	No.	%
No education	6	23			6	11.5.
Primary school only	7	27			7	14
Secondary school	8	31	16	62	24	46
Technical college/ secretarial	2	8	7	27	9	17
Teacher training/ University	3	11	3	11	6	11.5
<u>Total</u>	<u>26</u>	<u>100</u>	<u>26</u>	<u>100</u>	<u>52</u>	<u>100</u>

All the British women received secondary school education compared with half (50%) the Asian women (see Table XXX), and half as many Asian women (19%) as British women (38%) received further education (Table XXX).

The Asian women who received further education were - one Brahmin woman who went to Teachers Training College; one urban Muslim woman, B.Sc. at University; one low caste (chohra) urban Punjabi women who won a scholarship to Teacher's College where she obtained a B.Ed. and M.A.; one Punjabi Sikh Jat woman attended college and obtained a Diploma; and one Punjabi Hindu woman who was educated in Britain and went on to Secretarial College.

Among the Asian respondents there was no apparent correlation between high caste and further education. The largest caste group of the women studied were the Jats (Punjabi Sikh landowners) eleven (42%) of respondents belonged to this caste, yet only one (4%) woman went on to higher education. An explanation for this anomaly

is that Jats do not place heavy emphasis on the education of their daughters. It is taken for granted they will marry into another landowning family and status is accorded to those who own most land rather than degree of education. On the other hand, daughters of Hindu businessmen are often educated as this raises their status and makes them a more marriageable proposition (Kapur 1976).

The British women who received further education were one woman who started nursing training but became pregnant after six months and one woman who completed her nursing training; two (8%) women attended Commercial College and four (15%) women attended Technical College; two (8%) women went to Teacher's Training College and one (4%) woman attended University.

The Asian women who received secondary education and above were more likely to be able to understand and speak English. The Asian women who moved to East Africa when young tend to learn English at school there (one Ugandan Asian woman fell into this category and spoke English fluently).

#### Language - Asian respondents only

The majority of Asian respondents (nineteen - 73%) had a working knowledge of English. Of these nineteen women, fifteen (57%) said they could speak a little English and four (15%) could speak English fluently. Three (11.5%) respondents were interviewed in English.

Although nineteen (73%) respondents said they did not have any difficulty understanding the clinic staff at their first clinic visit, eighteen (69%) women said it would help if there was an

interpreter at the clinic. Moreover, thirteen (50%) women took someone with them to their first clinic visit to help interpret.

The majority (69%) of Asian respondents were Punjabi speaking; six (23%) were Gujerati speaking and two (8%) had Urdu as their first language. Fourteen (54%) women spoke another Asian language; Hindi was spoken by twelve (46%) women and one (4%) woman spoke Punjabi and another one (4%) Urdu. (See Table XXXI).

TABLE XXXI                      FIRST LANGUAGE OF ASIAN RESPONDENTS

Final sample	No.	%
Punjabi	18	69
Gujerati	6	23
Urdu	2	8
<u>Total</u>	<u>26</u>	<u>100</u>

Fourteen (54%) Asian women said they could read some English and eight (31%) women were able to read the booklets given out at the clinic.

The twenty (77%) Asian women who had Asian GPs tended to speak in one of the Asian languages when they visited him. At the time of the second interview several Asian women had experienced difficulty with communication as the following examples show:

"There was an Indian nurse. Whenever I wanted to say anything they called her".

and



"I don't know how to speak English ... I can understand some and not understand some. But I can ask for an Indian nurse (often there isn't one so I ask for anyone who can help)".

Two of the English speaking Asian respondents complained about how they were used as interpreters when they were in hospital ante-natally.

"They (Asian women) can't explain anything to the nurse, you know. Sometimes they used to call me, the nurse used to call me to explain. I used to be asleep and they used to come and call me. I said 'You call this rest and you call me to get out of the bed and go into the other room for an explanation, you know, because they can't understand'."

#### Employment status of respondents in current pregnancy

Earlier (p. 186 ) the last known occupation of the respondents was detailed (Table VIII) and compared with that of their male partner, (if supported). Here the focus is on the employment of the respondents in the current pregnancy.

In the initial sample, eight (20%) Asian women and eleven (28%) British women were in full time paid employment at their first interview. Twenty-nine (74%) Asian and twenty-seven (69%) British women were unemployed (Table XXXIIa). The figures in the final sample resemble these, with four (15%) Asian and nine (35%) British women in full time paid employment and twenty (77%) Asian and sixteen (61%) British women unemployed. In both the initial and final sample there was one Asian and one British woman in part-time paid employment and one Asian woman engaged in home-work (Table XXXIIb).

TABLE XXXII                      NUMBER OF RESPONDENTS IN PAID EMPLOYMENT  
AT THE TIME OF FIRST INTERVIEW

	Asian		British		Total	
	No.	%	No.	%	No.	%
a) <u>Initial sample</u>						
Full-time employment	8	20.4	11	28.2	19	24
Part-time employment	1	2.6	1	2.6	2	3
Home-work	1	2.6			1	1
Unemployed	29	74.4	27	69.2	56	72
	<hr/>		<hr/>		<hr/>	
<u>Total</u>	39	100	39	100	78	100
	<hr/>		<hr/>		<hr/>	
b) <u>Final sample</u>						
Full-time employment	4	15	9	35	13	25
Part-time employment	1	4	1	4	2	4
Home-work	1	4			1	2
Unemployed	20	77	16	61	36	69
	<hr/>		<hr/>		<hr/>	
<u>Total</u>	26	100	26	100	52	100
	<hr/>		<hr/>		<hr/>	

Two (8%) Asian and six (23%) British women had made arrangements to resume paid employment after the birth of the baby and a further five (19%) Asian and two (8%) British women said they hoped to be gainfully employed after the birth. The women's attitudes towards combining motherhood with paid employment are detailed in Chapter Six.

Caste - Asian respondents only

It is difficult to determine the importance of caste for the women studied and a more detailed study of larger numbers is needed before any substantiated statements can be made.

The largest caste group of the women studied were Sikh Jats (landowners) - eleven women (42%). (Table XXXIII).

TABLE XXXIII                      Caste of Asian respondents

Final sample	No.	%
Jat (landowners)	11	42
Ramgarhia (skilled artisan)	1	4
Chohra (untouchable)	2	8
Sani (agricultural labourer)	5	19
Brahmin	1	4
Business people	5	19
Muslim urban educated	1	4
<u>Total</u>	<u>26</u>	<u>100</u>

The ambiguous relation between caste and length of education has already been referred to and it is worth reiterating that there is no apparent correlation between high caste and length of education. This differs from the situation in western societies where there is a correlation between high social class and length of education, but it is dangerous to transpose a relationship existing in one society onto another. Moreover, social class cannot (and should not be) equated with caste which is ascribed at birth and immutable.

According to the Asian informants used, it is possible to determine a persons caste by the clothes they wear, how they wear them, the quality of the material in the sari, how they speak and the words used. Lower caste women tend to wear more jewellery to prove their status, whereas the status of high caste women is apparent without adornments.

Caste differences are probably most pronounced when marriage is being discussed and often override religious differences between Hindus and Sikhs. It is acceptable for Hindus and Sikhs to intermarry provided they both belong to the same caste.

### Religion

Religion is an important factor for Asian women in pre-scripting behaviour. The more traditional Muslim women have a faith in "God's will" which deters them from overtly questioning male authority. Muslim women are not permitted to worship collectively in the Mosque (except on special occasions) - this is the domain of the men. Sikh women on the other hand are encouraged to participate in collective religious activity and the Sikh temple, gurdwara, has two women only afternoons during the week. Sikh women are able to become priestesses and can conduct services. Hindu women tend to build their own miniature temples at home and worship there.

The variations between the Asian women of different religions is most marked in their knowledge of menstruation and sex education (Chapter Five) and in the restrictions placed on menstruating women and observance of the traditional lying-in period (Chapter Six). Table XXXIV shows the number of Asian women belonging to the three Asian religions (one Punjabi woman came from a family which had been proselytised to Christianity in the 19th Century).

TABLE XXXIV                      RELIGION OF RESPONDENTS

Final sample	Asian		British	
	No.	%	No.	%
Church of England	1	4	19	73
Roman Catholic			7	27
Sikh	13	50		
Hindu	8	31		
Muslim	4	15		
	<u>Total</u>		<u>26      100</u>	
			<u>26      100</u>	

Religion was mentioned as a significant factor by Roman Catholic British women when speaking of contraception (Chapter Five) and three (11%) Church of England women in relation to being "churched" after the birth of the baby (Chapter Six).

4) PROBLEMS WITH CLASSIFICATION

The way in which social researchers classify their data (or have it classified for them) often reflects dominant ideologies of the society. The invisibility of women in official statistics is a case in point (Oakley and Oakley 1979). Moreover, when attempting to stratify women there are further classification problems which arise and these can be firmly linked to the shortsightedness (or overt sexism) of previous researchers.

The most common shortcomings are 1) the universal acceptance of the family as the unit of social analysis; 2) women are not often studied in their own right, their social status is seen to be derived from their husbands (for example, Pahl and Pahl, 1972, Managers and their Wives; 3) there is an assumption that all women are maintained by a male who is the head of the household.

Watson and Barth (1964) look at some assumptions made in the stratification literature and question the validity of the family as "a unit of equivalent evaluation" (p.10). This point is taken up and developed further by Acker (1973) who details the number of people living outside the traditional nuclear family, that is, all those who are single, separated, divorced or widowed. To this list can be added those who live in extended families or communes.

The second assumption that women derive their status from their husbands is also questionable. As Acker (1973) rightly points out, women who work in the same occupation as husbands of housewives, have a higher status than the housewife (p.939). This implies that married women's "patterns of mobility and status are tied to that of her husband" (Steinmetz 1974). Moreover, it is possible for married women who are in paid employment to have a higher social class position (based on occupation) than their husband. Graham and McKee (1979) found that when they assigned social class on the basis of husband's/boyfriend's occupation there was a preponderance of manual workers compared with basing social class on the woman's occupation when there was a predominance of non-manual workers (pages 19-20). This pattern also holds for the women in this study (see Tables VII and VIII).

Thirdly, it is incorrect to assume that all women are maintained by a male head of household. According to the General Household Survey, one fifth of households are headed by women (quoted in Oakley and Oakley 1979, p.178) and about 8% of all mothers are bringing up children single handed.

Researchers who are sensitive to these problems and recognise the need to overcome them, face a dilemma when they attempt a non-sexist

classification of women. The most common method of determining one's social class position is based on occupation, however this assumes that everyone is economically active, an assumption which does not apply to many women and retired persons. Acker (1973) argues that women who are not economically active, i.e. they are housewives, should be given an occupational rating based on their housewife status. However, this proposal overlooks the difficulty of rating the work of housewives - there are sharp distinctions between the social status and income at the disposal of a woman married to a political figure and a woman married to a manual worker. Delphy (1977) states that "the wife of a business executive receives as much as ten times the benefits received by the wife of a worker" (p.14). These distinctions are reflected in the life chances of the woman and her children (if she has any).

The problems of classifying women are compounded when we look at women from Third World countries. For instance, in India, women's role in production outside the home is even more limited than in the western world where about two-thirds of married women work outside the home (West 1978). Moreover when Indian people migrate to Britain they may find a disjuncture between their previous position in the stratification hierarchy (based on caste in India) and their present position in the hierarchy which takes no account of caste.

A possible way of determining indigenous women's social class is to base the classification on the woman's terminal education age. This overcomes the previous criticisms of studies which stratify women in relation to men and at the same time is a useful indicator of the woman's life chances, job opportunities, child rearing patterns and so on. However, this is not a useful classification to make in relation

to Indian women in Britain for the terminal education age of a woman in India does not necessarily denote her position in the stratification system. As previously stated, daughters of the landowning caste Jats are less likely to be educated than the daughters of businessmen. Ownership of property is accorded higher status than education for the Jats.

Moreover in terms of social mobility there is more opportunity for British (indigenous) women to be socially mobile than women from a caste society. British women can marry out of their social class, however, in India it is expected that all women (and men) will marry someone from the same caste.

A further problem in the classification into social groups of Indian women (and men) in Britain is related to their migrant status. Educational qualifications obtained in India are often not formally recognised in Britain which means that some migrants find themselves in low paid, low status manual jobs.

Rather than using occupation as an indicator of social class (the basis of the Registrar General's classification), an approach which takes several variables into account seems more appropriate to the task in hand. As Osborn and Morris (1979) argue:

"The relationship between occupation and social class should be granted no more sociological significance than the relationship between social class and education, wealth, housing conditions or any other variable hypothesised as being an aspect of social class" (p.45)

By shifting the focus from an analysis of social class based solely on occupation to one which is composed of several variables, it is possible to include in the analysis all women whether or not they are



in paid employment. Moreover, those women who are employed in non-productive labour (for example, secretarial and clerical work) can also be included. This recognises the limitations of a strict Marxist definition of social class which is solely concerned with the person's relationship to the means of production. The theoretical problems of trying to incorporate women into a Marxist analysis of class are outlined by West (1978) and will not be pursued here.

What is needed, therefore, is a measure of women's position in society which provides an indication of their social status and access to material resources. To this end the women have been classified according to the following criteria which reflects their social class status: a) length of education; b) employment status; c) type of house lived in; d) area of residence; and e) caste (Asian women only). Points were allocated to all the women studied for each of the first four criteria on the following basis:-

- a) Length of education: No education, 0; primary only, 1; secondary, 2; further education, 3.
- b) Employment status: Never in paid employment, 0; manual, 1; service, 2; professional, 3.
- c) Type of housing: small terraced, 1; council, 1; flat/linked terraced, 2; semi-detached, 3; detached, 4.
- d) Area of residence: inner city, 1; council estate, 1; suburbs, 2; residential, 3.

Using these criteria, the maximum number of points a woman could obtain was 13, and only one British woman reached this score. All the women who scored nine or more points were deemed to have middle class status, in this case, twelve (42%). British women and one (4%) Asian woman. The lower scores of the Asian women reflect their

transitional class status as migrants in Britain and reflects the extent to which they are disadvantaged. These low scores also indicate the difficulty of attempting to classify women from a Third World country using criteria which are applicable to the life chances of women in western industrialised societies. For instance, women from rural India are not likely to have engaged in paid employment in their country of origin; on migration they are most likely to be employed (if at all) in manual jobs (mainly sewing) regardless of their previous employment status or length of education. This is shown most graphically in the case of an educated Asian woman married to a professional man who by the criteria employed did not fall into the middle class status category. Her position was anomalous because of the transitional nature of their accommodation (Case No. 10A).

The possibility of including family network as an indicator of social status was considered, but not pursued because of the difficulties of trying to compare women in extended and nuclear families with women living on their own. Moreover, to evaluate whether or not it was beneficial to live in an extended family compared with a nuclear family the researcher would need to know details of total family income (information which was not collected). Finally, and most important, the researcher would be assuming that the family (however it is defined) is an important index of social class, and women who are self-supporting would be excluded from the analysis.

To check whether the low social class status scores of the Asian women were in any way related to their caste position, the two were compared. The highest scores were obtained by women from the Brahmin, business, Jat (landowners) and chorha (untouchable) castes and the lowest scores by women from the agricultural labourers and ramgarhia (skilled artisans) caste. It would appear therefore that caste

differences do persist on migration, the agricultural workers and skilled artisans tending to fare slightly worse. However, it is interesting to note that the two women from the chohra (untouchable) caste obtain a higher score than might be expected. (One of these women had won a scholarship in India to college and was highly educated). The limitations of a small sample size and only a superficial knowledge of the implications of caste position make it impossible to do other than speculate on these findings.

Whether the Asian women will continue to have a low status position in Britain remains to be seen, but as yet there are no immediate signs of change.

To identify the respondents throughout the text they are referred to by their case number, parity and social class status. Case numbers 1 to 9A are primiparous Asian women while case numbers 10 to 26A are multiparous Asian women. Case number 7A is the only Asian woman accorded middle class status. Case numbers 1 to 9B are primiparous British women and 6B, 8B and 9B are middle class women; case numbers 10-17B are multiparous working class British women and case numbers 18-26B are multiparous middle class British women.

The woman's social class and whether or not it is a first pregnancy are taken as important determinants of the way the women use the maternal health services. One factor which has been excluded from this analysis is the status women derive from motherhood. In the western world some women are accorded status through their occupation or involvement in community activities. However, in rural India all women are accorded status when they become a mother, particularly if they bear sons. The status that is accorded to motherhood is detailed more fully in Chapter Six.

5) OUTCOME OF PREGNANCY

After delivery the women's hospital records were obtained to see if there were any significant differences between the two samples. Generally speaking the Asian women were more likely to have given birth to lighter birth weight babies. In the initial sample the average birth weight of the Asian babies was 3.13 kg compared with 3.34 kg for the British babies. (For a distribution of birth weights see Table XXXV). The birth weights of both sub-samples compare favourably with the figures given for all babies born in 1976. (Table XXXVI). As a group, the Asian primiparae gave birth to the lightest babies and the British primiparae also had lighter birth weight babies than the women expecting their second and third babies (Table XXXVII).

TABLE XXXVII                      BIRTH WEIGHT OF BABIES BORN TO WOMEN STUDIED  
- BY PARITY

Final sample <sup>1</sup>	Asian		British	
	No.	Average birthweight	No.	Average birthweight
<u>By parity</u>				
Primiparae	9	2.89 kg	8	3.38 kg
Parity 1	4	3.69 kg	9	3.53 kg
" 2	1	3.48 kg	4	3.49 kg
" 3 +	12	3.12 kg	4	3.26 kg
	<u>26</u>		<u>25</u>	

<sup>1</sup>Records not available for birth weight of one primiparous British born.

None of the babies born to the British women were admitted to the Special Care Baby Unit (SCBU), but five (25%) of the Asian

babies were. Table XXXVIII details the total number of SCBU admissions for the years 1976 to 1978 - in each year more Asian babies are admitted.

The Asian women were less likely to have their labour induced than the British women. In the initial sample ten (29%) Asian women and fourteen (41%) British women were induced. The total number of inductions both samples received, i.e. 35%, compare exactly with the total number of births induced in 1976 - 34.6% (Table XXXIX ).

The Asian women were more likely to have a Caesarian section [four (11%) women in the initial sample] than the British women (two, 6%, in the initial sample) (Table XXXX). The rate of Caesarian sections for the women studied was slightly higher than the percentage of the total number performed in the years 1977 and 1978 (Table XXXXI).

Two Asian women had forceps deliveries compared with six British women, and the percentage of forceps performed on all the respondents is comparable with the total percentage for the years 1977 and 1978 (Table XXXXI).

The Asian women tended to have different medical intervention at the time of delivery and also they tended to stay in hospital longer after delivery than the British women.

TABLE XXXXII      NUMBER OF DAYS RESPONDENTS SPENT IN HOSPITAL  
AFTER DELIVERY

Final sample N = 52 <sup>1</sup>	Asian		British	
	No.	%	No.	%
Up to five days	9	35	15	60
6 to nine days	13	50	10	40
Ten or more days	4	15		
	<u>26</u>	<u>100</u>	<u>25</u>	<u>100</u>

<sup>1</sup>Records incomplete for one primiparous British woman.  
Source: Hospital maternity Records.

Fewer Asian respondents than British breast fed their babies while in hospital (Table XXXXIII). In the initial sample, eleven (32%) Asian women and sixteen (47%) British women were breastfeeding. The overall number of twenty-seven (40%) is similar to figures supplied by the Maternity Hospital Statistics - in 1976, 1417 (40.5%) of women in the consultant unit were breastfeeding. Table XXXXIV shows the changes in the percentage of women breastfeeding from 1966 when the maternity hospital opened. Since 1969 the number of women breastfeeding has more than doubled.

TABLE XXXXIII      METHOD OF FEEDING RESPONDENTS ADOPTED WHILE IN HOSPITAL

	Asian		Britain		Total	
	No.	%	No.	%	No.	%
<u>Initial sample N = 78<sup>1</sup></u>						
Breast feeding	11	32	16	47	27	40
Artificial feeding	23	68	18	53	41	60
	<u>34</u>	<u>100</u>	<u>34</u>	<u>100</u>	<u>68</u>	<u>100</u>
<u>Final sample N = 52<sup>2</sup></u>						
Breast feeding	5	20	12	48	17	34
Artificial feeding	20	80	13	52	33	66
	<u>25</u>	<u>100</u>	<u>25</u>	<u>100</u>	<u>50</u>	<u>100</u>
<sup>1</sup> Records for five Asian and five British women incomplete. <sup>2</sup> One Asian baby stillborn and incomplete records for one primiparous British woman.						
<u>Source:</u> Hospital Maternity Records						

CHAPTER FIVE

SOCIAL CONTROL OVER REPRODUCTION

Introduction

This Chapter examines the restrictions placed on women's reproductive activities. Such an analysis is important in determining the amount of autonomy women have in controlling their reproductive behaviour. For instance, pregnant women are often advised by members of the medical profession to behave in an appropriate manner. Yet this advice often ignores the social factors restricting the woman's behaviour.

To understand the restrictions impinging on pregnant women, it is first necessary to describe the general restraints facing women in other areas of reproduction, for example, fertility control and the taboos which regulate sexual relations. The forms of control which prevent women being fully autonomous in these areas are:-

- 1) patriarchal control, either the direct control of individual men (e.g. husbands, boyfriends) over women, or, institutional control, for instance, those customs and norms which prescribe appropriate behaviour for women in male dominated societies. Often older women are delegated the task of ensuring that younger women act in accordance with traditional dictates. In those areas where women come into contact with members of the medical profession we become aware of medical theories of women as passive and dependent on men;

- 2) control over women's reproduction is often maintained through a lack of knowledge. Again, in male dominated societies, older women may collude to keep young women ignorant (c.f. Paul, 1974);
- 3) certain ideologies exist which militate against women's autonomy: a) ideologies associated with women's role as reproducers, and b) religious ideologies which prescribe appropriate reproductive behaviour;
- 4) State control and intervention in population policies. The interests of the State are maintained by certain optimal levels of population increase. Liberal legislation on abortion and sterilisation can be related to existing population trends. Women's access to fertility control can be mediated by the provision of services;
- 5) the final determinant of women's autonomy over their reproduction is the material resources at their disposal. For instance, private health services exist for those who can afford them. Lack of material resources, on the other hand, may mean that women are more dependent on
  - i) their male partners for access to money and
  - ii) the State health services, because they do not have the financial ability to seek alternatives.

If we focus on the amount of autonomy women have in controlling their fertility and the taboos which regulate sexual relations, we find there are significant differences between women based on their social class, religion and ethnic background. We also notice changes



for the Asian women on migration to Britain. Historically, changes in attitude towards sexual relations have taken place, but at varying rates for different social groups.

#### CONTROL OVER FERTILITY

Male control over fertility is most pronounced in those societies where property is passed down through the male line. Biological paternity is seen as important in ensuring the continuance of the patriarchal family.

##### a) Fertility Control in India

In India there are several mechanisms by which male control is indirectly exerted over fertility: 1) there are customs which segregate the sexes before marriage and attempt to ensure that all brides are virgins; ii) there are taboos on intercourse when women are menstruating, when they are pregnant and immediately post-partum. These taboos are related to fears of pollution and also act as a fertility inhibitor; iii) religious constraints on the use of contraception; iv) State intervention in population control which often conflicts with religious and traditional dictates.

In traditional Indian and Pakistani families, virginity at the time of marriage is seen as all important. Brides who are thought not to be virgins on their wedding night can be returned to their father. In some areas there is a custom when the mother-in-law actually checks the sheets slept on by the newly married couple to see if they are stained or not (personal communication, 1978). Rani Kareem (1979) an Asian woman in Britain, tells of the persistence of this custom when her husband checked the sheets for staining on their wedding night.

Male control over virginity is aided by enlisting the help of older women to ensure that young fertile women follow the appropriate behaviour. The older women derive power from their status in the private domestic domain and mediate between the public world of men and control over unmarried daughters. Older women often play a large part in enforcing taboos which regulate sexual relations (and are also associated with male fears of pollution). The traditional practice of returning the pregnant woman to her parent's home until the baby is a few months old (c.f. Gideon, 1962), is a very effective control on intercourse and also helps to maintain spacing between pregnancies.

Another way in which fertility is controlled in rural India is through abortion. The Report committee of 1966 claims that out of every hundred pregnancies, fifteen result in induced abortions. (Mandlebaum, 1974). Generally though, pregnancy is a desirable state to be in, however, if you are a pregnant grandmother, or worse still, pregnant and not married then the use of abortifacients is advocated. These abortifacients are usually in the form of a herbal tea which is provided by the village dai midwife. The dai's role in controlling fertility by performing secret abortions is an example of women colluding together to end what is perceived as an undesirable state of affairs. The threat the dais pose to the traditional male order means their status is ambiguous. A point which Morpeth (1979) makes very clearly:

"If we accept that it is in men's interests or more specifically in the interests of the patrilineal group to fragment women's solidarity with each other then the midwife must have a potentially threatening role and be a source of tension." (p.8)

Recent State intervention in fertility control in rural India has led to the widespread introduction of sterilisation. (1,385,084 sterilisations were performed in India during 1967/68 - India, 1968, p.104) In order to encourage people in fertility control, cash payments were made for IUD insertions and sterilisations and in some places transistor radios were distributed to males undergoing sterilisation. This State intervention in fertility control has led to violent clashes between male villagers and members of the Family Planning team. Vasectomy was advocated as the cheapest, most effective method of family planning, yet this was seen as a physical and sexual attack on men which gave rise to the flogging of Family Planning teams in certain areas.

State intervention in fertility control comes into conflict with religious doctrines and traditional beliefs. Certain forms of birth control are forbidden in accordance with the belief that God determines whether or not a child is born, and one must not interfere with God's will. (A view expressed by Muslim women studied c.f. page 228). Attempts at fertility control in rural India have tended to ignore the traditional beliefs of villagers and treated them "paternalistically and indiscriminately and have failed to provide a dignified and personalised service". (Bhatia and Neumann, 1973, p.27) There are, therefore, conflicts between the interests of the State and traditional beliefs, and between the State and different religions. The interest of the State in controlling population growth tends to overlook the economic advantages of a large number of male children to rural landowners.

On migration to Britain, rural dwellers face another set of conflicts which are related to the pressures of urban life, nuclear family life style and different attitudes to family size. Some women have more contact with their husbands and perhaps for the first time have their own separate bedroom (p.20). The implications of these factors are discussed more fully after a brief reference to the history of fertility control in Britain.

b) Fertility Control in Britain

In Britain the history of fertility control is very different and has been well documented by Banks (1964), Browne (1917), Fryer (1965), Rowbotham (1973). There has been a long struggle for fertility control in Britain and the demand has come from various groups of different political persuasions. For instance, the eugenicists have argued birth control was necessary (particularly among the poor) to improve the "stock" of the nation; socialist feminists, on the other hand, have argued that women's control over their reproduction was an important step in freeing "sexual relationships from legal or economic coercion". (Browne, 1922, p.7). More recent feminists have echoed the demands of the 1920's in terms of "a woman's right to choose" and "abortion on demand" (see Rowbotham, 1973, p.152). The eugencist argument is continued by people such as Keith Joseph (1974) who argue that only certain people are fit to become parents. When these arguments are pushed to the extreme they result in policies such as the compulsory sterilisation of blacks in America (National Welfare Rights Organisation 1974) and the indiscriminate use of Deproprovera on ethnic minority and working class women in Britain.

### Ideologies of Reproduction

All people have some idea about the number of children they expect to have which relates to their total ideology.<sup>1</sup> Therefore, some women may expect to have as many children as they can, while other women may consider two children to be the ideal. Women who subscribe to a middle class ideology which includes values such as deferred gratification and individualism, are most likely to consider two children to be the "ideal" family size. Six British middle class women made comments reflecting this ideology :-

"I only want two ... I won't get pregnant again. I don't want to anyway". (Case No. 18B, Parity 1 MC)

"Two's our quota" (Case No. 19B, Parity 1 MC)

"I think two's quite a nice number" (Case No. 20B, Parity 1 MC)

"Two seems to be the limit anyway these days". (Case No. 23B, Parity 2 MC, previous still birth)

"It's a question of economics really. I mean we've only got three bedrooms and if we had three we'd have to give them a bedroom each". (Case No. 22B, Parity 1 MC)

Women who go against this middle class ideology are likely to be reprimanded by members of the medical profession, as was a working class woman who gave birth to her third child when she was aged twenty-one:

"He (the consultant) came into the ward after I'd had him and he says 'I think its about time you went to a family planning clinic'. I thought, that's a bit of a cheek really, 'cos you get them how you want them. And when they go on as if its an accident, or something like that you know. ....I thought 'You cheeky devil' I thought, I wonder what they say to some of these others you know, especially some of the coloured people like, that really do have quite a few. But it really made me mad". (Case No. 10B, Parity 3 WC)

Similarly, Asian women were castigated by Asian and British doctors for having more than two children. One Indian woman (the mother

---

<sup>1</sup> Ideology is used to refer to the system of ideas which upholds and sustains the way a group of people behave. An ideology thus contains beliefs and values which legitimate the status quo.

of three daughters) who was told by an Indian doctor when she was in labour with her fourth child:

"\*You've had too many children, get yourself operated on.'  
...I said that I didn't want it yet and he said 'It's good if you have it done. What will you do if you have another daughter?' .... Later when the baby was born, he said 'Look sister, you've got a daughter again!' He said those very words to me." (Case No. 14A, Parity 4 WC)

Women from agrarian societies (such as, India and Pakistan) have different ideas about the number of children to have. In these societies children are seen as enhancing status and male children are expected to contribute to the future family income. These ideas tend to persist after migration to Britain, although there are signs of change among women living in Britain more than five years. Ten out of the fifteen Asian women who had lived in Britain more than five years said they were considering limiting their family size.

Religion is also an important factor in determining final family size. Two Muslim women who had lived in Britain six and nine years respectively were asked if they wanted more children. They responded:

"If God gives me" (Case No. 20A, Parity 3 Muslim)

"It's up to God ... If I get a child it's all right and if I don't that's all right as well". (Case No. 19A, Parity 5 Muslim)

These women did not consider that they could in any way determine the number of children they had. Likewise with a Catholic woman

"The doctor in hospital said 'Who's been a naughty girl ....You're not taking anything to stop it?' he says. I says 'No, in our religion we're not supposed to take anything". (Case No. 15B, Parity 1, WC)

Although doctors tended to subscribe to notions about the "correct" number of children to have and some doctors castigated women who deviated from the norm, there were also doctors whose own religious beliefs competed with the concept of an "ideal family size". For instance,

one of the three consultant obstetricians was Catholic and not only did he uphold the dictates of his religion but he also expected his Catholic patients to conform. A non-practising Catholic woman approached him about a sterilisation and found him resistant to the idea although her GP recommended the operation:

"He (GP) wrote to the consultant that in his medical opinion he wouldn't want me to have any more. Sterilisation was the best, because I can't take the pill or anything like that. I mean it's not a decision you go into lightly - I didn't want any more and that's it.... I think if you want to be sterilised they should talk to both of you to make sure you know what you're doing, but they shouldn't say 'No'.

I think he's (consultant) a Catholic, so I've been told. Whether you're a Catholic, Church of England, or whatever you are shouldn't come into it, if you're a doctor."

After all

"Religion can't come down and feed them". (Case No. 11B, Parity 4, WC)

Four out of the eight Catholic British women had renounced the dictates of their religion concerning fertility control. These women saw a tension between their material conditions and the religious ideology. Two of the women had attempted to control their fertility when they were married and another two decided after two and four children respectively that they would control their fertility because their material conditions were so poor:

"After I've had this baby I don't think I'll have any more. See my mother, she's had fourteen, and so she's always saying like, I don't want to turn out like her. I know better this time not to have any more 'cos you can get the pill or the coil to stop you having kids now. 'Cos it's a waste of time having kids if your husband's not working you know really. 'Cos you've got nothing for your kids to look forward to really". (Case No. 13B, Parity 2 WC)

The availability of contraceptives and the woman's recent knowledge of them, combined with her extreme poverty, led this woman to question the traditional dictates of her faith. In contrast, the

lower class Muslim women <sup>did</sup> not experience this contradiction, but obeyed their religion which was mediated through their husband. This is not to say these women were opposed to fertility control themselves, for example, a Muslim woman in her fourth pregnancy stated she did not want any more children, but her husband said:

"There should be no stop to children. After about two years, there should be another child." (Case No. 20A, Parity 3 Muslim)

The only educated Muslim woman in the study was prepared to negotiate with her husband over the number of children they had, but it remains to be seen which one of them was successful. As the woman said:

"My husband wants four children, he has only one brother and a sister, so they want a big family. But as I know, I've got five sisters and one brother, and I wouldn't want a big family. We'll see after this one... I would like this to be the last one". (Case No. 10A, Parity 3 Muslim)

The religious ideology of the Roman Catholic church and of Islam was circumvented by the type of male-female relationship of the couple involved; where the male was dominant in this relationship, he was likely to enforce the religious observances. In a more sharing relationship, a joint discussion of fertility control may take place and a decision made which contravenes the religious doctrine. Among the Catholic women, material conditions were in direct confrontation with the religious ideology. Busfield (1974) also recognises this tension when she says:

"In the long term, it may well be that it is economic and structural factors that are of major importance in changing beliefs about reproduction : that they encourage particular patterns of fertility and that existing ideologies adjust to them". (p.12)

One of the structural factors affecting women and the control of their fertility has come from the feminist movement. As stated



before, socialist feminists were demanding rights over their fertility earlier this century, and some of the demands they made were radical even by today's standards. Stella Browne in 1935 argued that "the woman's right to abortion is an absolute right, as I see it, up to the viability of her child". (p.113) During the war years and immediately after, these feminist issues became submerged by issues concerned with the good of the nation. As Rowbotham points out "the question of human control over sex and procreation became inextricably confused with state regulation of breeding, motherhood and childcare". (1973, p.106) This state of affairs continued into the sixties when, with the advent of the Pill some women were more able to control their fertility. The feminist literature of the sixties and seventies has also had an impact in challenging women's sexual stereotypes, particularly in the sphere of reproduction.<sup>1</sup> Ellen Peck in America perhaps went the furthest when she advocated that "none is fun" (1973) and this motto was certainly referred to widely in the popular press.

A population sample of women will make statements which reflect their ideological position in relation to fertility control. The responses evoked by the question "Do you want any more children?" is a good indication of this. The extreme responses to this question varied from a very adamant -

"No. Well I don't know about Chris (husband) thinks ... but if he wants another one he'll have to find someone else to have it for him, I'm not having it".  
(Case No. 19B, Parity 1 MC)

---

<sup>1</sup>Probably the most important book is Our Bodies Ourselves, by the Boston Women's Health Collective (1971) (British edition, 1978).

to

"I'll have to ask my husband". (Case No. 9A, Primipara Sikh)  
The first woman was familiar with current literature on reproduction<sup>1</sup> and as a biology teacher knew about the physiology of sex. The second woman, on the other hand, was newly married and had only been in Britain a month, she was completely unfamiliar with any writings on human reproduction. However, it is not just familiarity with feminist literature which leads women to want to control their fertility, as stressed earlier, material conditions also play a large part. Obstacles to women gaining self-determination in this area are constraints from husbands or partners and religious or traditional prescriptions. Most important, though, is the opposition women face in gaining access to the means of fertility control. In matters of contraception, abortion and sterilisation, women continually encountered difficulties, and this applies to Asian and British-born alike.

#### Control Over Access to Resources

Women wanting abortions may be refused by either their GP or consultant and if they were determined to have a termination they often had to go privately to do so. The hospital records show that a consultant psychiatrist recommended a seventeen year old woman have an abortion on the grounds that the woman felt she could not cope with bringing up a child on her own. By the time the woman saw the consultant gynaecologist he considered she was too far advanced at fourteen weeks for a simple vaginal termination. He recommended therefore that "she should have the baby in hospital and then arrange for adoption", and "If Miss N is not happy with

---

<sup>1</sup>Some of the books she had read include Brook's Nature Birth (1976), Every Woman by Llewellyn-Jones (1971, and The First Nine Months of Life by Flanagan (1963).

with this arrangement, I would suggest that she seeks another opinion". This she did, and managed to obtain a private abortion in another city.

Another British woman who was refused an abortion later gave birth to twins. Asian women also experienced difficulty in obtaining abortions on the NHS. One Sikh woman who was pregnant for the fourth time in five years went to her Asian GP requesting a termination. This he refused, whereupon she asked him:

"Why do you want me to have more children, when you only have two yourself?" (Case No. 22A, Parity 3 Sikh)

She managed to secure a termination later by going through a private agency, which is what another Sikh woman did:

"He (GP) said we had to get it done privately. He said that if I had any defect, or there is some bad effect on my health, or the youngest baby was too small, only then they don't take money. But if you get it done of your own wish...." (Case No. 14A, Parity 4 Sikh)

GPs in Coventry are aware that the consultant gynaecologists do not all hold a liberal approach to abortion and therefore they tend to refer women directly to private agencies. In 1976 for example, only 11% of abortions performed in Coventry were done under the NHS. However, GPs have their own attitudes towards abortion which may prejudice the action they take. For instance, a newly-married Sikh woman of eighteen was dismayed to find herself pregnant as she wanted to complete her hairdressing apprenticeship. She approached her Asian GP for help; he not only refused help but also went to her home that evening and announced the impending birth to her husband and his parents with whom she was living. The woman found it difficult to come to terms with her unwelcome pregnant state and at eight months pregnant broke both her ankles when she jumped from a second floor window after a row with her husband.

Local policy with reference to sterilisation has become more stringent since the fee-for-service was introduced in February 1976. The criteria for deciding who is eligible for sterilisation (see MacIntyre, 1976c, with reference to Aberdeen) has been altered so that:

"My doctor said I was too young for an operation. One should be about thirty, he said. I'm only twenty-three - I'm of young age". (Case No.20A, Parity 3 WC)

Another woman was more persistent and demanded that she be sterilised, but still to no avail:

"Well each time I saw him (consultant) it was a different reason he gave - 'the NHS couldn't afford it' - and to me that isn't economic sense. I said 'why pay for a woman's ante-natal care, take that into consideration, maternity grant, your family allowances until the child's sixteen - surely it costs more to do those? You're going to get your money back in a couple of months'. And then he said, the next time, if everybody paid more income tax, then I could get it done. And I said 'My husband does two jobs, he pays two lots of income tax, now can I get sterilised?' He said 'No'. I tried every trick in the book really - apart from getting down on my hands and knees and begging him." (Case No. 11B, Parity 4 WC)

It is not surprising women feel relatively powerless in determining their own fertility given the difficulties they experience in their encounters with some members of the medical profession, plus the fact they need their husband's consent before an operation for abortion or sterilisation. Women are constrained by their religion, their partners and members of the medical profession - reflecting dominant values in British society. They are also constrained by their material conditions. Because of all these constraints, some women felt it was useless to try and predict the number of children they would give birth to. They said "I'll wait and see" as if it was all predetermined anyway. While one woman thought that she would have three children because:

"I've been told I'll have three by the fortune teller"  
(Case No.4B primipara WC)

All these comments reflect the lack of self-determination some women have in controlling their fertility. The women express their inability to predict their final family size through fatalistic beliefs.

#### TABOOS WHICH REGULATE SEXUAL RELATIONS

Taboos regulating sexual relations exist in all societies. Most of the female taboos are directly related to aspects of women's reproductive role. Associated with these taboos is the ascription of gender identity which as Rubin (1975) says, ensures "an identification with one sex" and "entails that sexual desire be directed toward the other sex". (p.180)

Women's sexuality and the restrictions placed on it needs to be understood in the context of women's role as reproducers. This is not to say that women's reproductive capacity essentially constrains them, but that constraints are imposed on women because of their reproductive powers. As Paige (1977) says:

"reproductive sexual taboos in our society, as in most world societies, reflect important social values about marriage, reproduction and the purpose of sexual activity".  
(p.144)

The threat of women's sexuality is an important factor in perpetuating patriarchal social relations, and some writers argue that the role of pregnancy has been a focal mechanism of sexual restraint. Hall and Lloyd (1976) for example, argue that sexual restrictions during pregnancy have been "central in holding back the emergence of female sexual potential and has assisted the continuance of the sexual passivity of women". (p.16) Further, they argue that the major constraint of female sexuality is the lack of control women have over their fertility. (p.16) This point was also recognised as far back as 1935 by Stella Browne when she makes the associations between women's

control over reproduction and the means of defining female sexuality as essential factors in the creation of a society where the material conditions for childbearing and rearing were not oppressive. Why these conditions have not yet come about is because:

"for generations women have been discouraged in any independent thought or action in sexual matters; they have been systematically stultified, kept ignorant and dependent". (1935, p.118)

Present day control of women's sexuality is maintained through taboos on sexual relations which may be upheld by older women. However, there are significant differences between the taboos in India (and Pakistan) and Britain and it is the way in which these taboos are handled which is important. Moreover, taboos dominant in India and Pakistan which relate to women not exposing their body to males other than their husband, will be broken in doctor-patient relations in Britain.

#### Menstrual taboos

These taboos are most applicable to the Asian women as there are various restrictions related to fear of pollution which apply to women when they are menstruating. These taboos vary slightly according to the woman's religion, for example, the Sikh religion does not allow menstruating women to touch the Guru Granth Sahib (Holy Book) or attend the gurdwara (Sikh Temple).

"Then (while menstruating) we can't touch the Guru Granth Sahib (Holy Book), my bua (father's sister-in-law) told me and also in India I learnt. You can say the words path (the Holy words) but you can't touch the book. When they're over (the period) you have a bath and then you can do it (touch the Book)". (Case No. 16A, Parity 1 Sikh)

The restriction on attending the Gurdwara means that Sikh women who are permitted to be priestesses are prevented from conducting their religious duties while menstruating. This reproduces patriarchal social relations by excluding women from certain social activities.

Women of the Hindu religion did not use their Temple as a social gathering place as the Sikh women did, they were more likely to pray at home in front of their own home made Temple. Even then they would only pray after having a bath. The same restrictions applied to them when they were menstruating:

"When you have your monthlies you can't go in the Temple, not in our religion. After four or five days you can go, but not before then. You have to have a bath".

(Case No. 4A, primipara, Hindu)

The Muslim women were less likely to go to the Masjid (mosque) - it tending to be a male preserve:

"Only the men go, very few women go. Sometimes we do, but not many women go".

(Case No. 12A, Parity 2 Muslim)

Also, like the Hindu women they tended to pray at home, and again they were not able to do this when they were menstruating:

"When we have periods, we can't read the Quran (Koran) - but we can read it when we are unwell or pregnant".

(Case No. 20A, Parity 3, Muslim)

The Muslim women said there are traditional taboos against menstruating women touching food, cooking and washing clothes, these taboos are observed in Pakistan amongst women living in extended families. However, none of the Muslim women observed these taboos in Britain, they all lived in nuclear households where they were the only woman attending to the domestic chores.

The British women were not aware of religious taboos during menstruation, but they had heard about prohibitions on washing hair and

having hot baths. One woman was told by her mother not to let the boys know when she was menstruating:

"I remember she (mother) told me when I was about eleven. I can remember ever so well what she said to me, she said that I would start to bleed and I must never tell the boys about it, 'cos they mustn't know. That was before I started...I must admit that when it first happened to me, I was expecting it, but it frightened me".

(Case No. 23B Parity 1 MC)

Here the older woman is seen instructing her daughter not to inform men about her state of pollution, suggesting a still present avoidance of menstruating women.

The restrictions on menstruating women's activities are more marked for the Asian women although there are signs of change among those women now living in nuclear families. The British women were not aware of co-ordinated menstrual taboos although they knew of restrictions some menstruating women observed.

#### Control maintained through keeping women ignorant

##### a) Knowledge of menstruation

It is often argued that women in "primitive" societies learn about sexual matters through observation and experience. Paul (1974) however, argues that this knowledge may be deliberately withheld from girls through a "conspiracy of silence" among older women. Paul suggests this secrecy appears to support the ascendancy of men over women, of older women over younger, and of parents over children. (p.297) In societies where older women are given the task of maintaining order in the private domestic sphere they are held responsible for the behaviour of the younger women. In rural India it is the norm not to converse with girls about anything sexual and as Luschinsky (1962) says:



"Girls are not given any instruction about menstruation before it occurs...Just as girls do not talk to their mothers about sex, they do not tell them when they have begun to menstruate. A mother finds out from other women of the family or from neighbours." (p.256)

Traditionally, Indian girls will be given advice about menstruation when it has started by their būa (father's sister-in-law). She occupies a low status position in the family and is often given some of the more unpleasant tasks to perform.

The extent to which knowledge of menstruation is withheld from Asian women was indicated by the women's response to questions on this subject. Twenty-one (81%) Asian women did not know about their periods before they started compared with eight (31%) British women. To start menstruation and not be prepared can be very distressing as the following accounts illustrate:

"I was sixteen when I started, but I didn't know what to do. I would have asked friends but I was a Sikh girl working on the fields, taking food and going to the well. So I told my mother in the morning because they started at night when I was sleeping. I told her that I didn't know what was coming out and she was too shy to tell me, so she called her sister and she told me that I could keep a cloth or wear knickers. I didn't wear knickers before that." (Case No.14A, Parity 4 WC - uneducated - from rural background)

"I wondered what happened to me for two or three days. So I came to know myself as I was too shy to ask anyone... I got to know from a book that we had in our class".  
(Case No. 5A, Primipara - educated - from urban background).

- Q. "Did you learn about menstruation before your periods started"?
- A. "Not until it happened. No, it's enough to put you off for life! I wondered what on earth it was. And even then she (mother) only said 'Well that'll happen every month'. Great! You would think that I would have heard about it from someone else, but I didn't."  
(Case No. 21B, Parity 2 MC)

Three (11%) Asian women had been told about menstruation at school (one in Britain, one in India and one in Uganda) and one (4%) woman learnt about menstruation from her mother.<sup>1</sup>

Ten (39%) Asian women asked their būa (father's sister-in-law) questions about menstruation after their periods had started.

It is significant that all the Asian women who were given some information about menstruation were the women who had received secondary school education. Nevertheless, they were not always informed in advance as the following account shows:

"Down there (Uganda) we were living in the country, it wasn't a city. There was only classes for six years, for Junior six years, and there were more classes in the city, so I had to go to stay in a Hostel at twelve. So I started my periods down there, and the teacher told me everything. Before that I didn't really know anything about it. I had to go and see the teacher and she explained it to me".

(Case No. 3A, Primipara, Ugandan Asian)

The Asian woman who was told about menstruation by the mother came from a "liberal" upper class urban family in Pakistan.<sup>2</sup> This woman started her periods when she was eight years old:

"My mother told me, she is a very easy going person, she told us the facts. She said you know that periods are related to childbirth, and things - you should take care. ....She told me what to do, she showed me how to put on a pad and things like that. Then my sister next to me, she was nearly sixteen when she had her periods, so it varied. And my youngest sister she is now fourteen and a half, and my mother wrote that she has now started."

(Case No. 10A, Parity 3 - urban Muslim)

Eighteen (69%) British women were told about their periods before they started and they gained this information from their mother, sister/sister-in-law or school. The women with "liberal"

---

<sup>1</sup>One (4%) Asian woman was not asked this question as her husband was present at the interview.

<sup>2</sup>Promilla Kapur (1976) in her book Love, Marriage, Sex and the Indian woman has well documented the differences between educated Hindu working woman having "liberal" parents and those having "conservative" parents.

Mums were more often told about menstruation by their mother than any other source:

"My mother was great ... Her own mother had kept her very much in the dark, and she said that she was quite determined that her children would know things without having to find out and only half finding out and all the rest of it. Oh yes, she was great. It was a normal natural thing really, you know, ... she just used to tell us things as we grew, you know. And she was always easy to talk to, you could always ask her anything".

(Case No. 25B, Parity 1 MC)

There were few women who had "liberal" mothers; in the Asian sample it was only one, and in the British sample, two. Some of the other British women had mothers who were prepared to talk to them about menstruation, but did so in a less open fashion, for example:

"I think I was about ten (when periods started). I knew odds and ends before, but me mother told me when I was ten. She had to really, 'cos I'd come on me periods, so she had to explain from scratch."

(Case No. 14B, Parity 1 WC)

"She (mother) never told me how babies were made, where they came from or anything. In fact she only told me about my periods two days before they arrived. I honestly didn't know - that' just incredible".

(Case No. 20B, Parity 1 MC)

More middle class British women than working class women mentioned their mother as the source of information about menstruation. The working class women were more likely to learn about menstruation from sharing a room with an older sister and three (11%) working class British women mentioned this as their most important source of information:

"Well I seen me sister. She was very much older than me and we used to share a bedroom like you know, and I seen her one day putting on this thing, and I says 'What's that?' you know. And I wasn't very old then and she said what it was. Me mother never told us anything about the facts of life at all". (Case No. 15B, Parity 1 WC)

First menstruation signifies that the girl is fertile and entering into womanhood. However, rather than this being the cause for

celebration it was viewed by some mothers as a problem. Daughters were either taken to the doctors because they had "started" early or warned about announcing their fertility to members of the opposite sex:

"I was only ten when I started and me Mum took me to the doctors 'cos she was worried with it being that early".  
(Case No. 12B, Parity 2 WC)

b) Knowledge of sexual relations

In those societies which place a high premium on virgin brides a woman's knowledge of menstruation and childbirth is least and women are deliberately kept ignorant of these matters as a fertility inhibitor.

Given the strong taboos on pre-marital sex among traditional Asian families<sup>1</sup> it is not surprising that some Asian women did not know about sexual relations until their wedding night. Songs sung on the wedding day provide an euphemistic notion of the "conquering" of the woman by the man on her wedding night (See Appendix C). Moreover, eleven (42%) Asian women were not informed about pregnancy and childbirth until they themselves were pregnant (Table XXXV). Some of these women said:

"I didn't really know. I found out when I had my own - that was too late!" (Case No. 11A, Parity 1 Hindu)

"My mother told me when I was pregnant. When I started vomiting - I didn't know - then my mother told me".  
(Case No. 20A, Parity 3 Muslim)

"In our times, we never knew anything, we were never told anything. But these days the girls know everything because they go to school and watch T.V. But in India very few girls know".  
(Case No. 24A, Parity 2 Sikh)

---

<sup>1</sup>Promilla Kapur (1976) depicts the more relaxed attitudes of urban educated families.

School was the most important source of information about pregnancy and childbirth for all women (33%) and formal secondary education was an important factor in determining which women had knowledge. The second largest source of information for all respondents were their friends of the same sex. (See Table XXXXV). However, friends were not always well informed themselves:

"You just pick it up. I learnt more certainly after I went to work than when I was at school. I think that a lot of the girls were in the same situation as I was - I just didn't know".

(Case No. 21B, Parity 2 MC)

"We used to talk among the friends you know, but we didn't really know, and we were just guessing and making jokes out of it and things like that. But when I came down here (Britain) I came to know more about it".

(Case No. 3A, Primipara, Hindu)

The Indian girls who had been to school in Britain found the classes at school the main source of their information:

"When I came here, they tell a lot of things in school here...here they show pictures in schools for older children, and that's where I came to know".

(Case No. 17A, Parity 1, Sikh, school in Britain)

"At school they tell you everything...they show a film when you're leaving, you know".

(Case No. 4A, Primipara, Hindu)

Those who had been to boarding school in India found the lessons and other girls' company the main source of their information:

"After going to College I came to know...If you live with other girls you come to know".

(Case No. 6A, Primiparae, College in India)

Another factor affecting the likelihood of Asian women receiving sex education was religion - one educated Muslim had received formal sex education compared with eight Sikh women and five Hindu women. The only Christian woman had been to college and had lessons there.<sup>1</sup> (See Table XXXVI);

---

<sup>1</sup>It is difficult to isolate religion as a factor as it is cut across by class, caste, and urban or rural residence.

TABLE XXXXVI

KNOWLEDGE OF SEX EDUCATION BY RELIGION  
ASIAN RESPONDENTS ONLY N = 26

Final sample	No. in sample	No. who had sex education
Muslim	4	1
Christian	1	1
Sikh	14	8
Hindu	7	5

For the British born women the relationship between religion and sex education was much more clear cut. All women attended secondary school and although each school has a certain amount of autonomy over what it teaches, it is possible to analyse the schools on the basis of religious denomination. In doing this it becomes obvious that women attending a Catholic school were less likely to have lessons on sex education than British women in other schools:

"No, we didn't at all. No, oh definitely not. I went to an independent Catholic school run by Nuns and we certainly didn't have anything like that".

(Case No. 25B, Parity 1 MC)

"At fourteen we were told that it was a sin to kiss a boy, 'cos we were taught by Nuns. That's a bad thing you know, 'cos they're really prudes, those Nuns. And er...this Nun says 'If you ever kiss a boy it's a sin, a mortal sin'. 'Cos I was a Roman Catholic you know. And I dare say she terrified some of the girls, some of the strong believers in their faith, which I wasn't..."

(Case No. 8B, Primipara, MC)

The only woman attending a Roman Catholic school where they had some form of sex education lesson, did not seem to benefit from the classes:

"They used to show you films like, that's where more or less I learnt like. I never used to look at them, I always used to think they were dirty like, you know. Priests used to show us 'em."

Later she said:

"Me husband, well I was going out with them then, he says I looked like I was expecting like...He actually told me at the first, 'cos I never used to know that you'd stop having periods at the start...His mother told me I was putting on weight and everything and she took me to the doctor the first time, to her doctor and he says that I was expecting".

(Case No. 13B, Parity 2 WC)

The sex education classes were often placed in a particular moral context. Asian women who had received lessons at school in India and Pakistan were particularly aware of this:

"In our school we used to have classes for girls above thirteen years where they used to tell us about all these things, so that we don't have difficulty in the future... There is a part where they tell you about childbirth. After having periods at thirteen or fourteen, then marriage and the children like - that, we were told".

(Case No. 5A, Primpipara, Brahmin woman - College)

"There was no sex education. It is usually taught in say... Home Economics/Domestic Science. They teach you cooking and everything concerned with housework, planning, budget and all that, and Family Planning and all that is included in it". (Case No. 10A, Parity 3 educated Muslim woman - Matriculation Course)

In Britain, sex education was explicitly associated with reproduction and taught by either a Health visitor from outside the school, or by the school biology teacher:

"It was mostly about rabbits. I think when they told us about rabbits we were about sixteen anyway, it was all a bit late". (Case No. 19B, Parity 1 MC)

Ten (42%) British women remarked on the scant information they were given at school, which was often attributed to the embarrassment of the teacher:

"I think in our final term the teacher put on a brave face and said if anyone wants to know anything come and ask". (Case No. 21B, Parity 2 MC)

"At school we only had a couple of lessons 'cos the boys used to joke and tease the teacher who got embarrassed".  
(Case No. 3B, Primipara, WC)

"They were short and sweet at the time...I think we had two lessons and I think there again the staff were more embarrassed talking about it".  
(Case No. 6B, Primipara, MC)

The embarrassment surrounding sexual relations is related to the fact that by informing girls (and boys) about human reproduction, one is breaking taboos on the open discussion of sex. This taboo is most strongly adhered to among the Asian population, particularly those belonging to the Muslim religion. The middle class white families appeared to discuss sexual relations with their children most openly, while some working-class women had reservations about sexual matters being taught to young children. They felt it encouraged a break-down in the moral order, a belief which is strongly expressed in the press:

"They seem to be teaching them a lot about sex you know, but they're not giving them like what I've been through, bringing up a child on your own, and the hard facts...I don't know if you read in the paper, yesterday's paper, about that little girl, four, she's died through a twelve year old lad who learnt sex lessons at school. He interfered with her and killed her...They teach them too much I think, they're going way past it now".

(Case No. 16B, Parity 1 WC)<sup>1</sup>

"But it wasn't so promiscuous as it is today, like the girls seem to be going with anybody really".

(Case No. 17B, Parity 1 WC)

---

<sup>1</sup>The woman was referring to the case of Tracy Mairs who was killed after a twelve year boy attempted to have sexual intercourse with her on 8th June, 1977.



Both these women are implying that knowledge about sexual relations actually increases sexual activity, an argument which has been used over the years to deny women knowledge about their bodies and the physiology of sex. Despite the concern voiced by the above working class woman that young children are told "too much" about sexual relations at school, there was also a definite feeling among the British women that information about sexual relations should be openly discussed at home. Eighteen (68%) British women were resolved to educate their children themselves:

"I think personally I would start a lot earlier than people say. If they ask any questions about it I will explain as I go along. It helps with the embarrassment then." (Case No. 22B, Parity 1 MC)

"And I told Jackie (daughter) at eleven because she was such a big girl you know. And being as she's been such a big girl I've had to tell her more about the facts of life early because of boys expecting her, thinking that she was older than what she was. So I've had to prepare her a bit earlier than I would have done if she was the normal size you know".

(Case No. 16B, Parity 1 WC)

The reasons mothers cited for providing earlier sex education were quite diverse. As seen above, one mother thought it would reduce "embarrassment", while another mother perceived her teenage daughter to be "at risk". On the other hand, two women teachers saw sex education as an integral part of general education and had a much more positive approach:

"I shall make sure that my daughter gets a thorough education. And I feel that it's not only a mother's job, it's also a father's job as well".

(Case No. 19B, Parity 1 MC)

Of the eight (31%) British women who had not thought about sex education for their children, two (8%) said they would answer questions if they were asked; and the other six (23.%) said they did not know how they would deal with the subject.

Certainly, the British women were aware of changes in attitude towards the open discussion of sexual relations between mother and daughter. Some women had experienced this with their own mother or mother-in-law:

"I think it's changed a lot now. I think my mother's generation find it difficult to discuss these things anyway...But my husband's mother is a lot younger and she's entirely different and you can talk to her about anything". (Case No. 9B, Primipara, MC)

"She's (Mother) very um...like she's quite open now with my younger sister. But when I was young, it wasn't spoken about you know, it was just one of those things you learnt at school from your school friends."  
(Case No. 8B, Primipara, MC)

The Asian women on the other hand, although far more relaxed in their attitudes than their own mothers, did not see themselves playing a large role in the sex education of their daughters. Only five (19%) said they would give their daughters some education voluntarily, while two (8%) said they would answer questions if asked. The majority of the women, seventeen (66%), said they thought their children would learn about these things at school, while two women (8%) did not know how they could broach the subject. Typical responses were:

"I will tell her (about menstruation) so that she knows what's happening you know."  
(Case No. 11A, Parity 1 Hindu)

"Here they tell everything in school. My būa's (father's sister-in-law) daughter, she knows about everything and she's not even fifteen yet and she knows everything separately. They tell everything in school".  
(Case No. 16A, Parity 1 Sikh)

"How will I tell her? I'll be shy. But this generation will be clever - they will know".  
(Case No. 20A, Parity 3 Muslim)

One of the uneducated Muslim women said she would give her daughter information on how to deal with menstruation, after the periods had started.

Although there are changing attitudes towards sexual relations and sex education, these attitudes are changing at different rates amongst different social groups. The group with the fastest changing attitudes are the white middle class educated women. Those whose attitudes are changing slowly are the traditional uneducated Muslim women. Whereas the middle class women might expect her partner to participate in the education of her daughter, the Muslim woman may be constrained by her partner or religion from breaking out of the traditional role.

Some consequences of lack of information about sexual relations

British women who were not given full information about sexual relations said they thought sex was "dirty" or they were confused by conflicting tales:

"It's something dirty when they hear it from their mates at school. It's all tittering and laughing behind the toilets you know".

(Case No. 8B, Primipara, MC)

Some British women had been told that babies are made "by rubbing belly buttons together", they come in "a little black bag", the "stork brings them", or they are found "under the gooseberry bush". The mystification surrounding women's reproductive functions is a mechanism of "coping behaviour". It permits a normally taboo topic to be talked about without breaking the taboo. At the same time it confuses the young child:

"I can remember saying to my mother when I was about seven or eight, about where babies came from. And she said initially that you get them from the hospital. But when I pressed 'where does the hospital get them from?' She said 'Well, perhaps the doctor brings them'. And in the end I imagined that God dropped them from the sky..."

(Case No. 21B, Parity 2 MC)

Lack of accurate information about pregnancy and childbirth may lead women to have fears about how exactly the baby is born, how does it get out? This fear reinforces women's passivity and in some cases, their utter dependence on doctors. For instance, not knowing exactly where the baby comes from has led some women to devise "strange operations in the umbilical region". (de Beauvoir 1972, p.326). This was the case for one of the British women studied:

"I didn't know where babies came from till I was about thirteen...And when I actually knew where they came out of, I nearly died of shock. I'd always just assumed that they cut your stomach open and took the baby out. I nearly died, the shock, I couldn't get over it!"

(Case No. 24B, Parity 2 MC)

This woman recalls how she was shocked to learn that babies were born vaginally - she had imagined they were delivered operatively. Her attitude reflects an over-dependence on the medical profession and surgical intervention at the time of childbirth. Images of women in childbirth as passive and dependent on the male dominated medical profession can be related to theories (held by men) of women as weak and dependent. Theories about women as inferior to men have been put forward by members of the medical profession since the 19th Century and have had considerable impact.

### DOCTORS' DEFINITION OF WOMEN

The influence of Freud's (1931) work on female sexuality is of particular importance here as it provides a particular definition of women. Also of significance is the way Freud's work has been taken out of context and used by other professions to develop arguments about the passivity and dependence of women. The linking of Freud's ideas with beliefs, such as the relationship between hysteria and the womb,<sup>1</sup> has strengthened within the medical profession the notion of the female patient as helpless and dependent on the male doctor.

Some of the most striking and alarming examples of male doctors' opinions about women are found in medical text books. In a study of doctors and women in nineteenth century society, L'Esperance (1977) refers to the writings of some of the doctors of the time. He quotes a Dr. Ryan (1837) as saying:

"Women are more sensitive, weak, influenced by moral and physical causes, and more liable to diseases than the other sex". (p.112)

L'Esperance also refers to the Medical Times and the Gazette of 1874 which claims women in childbirth prefer male attendants:

"because men are stronger, truer, more trustworthy, more merciful, less capricious and altogether more helpful than women to each other", (p.191-2)

Medical practice in 19th Century America also comes under criticism, particularly the practice of sexual surgery common at that time. Barker-Benfield (1975) claims the operation clitoridectomy was "intended to re-impose the traditional sexual order" (p.279) and was a "reaction to female emancipation" (p.279).

---

<sup>1</sup>The origin of the word hysteria comes from the Greek "'pertaining to the womb', anciently considered the seat of hysteria" (Webster Universal Dictionary 1968).

More recently Weiss (1975) has looked at what contemporary medical students learn about women, taking the leading medical texts and analysing them in terms of what they say about women and reproduction. Weiss found that Obstetrics and Gynaecology (Willson et al., 1971), a medical text which is used in sixty of the medical schools in North America, describes women as "childlike, helpless creatures with animal-like or 'instinctive' natures who can't get through intercourse, pregnancy, labour or childraising without 'enlightened' physician intervention". (Off Our Backs, p.24) A further review of medical texts (Scully and Bart, 1973) argues that these books have not been revised in the light of more recent studies of sexuality.

These medical texts express an ideology which is held by members of the medical profession and relates to a theory of women as weak and dependent. Conversely, there is a theory of men as strong and virile. These two theories may clash with each other in circumstances when doctors want women to be responsible for their actions and also to influence the behaviour of their partners. For instance, when a doctor instructs a pregnant woman to refrain from intercourse because of the threat of miscarriage. This was mentioned by five (19%) British women in the study and the following is a particularly graphic account:

"The doctor said that sex does not give you a miscarriage, but violent sex does. I don't know what he meant by violent sex, you know. I suppose he meant real, physical hard sex, sort of thing, was dangerous and that could bring on a miscarriage. Like jumping off a wardrobe and things like that. But I was quite surprised because the doctors say

'Oh sex doesn't hurt you'. But he was a firm believer that sex could just at the early stages. He said he was not just on about lying there sex, very gentle sex. He says, I mean, some people do have a lot of physical sex, you know really, physical. So he says 'You will watch out', so I says 'Yes'."

(Case No. 8B, Primipara, MC)

In this account, the doctor is assuming the woman is able to determine her husband's behaviour, yet at the same time she is the weak, helpless one according to the medical theory. The extent to which the woman can determine her sexual relationship depends largely on her male partner and the kind of relationship they have. The advice that doctors give women concerning their sexual relations must be analysed in terms of the assumptions the doctor is making about male/female relationships.

The 19th Century theory of women being governed by their ovaries/wombs, has since been superseded by a theory which argues that women are at the mercy of their hormones. We are told that hormonal imbalance is the cause of pre-menstrual tension, post-natal depression and miscarriage.

A few British middle class women were familiar with this theory and three women cited hormones as the cause of depression and miscarriage. One woman attributed her current lack of tolerance with her mother-in-law to her pregnant state and said "It's just my hormones swimming about" (Case No. 19B, Parity 1 MC). Another two women mentioned previous miscarriages being caused by "hormone imbalance" (Case No. 24B, Parity 2 MC and Case No. 21B, Parity 2 MC). The women's knowledge of the hormone imbalance theory is difficult to judge as all the women were not questioned systematically about it. However, it does provide an interesting example of women's behaviour being defined by a dominant medical theory and thereby leading women to believe they are powerless against their "hormones".

Doctors and sexual taboos

Similar to the way medical theories develop about women are the medical definitions employed to facilitate the doctors' task. One area in which medical definitions are utilised is gynaecology, for in these instances, the doctor is breaking sexual taboos by performing internal examinations. As Emerson (1970) says, it is the "medical definition" of the internal examination which:

"grants the staff the right to carry out their task. If not for the medical definition the staff's routine activities could be defined as unconscionable assaults on the dignity of individuals". (p.79)

Some of the British women managed to overcome their embarrassment of the internal examination by accepting the medical definition that it was performed solely for the good of the baby.<sup>1</sup> The medical definition is most commonly expressed in the booklets . . . . given to the women on their first clinic visit.<sup>2</sup> These booklets present the view that the internal examination is merely a measuring process to make sure the woman can deliver the baby without operative intervention:

"Your doctor will also want to make quite sure that there is enough room for the baby to pass through your pelvis and birth canal. Therefore at one stage during the last few weeks he will carry out a careful examination via the vagina (or front passage). (The Baby Book, p.12)

British women who had read these booklets and accepted the medical definition of the examination in terms of the baby, were able to minimise their embarrassment:

---

<sup>1</sup>Moyes (1976) refers to "baby-centred" and "doctor-centred" coping mechanisms which women employ during their pregnancy. These mechanisms, she argues, helps the women to cope with that would otherwise be seen as sexual encounters. (p.294)

<sup>2</sup>These books are given to the women on their first visit and it is doubtful they read them before having the internal examination later in that same visit.



"And I'm just waiting now, more or less um...they give you an internal for the pelvis like you know, to see how big the pelvis is. And that'll be the next thing...it's to see if you can bring the baby yourself like you know".

(Case No. 2B, Primipara WC)

"I had thought when you're about thirty-six weeks, they usually do an internal, first-time round, to see if you're big enough to have the baby. And I do seem to remember them saying they thought it was a fairly big head".

(Case No. 19B, Parity 1 MC)

These women viewed the examination in technical terms, a measuring procedure which could indicate a difficult birth. Other women were particularly aware of physical contact between doctor and patient and this over-rode any medical explanation:

"With the first one I had that Mr. W (consultant) - he used to be full-time - and he used to frighten every woman because he'd got very large hands and everyone was terrified of him. You'd only got to mention W and everybody got the colly wobbles",

(Case No. 11B, Parity 4 WC).

Moreover, not all women are conversant with the medical reasons for carrying out internal examinations. Women who are unfamiliar with clinic procedures are not likely to be prepared for the examination, and may view it as an explicit sexual encounter, despite the medical profession's attempts at "depersonalisation and desexualisation of the encounter". (Emerson, 1970, p.81)

Authors who have looked at the gynaecological examination from the woman's view point, rather than observing the clinical encounter (which Emerson does), claim that sexual overtones are still explicit for most women. Frankfort (1972) for instance, indicates the contradiction facing most women. On the one hand, they have been taught "that both the doctor and anything done in the framework of disease are exempt from the usual taboos" (p.xxiii) and on the other hand, they have also been taught "that access to her body is taboo

unless love is involved". (p.28) Moyes (1976) argues that women who were given internal examinations by young doctors were more likely to experience the encounter as a sexual one. She considers that:

"Once a woman sees her doctor primarily as a male, rather than as a professional, it is difficult for her to perceive the examination in anything but sexual, and therefore embarrassing, terms". (p.293)

The sexual nature of the examination is personified for Asian women who have not been socialised into accepting the medical definition of such an encounter. Moreover, the examination itself breaks taboos on women exposing their body to men other than their husband. The breaking of this taboo meant many Asian women were tense and anxious at the time of the examination to the extent that doctors recorded it in the hospital records:

"Pelvic assessment couldn't be assessed as she is unco-operative"  
"Tense anxious patient"  
"Very tense ECV not possible"

One Asian woman refused to go to the ante-natal clinic again as "she felt she had been assaulted" (Letter from GP to hospital). In this context, the Asian woman had no idea of what to expect at the ante-natal clinic. This was her first pregnancy in Britain and with her previous pregnancies in India she had never been examined internally. She was therefore not prepared for the examination, nor was she aware of its medical definition.

The primiparous Asian women were surprised by the internal examination and were similarly ill-prepared for the encounter:

"I thought always the lady doctor examined you from the inside, because I was examined by a lady for the first time, I never thought a man would do it!".....  
(Case No. 5A, Primipara, Hindu)

and another Sikh woman said:

"One feels shy in any case, whether he is Indian or gora (white) - after all he is a man!"  
(Case No. 2A, Primipara, Sikh)

Even women who had been pregnant before in Britain and knew about internal examinations were still embarrassed by them. Many women said they would prefer a white doctor because of the shyness they experienced with the internal examination. They saw a white doctor as socially distant from them whereas an Asian doctor was subject to the same cultural and religious taboos:

"But still in my opinion the doctor should be white (even though I can't speak English) because in front of our own doctors, our eyes naturally drop down (an idiom for shyness)".  
(Case No. 14A, Parity 4 Sikh)

"The only thing I feel is that he should not be a Pakistani or Indian doctor...One always feels shy, but if its a gora (white) doctor it's not so bad. If he's an Indian or Muslim I'd feel very shy".  
(Case No. 20A, Parity 3 Muslim)

The three rural Muslim women found the examination most threatening and there were reports that some Muslim husbands prevented their wives attending the ante-natal clinic because of the examination (Coventry Evening Telegraph, 6th October 1976).

When the Asian women were asked which sex of doctor they would prefer for internal examinations, eighteen (69%) said they would prefer a "lady" doctor and eight (31%) said they didn't mind or had never been given a choice. None of them preferred to have a male doctor. For ordinary care, two (8%) Asian women preferred to have a male doctor, compared with thirteen (50%) women who

who preferred a "lady" doctor. Eleven (42%) did not have a marked preference for the sex of doctor performing ordinary care. (see Tables XXXXVII a and b ). The marked preference by Asian women for women doctors can be related to the rigid separation of the sexes in India and Pakistan which is perpetuated on migration to Britain. For Muslim women to be examined by a male doctor contravenes Islamic law which forbids physical contact between a woman and a man who is not her husband.

Although British women are not subject to the same rigid cultural and religious taboos on contact between the sexes, there was a slight preference for a woman doctor. The majority of British women found it difficult to express a preference because they had never been given any choice and had limited experience of women doctors. For the internal examination, four (15%) British women preferred a male doctor and seven (27%) a female doctor. Fifteen (58%) British women responded either, that they didn't mind the sex of the doctor performing the internal examination, or that they were not given any choice. Five (19%) British women said they preferred a male doctor for ordinary care and seven (27%) preferred a female doctor. Fourteen (54%) British women did not mind (or had never been given a choice) the sex of doctor for ordinary care (Tables XXXXVII a) and b)).

Both groups of women expressed a preference for female doctors performing the internal. Only one woman studied said that she definitely would not want a woman doctor for an internal, her reason was "I think it's a bit queer". (Case No. 16B, Parity 1 WC)<sup>1</sup>. This comment reflects how the internal examination is perceived as

<sup>1</sup> Moyes (1976) says "It is worth remembering that one or two of my women disliked being examined internally by a female doctor as they thought it held overtones of lesbianism". (p.295)

transgressing sexual taboos, irrespective of whether the doctor is male or female.

WOMEN'S PERCEPTION OF SEXUALITY IN PREGNANCY AND CHILDBIRTH

Several writers on sexuality in pregnancy see pregnancy as a time when women are less sexually attractive than usual. Rosser (1978) for instance says that:

"In our society, a woman is expected to be in her sexual prime, to be sexually attractive and active, at precisely the time when she is also expected to become pregnant. The contradiction arises because, by the criteria for sexual attractiveness in our society, pregnancy and motherhood are thought to reduce a woman's sexuality".  
(p.1)

Graham (1976b) similarly argues that pregnancy is a "bridge between sexuality and motherhood". (p.293) The underlying assumption here is that pregnancy is in some way asexual.

Some women though do experience pregnancy as potentially enhancing their sexuality. This response was not universal, but it does deny the asexual model of pregnancy suggested by Rosser.

Enhanced sexuality was most often expressed in relation to size of the breasts. For example:

"My mother she used to say 'Drink a lot of milk' and - as see my bust-line is very small - and she said that you should breast feed your baby, that will develop your breasts". (Case No. 10A, Parity 3 "liberal" mother)

"I haven't put on a lot of weight on my bust, I was expecting big boobs and all sorts, and I'm afraid it's never come my way - it's all fell to here (pointing to abdomen). But they say that the girls with the smaller busts feed better you know".

(Case No. 1B, Primipara, WC)

The latter example shows how the woman, although disappointed that her breasts had not developed as much as she had hoped, was quite prepared to accept this as long as it was in the interests of the baby.

(A point which will be referred to later). Not all women wished for larger busts though:

"And I want to get back to normal as quickly as possible as well, you know. Get your figure back to normal, and the breasts as well. I always thought you know, I'd have a big bust and I thought 'God' you know I hate big busts. I can't stand them you know. And er...I've been quite lucky it hasn't gone too big and been top heavy you know".

(Case No. 8B, Primipara, MC)

This woman in contrast with the other two did not want to breast feed her baby - she found the idea repulsive:

"I definitely don't think I'll be breast feeding. I've never felt happy about it to be quite honest. I think it's a bit er...animal-like. I don't know why, because I imagine sort of dogs going round and being suckled by their pups, you know. To me it's just not the sort of thing I want to do".

(Case No. 8B, Primipara, MC)

This was the only British woman who expressed disgust at breast-feeding; similarly there was only one Asian woman who found the idea of breast-feeding repulsive:

"I know (that breast-feeding is good for babies) I've had my mother's milk! I used to have it till I was quite big". (Case No. 14A, Parity 4, Sikh)

Her own memories of being at the breast continued to embarrass her.

The women's different conceptualisation of their breasts may be seen in terms of a dichotomy between those women who viewed the breasts in purely reproductive terms and those who were aware of the image of the breast as a symbol of sexuality. Women who perceived their breasts as sexual objects, or were aware of the media image of breasts felt embarrassed at the thought of breast-feeding their baby. Seven (27%) Asian and four (19%) British women expressed shyness about breast-feeding, particularly in front of other people:

"I want to bottle feed....So many times one has to go out and then it's embarrassing".

(Case No. 17A, Parity 1 WC)

"When somebody comes, you feel shy"

(Case No. 23A, Parity 3 WC)

"I'm going to bottle feed... 'cos if you go out anywhere you can't really do it in front of everybody, well I wouldn't anyway".

(Case No. 3B, Primipara, WC)

It would appear that on migration to Britain, Asian women have become exposed to the media image of breasts as sexual objects. This image contrasts sharply with the traditional practice of breast-feeding in India and Pakistan. Thirteen (25%) of all women did not intend breast-feeding because they were embarrassed at the thought of exposing their breasts in front of men. In India and Pakistan households are divided into separate areas for men and women. Babies are fed in the seclusion of the women's area. In Britain the organisation of the household is different and it is often difficult for there to be a separate women's room. (Saifullah Khan (1976) describes the social and spatial separation of male and female Mirpuri villagers in Bradford, p.231).

Modifications in the style of dress worn by Asian women in Britain presents a further difficulty when breast-feeding. Traditionally, village women wear either a chaddar (heavy shawl) which is worn over the head and covers the chest or a dupata (lighter piece of Muslim cloth) worn over the head and chest. Women can therefore breast-feed with the chaddar or dupata covering the exposed breast. Although twenty-four (92%) Asian women wore traditional dress at the time of interview<sup>1</sup>, there were variations on the form of head covering worn.

<sup>1</sup>Twelve (46%) Punjabi Sikh and the three (11%) rural Muslim women wore shalwar kameez (tunic and loose trousers); seven (27%) Hindu, one (4%) Punjabi Sikh and one (4%) educated Muslim women wore traditional saris. One Ugandan Asian Hindu women and the Christian Punjabi Sikh did not wear traditional dress.

The three (11%) rural Muslim women wore the chaddar over their head and chests; two (8%) Sikh women wore the dupata in the traditional way over their head and chest while thirteen (50%) wore the dupata in the less traditional fashion which is draped around the neck and shoulders with the ends falling down the back. Eight (31%) women wore no head covering at all.

Changes in the organisation of the household and modifications in the dress worn may provide an explanation for Asian husbands preventing their wives from breast-feeding. Four (15%) women said their husband would not let them breast-feed:

"I don't mind breast-feeding, but my husband doesn't like it. He does mind and he said when you go out you can't breast-feed down there".

(Case No. 3A, Primipara, Hindu)

"Even my husband doesn't want me to breast-feed because other men keep coming into the house - there might be some other trouble".

(Case No. 12A, Parity 2 Muslim)

The other reasons women gave for not wanting to breast-feed were convenience, difficulties with returning to work, not enough time with other children and so on. These reasons and the factors affecting the woman's decision on the method of feeding to adopt are developed more fully in Chapters Seven and Ten. The reference here to breast-feeding is to illustrate the tension between breasts as sexual objects and their function in lactation.

Pregnancy, for some women is definitely related to enhanced sexuality and most women associate pregnancy with a change in self-image. Some women experience a contradiction between the images presented to them of pregnant women (cf. Graham 1976) Weare (1979) recognises this contradiction when she looks to "The Great Earth Mother" image as an alternative to the "NHS image of motherhood". She says



"although it is a more constructive image than the previous one, going back to women as primarily physical, earthy beings is no help to someone like me who wants to have an active, working, intelligent image of themselves when pregnant." (p.17)

Both of these images are likely to be shattered when women attend hospital and procedures such as shaving the pubic hair and "stitching" after delivery are performed. These procedures were perceived as threatening to the woman's "sense of identity":

"A friend of mine gets her husband to shave her before she goes in. The way they do it, it's embarrassing. You lose your sense of identity".

(Case No. 11B, Parity 4 WC)

"Stitching" was also seen as a sexual encounter, especially if the woman had no previous childbirth experience and was young:

"When I had Simon I had to be stitched.....I mean, now I couldn't care less, but with the first one I was only seventeen and I was a bit embarrassed anyway"

(Case No. 11B, Parity 4 WC)

Another woman viewed being "stitched" in terms of the effect this had on her conception of her body image:

"I didn't look at my stitches, some women nip off and look at their stitches, well I daren't do that. I thought it might be a terrible nasty mess. But when I did come home I did look for them and was surprised to find - perhaps a lot of women don't look at themselves - anyway, having a baby you can obviously tell from an examination whether a woman's had a baby or not. And I wasn't - we weren't told about the physical changes. I thought I would be exactly the same you see, I mean, although as I say I'm a Biologist you know, I just thought once the vagina had expanded and the baby had come out, you'd all sort of...you'd be just the same. Though I had heard them saying that from an examination they can tell if a woman has borne a child or not. But I was very grateful that I had got this diagram in this book to sort of refer to. And there it was, it showed you sort of, before and after, and I could look at that and think 'Yes, it's definitely an 'after' now'."

(Case No. 19B, Parity 1 MC)

One other middle class British woman said she would be taking a mirror into hospital with her to look at "the damage" after the birth. None of the Asian women or the working class women mentioned looking at "themselves". The influence of women's self-help groups and some of the recent feminist literature<sup>1</sup> may have been important in encouraging the middle class women to examine themselves. The two women referred to were certainly familiar with some of this literature.

#### SUMMARY

This Chapter examines the social constraints surrounding female reproduction. There are many factors militating against women controlling their reproduction and these can be related to women's position in the dominant social order. Specific social relations are seen to restrict women's access to knowledge and resources and thereby limit their autonomy.

Although there are certain similarities in the way all women perceive these social constraints, there are also important differences which can be related to the woman's social class, religion and cultural background. In the following Chapter I examine the extent to which these similarities and differences persist when women are pregnant and their status as reproducers is temporarily raised.

---

<sup>1</sup>MacKeith's (1976) Women's Health Handbook and the Boston Women's Health Collective's (1971) (British Edition 1978) book Our Bodies Ourselves are probably the most important here.

## CHAPTER SIX

### PREGNANCY AS A STATUS PASSAGE

#### Introduction

In the preceding Chapter, the constraints on women's control over their reproduction were outlined. These limitations can in part be attributed to women's low status in male dominated societies. However, when women are pregnant their status changes, for now they are the bearers of new life which may enhance the status of the social group. The extent to which women's status is raised when they are pregnant can be related to the value placed on motherhood in the society, although as it will be argued later, the status of mothers in advanced capitalist societies is ambiguous.

A traditional anthropological analysis of pregnancy regards it as a "rite de passage" (Van Gennep, 1908) and stresses the importance of the rites and rituals which aid the woman through the transition from pregnancy to childbirth, from the barren to the mother, and ultimately from the "young wife" to the mature woman. Pregnancy is, therefore, a time of change and uncertainty, or as Leach (1976) says, of "abnormal time", and the rites and rituals which abound are seen as the key to understanding the management of pregnancy and childbirth. Earlier (p.60-61), some of these rites and rituals were described and the limitations of such an approach outlined. One of the shortcomings of this approach is that there is little attempt to examine the social relations involved in perpetuating these rituals, for example, the

way in which certain rituals enforce a social and sexual division of labour. A further limitation of these analyses is that the focus of study is the observance of ritual and not the pregnant woman herself - the woman thus becomes submerged in an analysis of the structure of society. Finally, the "initiates" (Leach, 1976) that is, the people in the process of status transformation, are often assumed to be a homogeneous group. In advanced capitalist societies it is incorrect to assume that all pregnant women form a homogeneous group, for the way women respond to changes taking place at this time largely depends on their social class and ethnic background.

A more comprehensive analysis of the changes involved during pregnancy, is one which looks at the meaning of the status transformation to motherhood from the perspective of the actors, i.e. the women themselves. Using this approach it is possible to evaluate the extent to which dominant values are reproduced when a woman is pregnant (for example, the status of women as reproducers, and the value placed on producing male children). Also, it is possible to look at the concessions which are granted to pregnant women. These concessions include, changes in the sexual distribution of food while women are pregnant (commonly referred to as cravings); abatement of the taboos associated with pollution potential; changes in the sexual division of labour in household activities (see Chapter Ten); and the concessions made by the State in the form of State benefits for pregnant women.

Although concessions are granted to parturient women because their status is temporarily elevated, there are also constraints placed on their actions to ensure they remain pregnant and give birth to live healthy babies. The intensity of these concessions and constraints depends largely on the class and cultural background of the woman and the meaning of the pregnancy to the social group. There is, therefore, an ambiguity surrounding the treatment of pregnant women, on the one hand, they are accorded status and are told that all their desires should be fulfilled, and on the other hand, they are prohibited from engaging in certain activities which are seen to endanger the baby.

The following account attempts to incorporate the perspective of the woman into an analysis of the status transformation of becoming a mother, while teasing out the tensions and ambiguities inherent in the status passage. The areas explored in depth are i) the status of women as reproducers, ii) the transitional stage of pregnancy, a) the concessions, b) the prohibitions; iii) separation at the time of childbirth; and iv) the re-integration of the woman into society. The last three areas are a variation on Van Gennep's original analysis.

#### STATUS OF WOMEN AS REPRODUCERS

The status accorded to pregnant women in a society depends on the value placed on motherhood and children. The first pregnancy denotes the transition from being childless, or barren, to motherhood and can be seen as a powerful symbolic confirmation of the value of womanhood. However, it was stated earlier (p.37) that motherhood

is not accorded the same status in all societies and there is a tendency for women's status as reproducers to be higher in societies where women are not involved in, or only play a marginal role in, production outside the home. To develop these ideas further, I shall briefly concentrate on women's status as reproducers in an agrarian society-rural Punjab, and advanced capitalist society-Britain.

In the Punjab, women's work is mainly confined to the home performing domestic labour. The Punjabi women in this study came mainly from the Jat (landowning) caste and only had experience of work in the home (eleven, 42% of women were in this category). A further five (19%) women were from agricultural labourer families (see p.209) and their work was mainly of a domestic nature, although one woman said she had been involved in seasonal agricultural work. Women in the rural Punjab are therefore only marginally involved in production outside the home, their main duties are to service (i.e. feed, clothe) the male workers and other family members and to produce children, particularly male children who will contribute to the family as future workers.

Childless women in rural Punjab are accorded low status and this is depicted by the stigmatism of barren wives (see page 19) - they can be returned to their family of origin, and are often seen as causing miscarriages by possessing evil spirits. On the other hand, motherhood is accorded high status and the strength of this belief is shown by the reaction of Indian people to the family planning programmes. "Pregnancy is normally a welcome condition for a married female setting her above her less fortunate sisters,

making even a poor or low caste woman an object of envy".

(Marshall, 1973) Pregnancy among the unmarried is almost unheard of in the Punjab and in those rare cases when it occurs the unmarried mother is treated as a social outcaste.

In some societies, Van Gennep (1908) notices that marriage is not considered valid until after the birth of the first child, thus "the rites of pregnancy and childbirth constitute the last acts of the marriage ceremony and the woman's transitional period stretches from the beginning of her betrothal to the birth of her first child". This is the situation in the Punjab where the marriage is not deemed legitimate until the wife becomes pregnant. A village woman is therefore socialised "to believe that the only meaningful roles she could assume, her total social identity, demanded that she bear children". (Marshall, 1973)

Mothers in rural Punjab are accorded higher status than childless women, and women who have borne sons have a higher status than those women who only have daughters (see earlier discussion, page 19). The desire for children, particularly sons, tends to be greater in agrarian societies where the children make a contribution to the future livelihood of the family. In the Punjab, sons will play a future role in production bringing a wife into the family to help with domestic labour and producing children. Daughters on the other hand are a financial liability, they marry and move to the home of their husband taking with them a substantial dowry. Morpeth (1979) quotes some of the traditional sayings in the rural Punjab, for example, a daughter is "a guest in her parent's house" and "bringing up a daughter is like manuring and watering a plant in some-one else's courtyard".

In Britain, the status of women as mothers is more ambiguous than in the Punjab for women tend to have a dual role as both producers and reproducers (cf. Myrdal and Klein 1956; Beechey 1977) Women in Britain have been increasingly involved in paid employment outside the home since the second world war:

"By 1986 it is estimated that nearly two out of three married women aged between thirty-five and fifty-nine years will be economically active compared with one in five in 1951". (Land 1976, p.118)

At the same time, women have had more control over their fertility than ever before and the average family size has decreased. Thus, women in Britain may have a self-identity which is not necessarily one of motherhood. However, this is not to suggest that women unilaterally derive satisfaction from work outside the home, for this would be to ignore the class differences between women which to a large extent determine the kind of employment they have. What it does suggest is that women do not automatically consider motherhood to be their only adult role.

Moreover, motherhood and the state of pregnancy are not always welcomed in advanced capitalist society. For example, high status is only granted if the birth is legitimate; unmarried women who fall pregnant are ascribed low status as irresponsible women or "victims". The norm in Britain is that pregnant women should fulfil certain conditions. One condition is that the birth is legitimate and the woman is married; women who are not married are referred to as if they were, when they attend the ante-natal clinic. All women at the ante-natal clinic are called Mrs. irrespective



of their marital status which the staff, but not the mothers, see as courtesy. Moreover, any unmarried woman at her first visit to the clinic is asked to see the medical social worker, unless she is getting married when this interview is not deemed necessary. (See also Macintyre 1976c;p.168-170) Three women in this study saw the social worker when they were pregnant (two of the unmarried mothers refused to see her, and a further two women married before the baby was born). One unmarried mother expected the social worker to inform her about abortion and her entitlements, but found that this was not the case:

"She didn't tell me that I could have an abortion, how to get one or anything. Neither did she tell me what I could claim, the Maternity benefits. I've since found out that I can get an Affiliation Order out against him (father of the child), but I had to go and see the solicitor to find that out". (Case No. 4B, Primipara, W.C. unmarried)

Another woman who saw the social worker was surprised her visit was so short:

"I told her I was getting married and she didn't seem very interested ... she didn't give me any advice or nothing". (Case No. 7B, Primipara, W.C. married at seven months pregnant)

Motherhood is therefore a status which is accorded great respect, but only to those who do not deviate from the cultural norms (see earlier discussion, p.111-113). Other categories of women who may be seen to "deviate" are low class women and immigrants (these areas are more fully dealt with on pages 70-72 and 108-110).

To judge the extent to which the status of motherhood differs among Asian and British women in Britain, it is necessary to look at their attitudes towards motherhood. As all the women studied were

pregnant, it is difficult to make any conclusive statements about their attitudes towards childlessness, but it seems that among certain groups of women to have a child raises their status. One Punjabi woman spoke of a friend who was so desperate to become pregnant that she experienced a "phantom pregnancy".

"She (the friend) was married about ten years I think and she didn't have any babies at all. And about a year ago, me Mum told me she was pregnant. And I keep on thinking about her you know, that its good and all that. So I asked me Mum when it was nine months and that 'What's she had?' But the doctor told her that she didn't have anything at all. But she used to say that she's feeling kicking and she's feeling sick and all that you know. After ten months she didn't have anything and they gave her pills to clean her....She really wanted it, she was really happy for nine months. I think it was just imagination with her." (Case No. 11A, Parity 1, Punjabi)

This account suggests the continuing importance of motherhood to Asian women residing in Britain.

The British women studied also placed importance on becoming a mother and three out of the five British women who had not given birth in the first four years of marriage were treated for infertility. One of the other women was waiting for an appointment to see the gynaecologist when she conceived. Pregnancy for these women meant something they had been looking forward to for a long time. As one woman said:

"I can't wait for it. I've waited nine years for this" (Case No. 1B Primipara, WC, two previous miscarriages)

Although the women in this study did not view childlessness as a welcome condition, it would be unwise to assume their comments are universal. Recently the idea of voluntary childlessness has been purported as a viable alternative to motherhood, for instance Peck (1973) in America. However, it would appear that this ideology

is primarily restricted to white, middle class women. Research in London shows that childlessness is taken more seriously by working class women who do not have alternative means of self-fulfillment (Newton 1979).

The Asian and British women studied expected to have a child at some stage in their fertile years, though there were significant differences between the two samples as to when their first child was born. The Asian women (all of whom in the final sample were married) were far more likely to marry earlier (see Table XXIV) and to conceive soon after marriage (84% of the Asian women had given birth before they had been married two years). The married British women (85% of the British sample) were more likely to wait longer after their marriage before giving birth (66% of these women gave birth after two or more years of marriage). See Table XXXXVIII (Four (15%) British women were not married when they gave birth). These figures suggest there are strong social pressures on Asian women residing in Britain to conceive soon after marriage. (Two first-time pregnant Asian women migrated to Britain when they were pregnant). Only one of the first-time pregnant Asian women said she had used contraceptives after marriage (this woman had been educated in Britain and said she came from a "liberal" home).

Earlier, it was argued that women in Britain can derive status from paid employment as well as motherhood. However, most women with young children stay at home to look after them until they are of school age at least. As Land (1976) says:

"In 1971 less than one-fifth of mothers with children under five years old and two-fifths of those with children of primary school age worked either full or part-time whereas half the mothers with children of secondary school age went to work." (p.118)

One of the reasons women with under school-age children do not work outside the home is the shortage of adequate child care provision. Another reason, however, is the dominant ideology of mothers as individually responsible for their children. This ideology was strongly espoused by Beveridge (1942) in his report (see page 27) and later reinforced by Bowlby (1951). Bowlby stressed the importance of the family as the "correct" socialising agency for the rearing of children. More importantly, he emphasised the exclusive early mother-child relationship as crucial to the future well-being of the child. The physical and psychological development of the child, according to Bowlby, depended on the mother's total care for the child up to school age.

The contradiction between being a "good" mother who stays at home to look after children (at least till school age) and being economically active outside the home, is not easy to resolve. Inevitably, economic necessity is a determining factor. Another factor is the extent to which a mother can rely on familial support for child care.

The women in this study were asked at the time of their first interview, if they were working outside the home: six of the nine first-time pregnant British women were, but only one of the nine first-time pregnant Asian women. The reasons the Asian women gave for not working outside the home (although they would have liked to) were: 1) lack of spoken English; 2) not long arrived in this country and 3) their qualifications were not recognised in Britain.

The women were also asked when they were eight months pregnant if they intended to engage in paid employment after the birth of the baby. The responses from both British and Asian women were remarkably similar and fell into four main categories. (see Table XXXXIX)

- a) Seven (13%) women (four Asian and three British) said they would engage in paid employment after the birth of the baby because it was economically necessary.

For example:

"Without work, one can't manage. Whatever time I find free I do some stitching. I have been stitching from the very beginning. In England I've only worked for five months (outside the home) after my first baby was born, in the canteen and then again my periods stopped coming - I was going to have another baby. So I worked only for five months. After that the other one followed and I just couldn't work outside the home".

(Case No. 14A, Parity 4, home worker)

"I would like to go back to work. I would have the baby at the nursery as well 'cos they take them from any age...It's just a case of whether I could get a job. The money would help."

(Case No. 12B, Parity 2, W.C. unmarried)

All of the British women who said they needed to work for financial reasons, were working class women.

- b) This group consisted of eight (15%) women who wanted to work outside the home because they were lonely (three Asian women), career-minded (three middle class British women), or just fed up with being a Mum (two working class British women)

"I feel lonely with nothing to do at home".

(Case No. 5A, primipara, Brahmin)

"I'm career-orientated rather than Mother, sort of. Finding great satisfaction in motherhood and just being a wife doesn't interest me - I've got to have some outside interests."

(Case No. 19B, Parity 1 MC, teacher)

"It's good if you work, instead of sitting uselessly at home."

(Case No. 16A, Parity 1, Sikh)

"I would love one (a job after this pregnancy). To be me again, not to be a slave, a machine for everyone....The children don't need you twenty-four hours a day...a child needs you most when it's sick, it's ill."

(Case No. 11B, Parity 4, WC)

The women in this group felt they needed an identity other than motherhood which they hoped to find in the company of people outside the home.

- c) Six (12%) Asian women living in nuclear families said it was not possible to work outside the home because there was no-one to look after the children.

"How can I leave them and work?"

(Case No. 22, Parity 2, Sikh woman living in nuclear family)

"No. It will be difficult with the children".

(Case No. 17A, Parity 1, Sikh woman living in nuclear family)

- d) This was the largest category - thirteen (25%) women (five Asian and eight British) felt it was their duty to stay at home and look after the children, especially until school age.

"I don't think you should work until they go to school".

(Case No. 25B, Parity 1, MC)

"I think, let the baby grow for about three years and when the baby's older."

(Case No. 11A, Parity 1, Hindu)

Some women felt particularly uneasy about the prospect of leaving the children in the care of some-one else:

"I don't feel I can trust any-one else with the children."

(Case No. 21B, Parity 2, MC)

"I would like to work. But how can you do it with the children to look after. If I leave them with some-one else I don't feel easy."

(Case No. 15A, Parity 4, Hindu)

These different responses show the way in which women react to the various images of women as mothers and workers. The first group of women did not see there being any choice, they had to work to earn money; the second group of women did not identify themselves with the image of mother and wanted to work outside the home in order to gain an independent idnetity. The third group of women did not have relatives present to help with child-care. This is an important point, for three Asian women who said they were going to work after the birth of the baby were relying on their mother-in-law to look after the baby. In one Punjabi household the mother-in-law was looking after the children of her three daughters-in-law while they worked to contribute to the family income. The final group of women illustrates the ideology referred to earlier of the mother being solely responsible for the child for the first few years of its life.

From the women's responses it would appear that it was mainly the British middle class women who derived status from work outside the home (three of these women were teachers who had a more flexible working day than other workers). The lower social

class Asian and British women tended to work outside the home because it was economically necessary - this work was in no sense "liberating" or gave them high status. Two of the British working class women considered motherhood gave them a legitimate reason to terminate a boring job:

"I worked at GEC (General Electric Company) right from when I left school till I got pregnant (twelve years). I couldn't stand it you know. I was never happy in my work anyway, it was just one of those jobs I went into you know, because I didn't have any qualifications so. There's not many jobs you can get anyway, and the money was there".

(Case No. 2B, primipara, WC)

On the other hand, five women wanted a job because they were socially isolated at home, and some women had no choice over whether they worked or not. This was most marked among the Muslim women in the Asian sample who said:

"Our men don't want us to work. They don't like us to go out".

(Case No. 20A, Parity 3, Muslim)

The question of whether a woman considers her total social identity to be that of mother, depends greatly on the women's social class position and also her relationship with her husband (or partner). The value placed on motherhood and its relationship to women's work is an important indicator of the extent to which women's status is raised when they are pregnant.

In societies such as India, where there is a particular preference for male children, the woman's status is further enhanced if she bears a son (cf. page 19). The preference for male children persists among Asian women in Britain and twice as many Asian women as British said they would prefer a boy (see Table L).



TABLE L                      RESPONDENTS' DESIRED SEX OF CHILD

	Asian		British		Total	
	No.	%	No.	%	No.	%
a) <u>Final sample</u>						
Male	16	61	8	31	24	46
Female	1	4	15	58	16	31
Don't mind	9	35	3	11	12	23
<u>Total</u>	<u>26</u>	<u>100</u>	<u>26</u>	<u>100</u>	<u>52</u>	<u>100</u>
b) <u>First-time pregnant women only - Final sample</u>						
<u>Desired sex of child</u>						
Male	5	56	2	22	7	39
Female			4	44	4	22
Don't mind	4	44	3	33	7	39
<u>Total</u>	<u>9</u>	<u>100</u>	<u>9</u>	<u>99</u>	<u>18</u>	<u>100</u>

These figures should be looked at in the context of the sex of the women's existing children. Both groups of multiparous Asian and British women had a total of fifteen boys; whereas the multiparous Asian women had a total of twenty-five girls compared with the British women who had a total of nine. The figures probably reflect the multiparous British women's greater desire for daughters because they were more likely to already have a son and vice versa for the Asian women. Although the strong social pressure on Asian women to produce sons should not be forgotten. One first time pregnant Asian woman said:

"He (husband) wants a boy and I want a girl.  
I prefer a girl ... He said 'If it's a boy  
I'll celebrate, if it's a girl, I won't!  
I said never mind I'll celebrate".

(Case No. 3A, primipara, Hindu)

Another Asian woman who had four daughters (and no son) said  
she had dreamt about kidnapping a boy:

"I saw children running around and I pick up one and  
my husband gets annoyed and says why do I have to take  
this child, and I say if it is a girl we'll leave it  
and if it's a boy we'll take it. It turns out to be  
a boy. He says 'How can we take a child that is not  
ours, what will the people say? We'll take it to the  
gurdwara (Temple)' And then I woke up".

(Case No. 14 A, Parity 4, Sikh)

The social pressure on this woman to give birth to a son was so  
strong that she imaged<sup>in</sup> herself kidnapping a boy. Other women  
mentioned observing certain rituals to detect and/or ensure the  
sex of the child in utero and these will be discussed later. The  
uncertainty these women experienced during pregnancy can be related  
to the social changes taking place and therefore a closer  
examination of the transition to motherhood is warranted.

#### TRANSITION FROM PREGNANCY TO CHILDBIRTH

The transition is concerned with the difference between  
"becoming" pregnant and "being", or learning how to be, a mother.  
There is also another distinction to be drawn, and that is the  
comparison between first-time pregnant women for whom the process  
is a new experience and those women who have been pregnant before.

This latter group, although having experienced pregnancy before, may find that this time it is different from the previous one(s) and they may have to change their behaviour accordingly.

Change has a disturbing influence both on the individual and upon social relations. To compensate for these disruptive effects, the processes of change are often ritualised, thus giving meaning to unavoidable danger. Pregnancy is therefore, a dramatic time for the individual and also a favourable time for intense education into new roles. For example, Mothercraft classes exist to instruct women how to become "good" mothers. Moreover, a certain behaviour is expected of the mother-to-be, and for the young woman her first pregnancy denotes the end of childhood:

"When I had me first baby I went to the fair and I was you know (pregnant) and things like that - I did go dancing. And me Mum wouldn't believe in it and she said that's why people do have miscarriages."

(Case No. 12B, Parity 2, WC, first pregnancy aged fourteen)

Primiparous British women who had been in paid employment before becoming pregnant remarked that on leaving work they experienced social isolation for the first time. This was one aspect of the status transformation they had not anticipated:

"No-one explained depression in pregnancy. I'm a very impatient person and it seems such a long time...This is one of the problems, if I'd got more to do - and all my friends, my work friends and that, I've got so far to go...and there's none of my old friends around here...I mention it to the family at times, but I haven't told the doctor because there's nothing really you can do about it."

(Case No. 5B, primipara, WC)

Other uncertainties are managed through numerous rituals which serve to stabilise the situation and ensure a successful transition. These rituals usually take the form of prohibitions on the pregnant woman's actions, however, before looking in detail at these prohibitions I want to focus on the concessions made to pregnant women because of the temporary elevation in their status.

a) CONCESSIONS

1. Cravings. Earlier (p.10-16) it was argued that there is a sexual and social distribution of food in society. When women are pregnant there is an adjustment in the sexual imbalance of the distribution of food (but not the social inequalities). Changes in the sexual imbalance are not necessarily consciously made, but have become institutionalised over time. They constitute what are commonly known as the "cravings" of pregnancy. These cravings are usually for foods the woman would not normally eat in any quantity, and the most common cravings are for fruit, sweet foods and sour or spicy foods. These cravings can be distinguished from "pica", a term originating from the Latin for "Magpie", a bird which collects strange articles. (Llewellyn-Jones 1971, p.196). In pica of pregnancy "substances such as soap, disinfectant, toothpaste, metal-polish, coal and plaster off the walls are eaten..." (Trethowan and Dickens, 1971, p.127). True pica is quite rare and only one woman studied said that she had heard of it:

"My mother...said if you feel like something just eat it...I mean if it was something like soap, bars of soap, some women have been known to do that. Coal - that's Simon's (husband) mother, she used to eat coal. I'd be a bit worried if I went on things like that."

(Case No. 8B, primipara, MC)

Cravings in pregnancy, on the other hand, are quite common, Trethowen and Dickens (1972) in their study of women in Birmingham found that between one-third and two-thirds of pregnant women were affected. Some schools of thought argue that cravings are physiological in origin and may be due either to dietary deficiency or hormonal imbalance. One of the women interviewed was aware of this literature and said:

"the information I was given was 'follow the cravings because you need them'....The diet books I read did seem to indicate that there was a lot of sound physiological common-sense in the cravings, you really did eat certain things because you needed them."

(Case No.26B, Parity 1, MC)

The physiological basis of cravings in pregnancy has not been established and Obeyesekere (1963) argues that cravings for foods "cannot be significantly related to nutritional needs" (p.334). Obeyesekere's work on dola-duka (pregnancy cravings) in Ceylon<sup>1</sup> argues that it is a "well defined and clearly marked out cultural complex, importantly related to the social structure of the village" (p.323). The cravings are, therefore, socially constructed.

In the traditional Hindu system of medicine (Ayurveda) the desire for particular sorts of food by pregnant women is seen to indicate the disposition of the infant and the form of its body.

---

<sup>1</sup>Now Sri-Lanka

"When the mother wishes to eat buffalo flesh the child will have blood-shot eyes, much hair and he will be war-like; and when hogs flesh, he will be sluggish and sleepy". (Wise 1845) More recently Thakkur (1975) says that in the fourth month of pregnancy the foetus:

"needs various objects which express themselves as the longings of the pregnant woman. As the woman now has two hearts (her own and that of the foetus) her desires should be satisfied as far as possible. If these desires are fulfilled the child becomes brave and strong and lives long enough. The child possesses a body form and behaviour similar to the subject for which the pregnant woman has strong desires or longings". (p.25)

Obviously these sayings do not occupy the minds of all pregnant Indian women today, but some women are familiar with them and if they desire a child of a particular sex then they may bear some relevance. For example, the mother of four girls expecting her fifth child said the following:

"some say that if you are going to have a boy then you feel like having things that boys like...Take for example, vegetables and lentils and karhi (a dish made from gram flour and yoghurt) - if you are going to have a girl then you feel like having these things ...Boys like mangoes and pomegranates (symbol of fertility). Even in the dreams you can see these things..."

(Case No. 14A, Parity 4, Sikh)

In many societies women are told when they are pregnant that all their desires should be fulfilled. For example, Kitzinger (1978) says that the midwife and mother-in-law in Guatemala collude to satisfy any cravings the pregnant woman may have. (p.84) If the woman does not receive the food she craved then the baby may be in some way marked or deformed. These

rituals are seen to be "remnants of a once co-ordinated system of prohibitions and instructions about conduct" (p.87). These rituals still persist in Britain today and so does the belief that the woman's desires should be fulfilled to avoid damage to the baby:

"My mother said if I ever fancied anything and I didn't get it, it'd have a birth mark looking like whatever it was I wanted. So if I've ever said 'Oh I fancy something' somebody's had to get it."

(Case No. 5B, primipara, WC)

In India, cravings for unusual foods are humoured and the woman in a joint family is allowed to refuse foods she disliked. (Marshall 1973) This situation is only tolerated when the woman is pregnant, in a non-pregnant condition she would be expected to eat what she is given. Indian women in Britain also tend to have more choice over their diet when they are pregnant:

"I only have what I feel like eating"

(Case No. 23A, Parity 3, Sikh woman, living in nuclear family)

"I eat whatever I feel like, whether it's cheap of expensive".

(Case No. 22A, Parity 2, Sikh woman living in nuclear family)

Not only are the cravings of pregnant women indulged, but also she is "given somewhat better food than usual" (Lewis 1965, p.47) and as Luschinsky (1962) says:

"Women of all castes agree that expectant mothers should receive as rich a diet as possible and that, ideally, they should be given any food which they desire". (p.63)

The practice of eating the food desired, seems to have persisted among Asian women in Britain as long as they can afford it:

"I just started having a lot of everything - more meat and I used to drink more milk...."

(Case No. 17A, Parity 1, Sikh woman living in a nuclear family)

Women living in nuclear families were more likely to control what they ate than women living in extended families, who were likely to have their food prescribed for them by their mother-in-law. This also happens among "traditional" British women as the following example shows:

"And me Mum asked him (G.P.) 'Do you still have to keep to the old fashioned way of having to eat twice as much of everything?' He said 'No you don't - that's old fashioned!' Which I was pleased about 'cos I don't eat that much at the best of times".

(Case No. 14B, Parity 1, WC, unmarried woman)

All of the British-born women were aware of the existence of cravings in pregnancy and they are also mentioned in the literature given to them at the clinic (You and Your Baby, Part I, p.10). However, a belief in cravings was for some women an excuse to indulge themselves while in the temporarily elevated pregnancy state.

"Well before I never used to eat a lot of cakes and biscuits and things, but I've realised I've been eating a lot of these"

(Case No. 12B, Parity 2, WC)

"I think you do eat more, you need to eat more when you're pregnant".

(Case No. 23B, Parity 2, MC)

The British working class women admitted to eating more in pregnancy, particularly more starchy foods. They saw pregnancy as a time when they could eat what they wanted and would try and satisfy their cravings if they could afford them:



"This time I had a craving for icing and marzipan. So I went and bought an iced cake and ate it all myself."

(Case No. 16B, Parity 1, WC)

"But I don't really think I've had a fad on anything you know, well only potatoes, I did have potatoes for a time. The worse thing out I could have, but er... mashed potatoes and potatoes in their jackets. I could eat them till they came out of me ears..... Oh, and bottles of pop, I could get through a bottle of pop a day quite easily. But I didn't want it in the glass, it's got to be out of the bottle".

(Case No. 2B, Primipara, WC)

"I couldn't pass the chip shop up the road, I had to go in...I was eating normal food as well. I'd eat a cooked dinner here and I'd go up the road and the smell of chips and I'd have to go into the chip shop and have roe and chips".

(Case No. 11B, Parity 4, WC)

However, not all the women were fortunate enough to be able to indulge themselves and the following woman whose husband was unemployed said:

"He (G.P.) just said I'd have a craving for different foods like. Sometimes I do like, but I never get them till the end of the week or something, then the cravings gone off."

(Case No. 13B, Parity 2, WC)

The more affluent women on the other hand could afford more exotic tastes:

"I ate whatever I felt like, which at one point was Mexican food and dill pickle dipped in yoghurt".

(Case No. 26B, Parity 1, MC)

"In the beginning I found I was eating foods I wouldn't normally eat. I would suddenly fancy pilchards on toast. I wouldn't normally buy pilchards, but I suddenly fancied a more varied diet - it's one long round of sausages and mince".

(Case No. 21B, Parity 2, MC)

The idea that food ingested by the pregnant woman had a direct effect upon the developing child was also quite common. In the same way that the Indian woman felt she could determine the sex of her child by eating certain foods. British-born women

were familiar with the idea of the food ingested determining the baby's future tastes (a belief also held by health care professionals):

"I've been eating a lot of apples and the woman in the grocer's shop 'That poor baby' she says 'it'll hate apples when it's born, you'll give it a tummy ache'." I thought 'God, you know, how can you say something like that, it's ridiculous, all the apples I eat are going to give the baby a tummy ache sort of thing'. Mind you, my mother reckons when she was having my sister she took a fad for chocolate, she was always eating chocolate you know. And er...when she was born she was really suckling like this (demonstrates), and the nurse at the hospital said 'Fod God's sake what is it you were eating through your pregnancy?' Me Mum says 'Chocolate caramels' and the nurse says 'That baby's dying for one, she's probably been getting a taste of it and she's dying to actually taste it on her tongue".

(Case No. 8B, primipara, MC)

Women have been able to use the idea of the correlation between food eaten and the health of the unborn child to argue for foods they want during pregnancy. Some women realise they, for once, have power to manipulate the controllers of food (or income) in the household, i.e. among the women studied here, either their male partners, or their mother or mother-in-law. This giving of extra or special foods to pregnant women is similar to the practice amongst Javanese women of giving ritual meals to pregnant women. (Tanner, 1973, p.136). The idea of cravings in pregnancy is so institutionalised women felt able to use it as an excuse for exercising control over their husbands. As one woman said who had not experienced any cravings:

"I just put it down to being spoilt and getting what you want really....I find that being pregnant I can always get what I want, so I've found it's just greediness really".

(Case No. 17B, Parity 1, WC)

While another woman said:

"I often wished I craved for something so that my husband had to leap out and get it".

(Case No. 19B, Parity 1, MC)

Cravings of pregnancy are therefore an opportunity to

1) redistribute the sexual division of food and/or 2) exercise control over males by making them go in search of "craved" food.

However, the lower income women were less likely to be able to afford the food they craved, or as was more often the case, they were more likely to crave for food they could afford, e.g.

chips, cakes, potatoes. So although Graham (1976b) says that pregnancy "is an occasion to enjoy activities and objects

normally denied; the expectant mother can and should be spoilt"

(p.296) the findings of this study show that women's ability to spoil themselves or to be spoilt by others, largely depends on

their class position. (As was the case of the women in the

Co-operative Guild at the beginning of the century, see earlier

discussion, p.13). Thus, when writers portray self-indulgent

pregnant women this is usually upper class women they are talking

about - the poor cannot afford to be self-indulgent. On this

subject de Beauvoir (1972) says:

"the well-known longings of pregnant women are obsessions of childish origin, self-indulgently retained; they always have reference to things to eat, in consequence of the childish idea of alimentary-fecundation; the woman feeling herself physically upset, expresses this sensation of strangeness through a longing with which she is sometimes obsessed...There is moreover, a cultivation of these longings as a matter of tradition, just as there used to be a cultivation of hysteria; the woman expects to have them, she is on watch for them, she invents them".

(1972, p.516)

This account is not typical of all women and although it may well be representative of middle and upper class women, it cannot be

be assumed to be so for working class women. A most graphic picture is portrayed by Kollontai (1977) written in 1914 when she describes the pregnancy experiences of four Mashenka's - the factory director's wife, the laundress, the maid and the dye-worker. Mashenka, the factory director's wife is told to "eat just what she fancies" and not to be "worried or distressed in any way" (p.127). In contrast the other three Mashenka's are not granted any concessions because they are pregnant and are expected to continue work until delivery. As Kollontai says of Mashenka, the laundress:

"If only she could lie down for an hour....have some rest...but working women are not allowed to do such things. Such pamperings are not for them. For, after all, they are not ladies." (p.128)

Kollontai recognises the presence of cravings among the bourgeoisie and the absence of concessions accorded to working women in pre-revolutionary Russia. To a lesser extent these class differences are reflected in the cravings of pregnant women in Britain today. Remember the working class woman who was told by her doctor to expect cravings, yet could not afford to satisfy them when she experienced them. As far as the Asian women are concerned, nearly all of them form part of the working class when they migrate to Britain (see page 183), or to be more accurate, they are the dependents of men who form part of the working class. Only one of the Asian women in the sample was married to a man occupying a professional position in Britain and her status position was anomalous (p.216).

The main difference between the British-born and Asian-born women was that in the Asian sample food cravings were more likely to be mediated by their mother or mother-in-law:

"My mother says every time she phones, she tells me - gives me a good lesson about how I'm eating at the time. She says 'Eat more fruit' because I don't eat eggs or meat like - I'm a vegetarian. And she gave me a good lesson about eating 'eat more fruit and eat this and that and have more milk, cheese'. She just carries on when she starts".

(Case No. 11A, Parity 2, living in extended family)

"They (mother and mother-in-law) tell you milk, roti (unleaven bread) and what vegetables to have".

(Case No. 9A, primipara, living in extended family)

Women living in nuclear families were more likely to exercise autonomy over what they ate. However, the actual presence of the mother-in-law in the household was not the determining factor, as some women lived adjacent to their mother-in-law. These women had less autonomy over what they ate and how they behaved in pregnancy than those women whose mother or mother-in-law lived in another city, or was still in India.

It would appear that when a woman is pregnant there are changes in the sexual distribution of food, additional foods are prohibited because they are viewed as dangerous to the developing child (and these will be discussed in more detail later), while "craved" foods are permitted. The extent to which women are able to alter their eating habits while pregnant depends on their social class and the absence or presence of older women (usually the mother or mother-in-law). Irrespective of whether there is a physiological basis for cravings, they are socially constructed and part of a much wider system of social control of pregnant women and of the eating patterns of women more generally.

ii) Abatement of pollution controls

When women are pregnant the menstrual taboos detailed earlier (pp.236-238) no longer apply. Thus for the Sikh women there were no restrictions on them attending the gurdwara during pregnancy. Despite this, when the women were interviewed at eight months pregnant none of the women had been in the Temple in the last week. However, this was for purely pragmatic reasons as the women have to sit on the floor for the duration of the service:

"We try to go every Sunday to the Gurdwara - but now I don't go in this condition because I can't sit for long and I find difficulty in getting up."  
(Case No. 26A, Parity 3, Sikh)

At the time of confinement women are again seen as potentially polluting and various rituals are observed to control pollution. These are referred to later in the section on separation at the time of childbirth.

iii) Concessions made by the State to pregnant women

Concessions to pregnant women by the British State are in the form of cash benefits, free prescriptions, free dental treatment, and free milk and vitamins (for those women with under two school aged children). These concessions have not always been available to pregnant women, the cash benefits were introduced when there was national concern about the quantity and quality of children being born (see pages 26-31). Neither, are State benefits paid universally, often the women most in need are not entitled to them, or if they are they may be ashamed of applying for them:

"Mrs. S at the welfare at Bell Green clinic explained the ins and outs of what's going on. I don't think I'm entitled to a maternity grant 'cos I'm not married".

(Case No. 14B, Parity 1, WC, unmarried)

"Mind you I was pregnant before I was married, so I was a little bit ashamed I think. Today I wouldn't have batted an eyelid ... but I didn't even apply for free prescriptions then".

(Case No. 11B, Parity 4, WC)

The free prescriptions, free dental treatment and free milk and vitamins are the remains of a much more thorough going system aimed at encouraging pregnant women to engage in preventive health. Despite the fact that the first two of these benefits are for all pregnant women, some women do not know of their existence, while others experience considerable difficulty in obtaining them. Of the women studied, five (19.2%) Asian women and one (3.8%) British woman did not know they were entitled to free prescriptions; seven (27%) Asian and two (7.7%) British women did not know of their entitlement to maternity benefit or allowance; and thirteen (50%) Asian women and three (11.5%) British women did not know free dental treatment was available during pregnancy.

The difficulties some women experienced in claiming their entitlements are illustrated in the following two examples:

"I've applied three times before (for Maternity grant) in Wales and I got it, I sent my marriage certificate - I got married in Pakistan (my husband is an Indian) - I sent my marriage certificate and my certificate of confinement two times. They sent me my money without any questions asked. And I had a miscarriage - no a still birth - still born daughter the third time in Wales, so they sent me my Maternity Grant. Now, this time I send them the form, and they replied 'As you were married **abroad**, we don't recognise this marriage.

So you and your husband must come in the Council and talk to someone'. I got so mad, I was furious..... I told this to the Social Welfare Officer and she said 'You should write to them - this is ridiculous!' I said 'I won't write to them, they should come and find out for themselves'. I won't reply to their letter. I won't do this for only £25."

(Case No. 10A, Parity 4 - University educated and English speaking)

"In my first pregnancy, the midwife refused to give it (claim form for Maternity Grant) to me as she said I wasn't as many weeks as I should have been...As I say I had a battle with the midwife. In fact she refused point blank to give me the form and I had to surreptitiously go back and ask at reception....I knew that I wanted this BM4 something and I had to go and ask the receptionist if she'd got it and she gave it to me....."

(Case No. 19B, Parity 1, MC, Part time lecturer)

Both of these well-educated women experienced considerable difficulty when claiming their maternity benefits. Other less well-educated women did not claim because of similar experiences. The way in which maternity benefits are administered - they have to be claimed, they are not provided automatically - means that only those women who know of their entitlements and the procedure for claiming them are in a position to do so. Thus, non-English speaking women and newcomers to the country are disadvantaged when it comes to claiming maternity benefits:

A. "I was only told that medicines are free....No, I wasn't told about dental treatment, whether it was free or not. He (GP) has only told me about the medicine - he has given me a card - a year after the baby is born it is free and they give the card when you're pregnant.

Q. Nothing else? Maternity Grant?

They haven't given it to me this time. The doctor usually gives me the forms. He didn't this time, so I thought I didn't get it".

(Case No. 14A, Parity 4, non-English speaking)



This woman was dependent on her GP for information regarding her entitlements and if this was not provided then she assumed she was not entitled. More experienced British women admitted it was something they had to find out for themselves:

"There's a lot of things that you are entitled to and you don't know, but you've got to find out yourself".

(Case No. 17B, Parity 1, WC)

"It's very much up to you as an individual to find out what your rights are".

(Case No. 20B, Parity 1, MC)

Throughout this section it is apparent that the concessions accorded to pregnant women reflect the nature of the society and women's position in it. The individualistic nature of British society encourages those who are educated and know their rights to claim them, while those who are less fortunate often go without. Similarly, with cravings of pregnancy, middle class women are able to indulge themselves, while working class women have less exotic cravings. Furthermore, the concessions made to pregnant women are mediated by prohibitions on their actions. These prohibitions attempt to ensure the woman remains pregnant and gives birth to a healthy baby.

b) PROHIBITIONS

The prohibitions which appear universal among both Asian and British women are restrictions on certain foods and actions such as, bending and stretching, and an emphasis on not lifting heavy objects (see Appendix, D, p.1). Twenty-four (62%) Asian women mentioned not lifting heavy weights when pregnant and twenty-three

(59%) British women said they would not lift heavy weights or do strenuous work. It was most often the mother or mother-in-law who enforced these prohibitions:

"She (mother-in-law) did say not to lift heavy things, or not to overdo it, things like that - or do anything out of the ordinary. Don't do any heavy washing or anything like that...She always used to say 'Take things easy, otherwise you don't know what might happen'".

(Case No. 10B, Parity 3, WC)

"They (mother and mother-in-law) just told me not to pick up weights - lift weights or heavy things".

(Case No. 11A, Parity 1, living in extended family)

The Asian and British women were both told by older women that the lifting of heavy weights caused miscarriage. Another reason for miscarriage which the Asian women cited was that it happens when "a barren woman's shadow falls on the pregnant woman", thus reinforcing beliefs about the powers of childless women. Although nearly all the women studied took precautions to avoid miscarriage, three of the British middle class women said they would rather miscarry than give birth to a "deformed" child:

"I just felt I knew it all along. I'd got the feeling it wasn't right - some strange reason. I'd got the feeling all the time I was going to lose it for some reason and I was going to start to bleed. I don't know why, I just had you know".

(Case No. 24B, Parity 2, MC, one previous miscarriage)

"When I did start to miscarry I didn't want to save it. My friend had been in a similar state to me, though slightly later in pregnancy, 'cos I was only nine weeks. And she had taken the advice of her doctor and gone to bed with her feet up for a few days. But I was so frightened that it might be deformed that I wanted it all to come away".

(Case No. 19B, Parity 1, MC, one previous miscarriage)

These comments reflect the fear at the back of every woman's mind about giving birth to a deformed child. It is interesting to note that it was only the British middle class women who articulated preferring to miscarry than give birth to such a child.

Another set of prohibitions to be observed in pregnancy were those relating to food. These restrictions were most applicable to the Asian women whose Ayurvedic system of medicine distinguishes between the heating and cooling effects of foods (see Appendix E p.1) for a classification of foods into their "hot" and "cold" properties and Chapter Seven for a fuller discussion of the importance of diet in maintaining health). During pregnancy, "hot" foods are prohibited especially during the early months. The mother or mother-in-law is the key person in instructing the first-time pregnant woman what foods to avoid:

"Mother-in-law says "Don't eat too many "hot" things. Things like sundh (ginger), garlic and chillies".

(Case No. 1A, primipara, living in extended family)

As more of the first-time pregnant women were living in an extended family (78% of them) they were more likely to observe the prohibitions of the older women. Pickering (1974) argues that in earlier and pre-literate societies people are compelled to observe rites de passage - they "were and are accepted without equivocation" (p.74). However, he considers that compulsion is absent in contemporary society and people only observe the rites if it is convenient to them. Certainly the Asian women in this study who were not living in an extended family could choose not to observe the traditional rituals prescribed by the older women.

Dietary restrictions which the British women observed tended to be self-imposed and relate more to foods thought to cause indigestion and heartburn (for example, cheese sauce, fried foods); the Asian women also mentioned avoiding these foods. Three British women said they had not eaten "blighted" potatoes as they had heard they may cause spina bifida. Other British women considered that the consumption of alcohol, smoking of cigarettes, the taking of unprescribed drugs and "violent sex" could harm the baby. (None of the Asian women smoked and alcohol was rarely consumed):

"I haven't taken anything. I haven't even taken an aspirin for a headache, just in case, perhaps it's going too far - I don't know".

(Case No. 19B, Parity 1, MC)

The media and members of the medical profession were likely to provide guidelines for the behaviour of British women, although the advice they provided was not always consistent and often contradicted lay advice. Four (15%) British women smokers made reference to this:

"Well it's mainly the size they (doctors) go on about, and me Mum when she was having me couldn't even stand being in the same room as anybody who smoked. Before she smoked, but she packed it in when she was carrying me. And er...I wasn't very big born. And now me brother, she smoked all the way through and he was eleven pound born and I mean he's over six foot now....I can't understand it because as I say, I know they're no good for it (baby), but I think it's because they (doctors) haven't really given me any proof, or proved to me that the cigarette does harm".

(Case No. 6B, Primipara, MC)

"But I don't really believe it (smoking) affects the baby you know, because I've sort of watched programmes about the placenta and what it does to the baby, and it only takes in what it wants for the baby to feed it. So it's doing me more harm 'cos it's not getting to the baby as far as I'm concerned. Because you know the afterbirth's supposed to be taking the goodness out of what you eat and doesn't take anything else. The badness doesn't get through".

(Case No. 8B, primipara, MC)

The contradictory advice women receive does not help them cope with the uncertainties faced in pregnancy.<sup>1</sup>

The transition to motherhood is a time of uncertainty, when the woman attempts to adjust to impending motherhood.

"The one thing that has happened this time which I'm convinced is connected to the pregnancy...I have been more, more fearful about things. It isn't so much that I've had nightmares, but things I've read in newspapers and so on have had a much more powerful effect. I've mentioned this to a number of friends who have been pregnant recently and they've all said the same....it's a sort of heightening of emotions..... And I've been much more affected by things I've read in the newspapers.....things connected with children....cases of cruelty to children and cases of deaths to children bothered me very much".

(Case No. 26B, Parity 1, MC)

Pregnancy is also a time when the woman is full of doubts about her health and well-being; some of these doubts are expressed and others are not. The first time pregnant woman wonders what the birth experience will be like; whether her figure will return to its original dimensions after delivery; how long the vomiting will continue; what other kinds of discomfort can she expect? Most pregnant women are concerned with how their behaviour can affect the unborn child. Other women continue "as normal"

---

<sup>1</sup>The tension between information given by experts and that provided by experienced women is dealt with in Chapters Nine and Ten.

throughout the pregnancy, -but at the same time wondering if their habits are affecting the foetus:

"I try not to think about these things as it only makes you worried".

(Case No. 15B, Parity 1, WC)

"So I go tell Mum 'Is it all right?' 'Cos I get frightened if somebody talks, well not frightened, you get these feelings - am I all right? have I done everything?"

(Case No. 3A, primipara, living in nuclear family)

Occasionally, the worries and uncertainty become too much for the woman and she sits down and cries:

"I did get quite depressed about a fortnight ago, you know, sometimes I just sat and cried and my husband tried to pull me out of it and that made me worse. Maybe now because it's the last couple of weeks, I hope I don't go over - I'm just looking forward to it that much I want to get it over with and get back to how I was before. Because I was always an active person and this has slowed me down, it takes a bit of getting used to really.....It gets on top of you, plus the fact that they did frighten me, they said they'd start me off".

(Case No. 10B, Parity 3, WC)

This woman's worries were connected with restrictions her pregnancy condition placed on her actions and also her fear of medical intervention at the time of delivery (a point referred to again in Chapter Eight).

Thoughts of the well-being of the unborn child occupy the minds of all expectant mothers at some stage - some will manipulate their stomach externally to stimulate action if they have not felt the baby move for some time; others are particularly careful at specific times of the month to ensure that their pregnancy is carried to term; and questions may be asked about the possible deformity of the child, depending on the age and parity of the mother. For instance among British women, third pregnancies are considered to be unlucky:

"If there's going to be something the matter with one of them, like mongolism, it's supposed to come out in the third child".

(Case No. 21B, Parity 2, MC)

And some British and Asian women think that their thoughts and feelings can be transposed on to the child in utero.

"They say that if you see the face of a good thing in the morning you will have a good-looking child".

(Case No. 28A, Parity 2, Sikh)

"If you're happy and relaxed in pregnancy, then the baby will be contented."

(Case No. 1B, primipara, WC)

A further area of apprehension relates to the sex of the child and rituals may be performed to determine the sex of the unborn child. This is more likely to be the case where there is a strong preference for a boy or girl, on religious or cultural grounds. (The importance of male children to Asian women was discussed, earlier, pages 19, 278-80). In the Hindu religion for instance, it is believed that the time of conception plays a part in determining the sex of the child (Mamdani, 1972).

As one young Hindu woman said:

"Me mum says if its moonlight (when conception takes place) it's going to be a boy, and if it's later when it's getting dark then you're going to have a girl".

(Case No. 4B, primipara, Hindu)

However, women in the British sample also performed certain rituals to inform them of the sex of the unborn child:

"Oh yes, the ring test, my mother-in-law told me about it. She told me about putting your wedding ring (which I can't wear at the moment) on a chain or piece of string, and if it turns to the left it's a boy and if it turns to the right it's a girl. I did it with the first child and it worked".

(Case No. 19B, Parity 2, MC)

Among both samples older women had told the pregnant woman what sex of child to expect. The mother-in-law of a Punjabi woman claimed:

"I can tell by the face whether a certain lady is going to have a girl or a boy. When the person appears happy she is bound to have a boy, but if she is irritable and grumbles, she will have a girl".

A more universal belief among Asian women is that if the baby is lying on the right side it is a boy, and on the left side, a girl. This belief is similar to that held by British women when they say if you carry the baby at the front it will be a boy, and if you carry it all around then it will be a girl:

"They (older women) say that if its on the right side it's a boy, and on the left side a girl - but I can never tell which side the baby is on".

(Case No. 25A, Parity 3, Sikh)

"They (older women) say that if your lump's all at the front it's a boy and if it's spread all round it's a girl.

(Case No. 1B, primipara, WC)

Other beliefs held by the British women refer to the movement of the baby in utero; these beliefs strongly reinforce ideas about men being active and women as passive:

"Well I happened to mention it to me mother-in-law when she 'phoned up one day, that er..it (the baby) was moving about more. She said it must be a boy. They say boys are more active".

(Case No. 10B, Parity 3, WC)

"I mean he kicked me so hard he bruised all my stomach and that's another reason why I was convinced when I went into labour that it was a boy".

(Case No. 11B, Parity 4, WC)

Despite these beliefs surrounding the sex of the child, the pregnant woman's over-riding concern is that the baby will be allright



"One always keeps wishing to have a boy, but whatever God gives is welcome."

(Case No. 26A, Parity 3, Sikh)

"If you have a healthy baby, it doesn't really matter what sex it is."

(Case No. 12B, Parity 2, WC, previous neo-natal death)

These comments again reflect different attitudes towards children - the Asian woman was pleased to have any child (but had a definite preference for a boy), the British woman's main concern was that the baby was healthy. However, both groups of women knew of things they should avoid if they wanted to prevent giving birth to a handicapped child. The Asian women said they would move around during the grahan (an eclipse) and not look at it, while for the British women, exposure to X-rays and eating "diseased" potatoes were seen as particularly harmful:

"They (older women) say that if you look at an eclipse, then the child loses the power of one of his limbs or organs."

(Case No. 14A, Parity 4, Sikh)

"It turned out that I'd been exposed to X-ray right in the very first few weeks of pregnancy. And I was panic stricken...I didn't know I was pregnant when I was first X-rayed. I hadn't missed a period then, so that was right at the very dangerous part of pregnancy. This is what worried us. But we were assured that everything would be alright - so I hope he (consultant obstetrician) is right because it's not fair on me or the child if he is wrong."

(Case No. 11B, Parity 4, WC)

There is a difference between the two groups of women in terms of amount of retribution they expect when they transgress ritual practices. The Punjabi woman who looks at the grahan can expect to give birth to a deformed child, it is in here fate. However, the British woman who is exposed to X-rays early in pregnancy expects members of the medical profession to detect abnormality and to offer her an abortion should any abnormality be

diagnosed. In the last instance, it is the doctor who decides whether certain tests should or should not be carried out, if he (all the clinic consultants were male) decides against screening procedures (such as amniocentesis) then the woman may continue to worry throughout the pregnancy that something is "wrong" with the baby. This is what happened to the British women quoted above.

Other British women who were worried about the possibility of the baby being handicapped said they did not receive any reassurance from the hospital ante-natal clinic and their husbands were particularly loathe<sup>to</sup> talk about the subject:

"I hope it's alright, that's the thing that worries me...It worries me it really does. I've never spoke about it. If I say to my husband he'll say 'Oh don't be so stupid, why should you? And it's not a thing you like really to talk about. You're the first person I've really spoken to about that now..."  
(Case No. 21B, Parity 2, MC)

"I think your first thought is well as long as it's alright and everything's there that should be there you know. That's what I've said to me husband many a time and he's said don't talk like that, but I said well you have to face these things."  
(Case No. 8B, primipara, MC)

These comments reinforce the strength of the belief that pregnant women should only think "good" thoughts - to think about deformity and handicapped children is to tempt fate.

Fatalistic beliefs are most common amongst those people who do not have control over their day-to-day existence. Many of the women, both Asian and British, expressed beliefs about the inevitability of the outcome of their pregnancy. Comments were most often made about the pointlessness of doctors trying to "turn" a breach presentation baby for "it'll only turn back again" or

"it will right itself when the time comes"; also a few women argued against induction of labour as "it'll come when it's ready" (see pages 444-445).

The fatalistic beliefs held by Asian women towards miscarriage and still birth, are most often expressed as "It's God's will" and can best be understood in terms of the high death rates in rural India. The maternal mortality rate in rural India is twenty-three times as high as the UK rate (Morpeth 1979 - figures based on the 1968 Census returns); infant mortality in rural India is six times the rate in the United States, while death in the second year of life in rural India is twenty-seven times greater than the U.S. (Gordon, Chitkara and Wyon, 1963). This high death rate leads to the belief that the death was beneficial, for example, in cases where the unborn child was thought to be possessed by evil powers and who would therefore have developed into an "unlucky child". However, this belief in the destiny of God does not exclude extensive measures being taken to ward evil spirits away from the expectant woman. For example, women moved around during an eclipse so that a shadow is not cast over their child making it deformed; avoid barren women; and look at "good" faces (usually one of the Gurus) and think "happy thoughts" throughout the duration of their pregnancy.

In contrast, the higher standards of living in advanced capitalist societies (for instance, better nutrition and housing) combined with increased medical intervention in pregnancy

and childbirth have led to a decrease in the maternal and perinatal mortality rates. Women in Britain therefore have come to depend on medical intervention in pregnancy and childbirth often equating hospital confinement with the reduced mortality rates.

Although the mortality rates have decreased there has not been a concomitant increase in preparing women for a medicalised pregnancy and childbirth. First-time pregnant women had very little idea of what it would be like to go into labour:

"Because it's my first chance I don't know anything"  
(Case No. 8A, primipara, Sikh)

"The only thing I'm worried about is (she laughs ) I don't know whether I'll be able to feel the contractions. I keep telling everyone that and they keep saying: 'Yes you will when they come!' But I get loads and loads of different pains. They say it's like a period pain, pushing down pain - I don't know, I've never had trouble like that, so..."  
(Case No.7B, primipara, WC)

While those who have given birth before say:

"The question is that the baby should be born with the greatest possible ease, but the babies are always born with pain and trouble".  
(Case No. 19A, Parity 5, Muslim)

"This time I've had funny fears. The main fear is that it was so painful and so long last time, that even though I'm reassured all round that it won't be painful, I'm still worried".  
(Case No. 26B, Parity 1, MC)

The concerns women have about going into labour, coupled with the anxieties about the healthiness of the forthcoming child, are rarely dealt with sensitively in the hospital ante-natal clinic setting. In the past, these fears may have been allayed by

older women who had given birth themselves, however, the medicalisation of pregnancy and childbirth has tended to undermine the traditional skills of older women and emphasise the importance of consulting the "expert", i.e. a person who is medically qualified, (a point which is more fully discussed later).

When women consult members of the medical profession about their uncertainties they are often consoled with "There's nothing to worry about". Sometimes the woman is not satisfied with this negative reassurance and leaves the clinic distressed, and occasionally in tears:

"Well actually after last week when they upset me at the hospital, I came home and went up to my own doctor that night. I made an appointment because I wanted to know if anything was dreadfully wrong and what they were doing about it".

(Case No. 23B, Parity 2, MC - previous still birth)

This example shows how the impersonal nature of the hospital clinic did not provide the support and reassurance this woman needed (see Chapter Eight). Also, it cannot be assumed that women are receiving support from kin in the social network, as Hart (1976) says "passage from one status to another seems frequently to lack the ritual expression of institutional support" in modern secular society. These observations apply particularly to those Asian women in Britain who do not have the support of the extended family and to unmarried British women. However, it is wrong to assume that Asian women living in a nuclear family totally lack support, the evidence in Chapter Ten suggests that Asian husbands play a more active role in nuclear families.

This section has attempted to map out some of the uncertainties and worries facing women in their transition to motherhood. It has also looked at the extent to which their behaviour is prescribed by rites and rituals often suggested by older women, namely mothers and mothers-in-law. The importance placed on observing rites and rituals relates to the meaning of the successful pregnancy outcome to both the woman and her social group. Beliefs and sayings (mainly perpetuated by older women) serve as guidelines piloting the woman through her safe transition to motherhood. Moreover, some sayings reproduce ideas about the value and characteristic of male babies vis-a-vis female babies. The value of a male child varies depending on the cultural background of the social group.

The lack of sensitivity on the part of the members of the medical profession towards the woman's social transformation to motherhood has been alluded to and will be discussed further in the context of the woman's status as patient (Chapter Eight).

#### SEPARATION OF PARTURIENT WOMEN FROM SOCIETY

The practice of separating the parturient mother from the rest of society is widespread. In rural Punjab the pregnant woman tends to continue her duties as normal until the onset of labour, there is a belief that "labour helps labour". However, apart from the occasional woman who gives birth in the fields, the birth process is isolated from the rest of the village life and located within the home. In attendance are specific other women, married and usually older than the woman in labour. After the birth

young girls may be called in to help (cf. Gideon, 1962). The village dai (indigéneous midwife of the barber caste) is the central person at this time and it is she who "manages" the birth giving directions to <sup>the</sup>labouring woman and other attendants. Thus the transition to motherhood while painful is accomplished with the minimum of interference and dislocation.

In advanced capitalist countries pregnancy is treated differently - it is predominantly taken out of the home, the familiar and familial environment - and located in the hospital under the "gaze" of the male obstetrician. The rituals associated with pregnancy and childbirth within the clinical setting are scientific in origin and prescribed by modern technology. The woman is subjected to various rituals which have little meaning to her and in no way aid her social transition to motherhood.

The reason for the separation of women in childbirth can be related to the "sacredness" of their status as creators of new life (and the subsequent envy this inspires in men) and to the control of the parturient woman's potential pollution. Childbirth is, therefore, both polluting and powerful. As Leach (1976) says of sacred states, they are both dangerous and dirty - to be brought back to normal life the initiate must be cleansed. . Moreover, as Douglas (1966) says, the sacred needs to be continually hedged in with prohibitions.

The potential powers of pollution of the woman in confinement are in contradiction with the "sacredness" of her condition, and make her status even more ambiguous and uncertain. In India, for example, confinement is considered ritually unclean and ceremoniously

impure and the traditional practices associated with childbirth according to Chandrasekhar (1959) are founded upon three sets of ideas: i) the religious belief that a woman at the time of childbirth is ceremonially unclean, more defiling than the lowest outcast; ii) the belief that fresh air, whether warm or cold, is dangerously harmful for mother and child, and iii) a group of beliefs which advocate the extreme depression of the mother's physical strength during the lying in period. Traditionally, then, the woman would be confined in her home with no circulation of air; windows and doors being blocked to prevent the entrance of evil spirits. Morpeth's (1979) more recent account of childbirth in the Punjab reiterates the seclusion of the labouring and newly delivered woman. The analogy with the highly antiseptic, precisely ordered maternity hospital with restrictions on intrusions from the outside world in advanced capitalist society, leads to interesting hypotheses concerning European fear of pollution and of the unknown. Examples of pollution control in Britain are the rituals observed when a pregnant woman is admitted to hospital in labour. These include the purging of the body through enemas and catheterisation, the cleansing of the body by bathing, and the shaving of pubic hairs. Another classic example of the threat of pollution by women, is the treatment of the placenta - there are specific rules in most societies as to who can touch it and how it should be disposed of. Burning (in Britain) and burying (in the Punjab) are two of the most common methods.



The foregoing provides some insights into the reasons for the separation of the pregnant woman in her passage to motherhood. The experience of the separation for the women concerned will now be looked at. All the women were booked for hospital deliveries and only one Asian and one British woman would have preferred a home birth. The Asian woman had arrived in Britain at four months pregnant and felt she would receive more support if she had a home birth:

"In hospital you're alone and can't tell how you're feeling. At home you have people you know around you".

(Case No. 2A, primipara, non-English speaking)

The British woman, on the other hand, had already given birth four times, she knew what to expect and was quite confident of her ability to have a baby outside the hospital setting. She also considered that a home birth would lead to a better relationship between herself and the baby, and the rest of the family and the baby. She clearly saw childbirth as a social event rather than a medical procedure:

"If I could choose I would have one at home....mainly because I would be happier at home, I would know what was happening to my children. I've talked to Mary who is a midwife and she's found that a mother is more contented and you usually get a more contented baby, when they've had the baby at home. Especially with other children around because the other children see the baby as soon as it's born and it works for a closer relationship.....Psychologically and mentally it is better for a woman to be at home with her children rather than in hospital....You're mentally more relaxed when you're at home and you can see how your own home is being run".

(Case No. 11B, Parity 4, WC)

The reasons women gave for preferring a hospital birth were - a) they assumed all women were delivered in hospital; b) they felt safer in hospital and c) they wanted to go in hospital for a rest.

a) The lack of information given to women about the location of the birth made most women assume that there was no alternative to a hospital delivery in the consultant unit. None of the Asian women expressed concern at this lack of information, but seven (27%) British women did:

"You don't get any choice at all....'cos there's not many GPs who'll take you"  
(Case No. 20B, Parity 1, MC)

b) The British women who argued most strongly for hospital deliveries were those who had already experienced complications in a previous delivery:

"Because of the complications with the first child I wouldn't have it at home, even though I think it would be much better, much more pleasant".  
(Case No. 19B, Parity 1, MC)

The Asian women almost unanimously felt that hospital deliveries were "safer", it must be remembered that in India and Pakistan maternal and infant mortality rates are high and in many cases hospital services have to be paid for:

"In hospital they have everything ready, they can do things quickly.....it's good in hospital, because if something goes wrong they can do things quickly, but if you are at home, you have to ring the hospital and it takes so much time."  
(Case No. 21A, Parity 4, living in nuclear household)

Underlying what most Asian women said about hospital deliveries was the notion that the hospital was the only place where they would receive constant attention. They compared the situation in Britain with their previous experiences of birth in India:

"Here it is difficult to be looked after at home - in India you have so many people to look after you, even in the middle of the night. No-one comes to help here at all times".

(Case No. 16A, Parity 1, living in nuclear household)

c) It was the lack of support available to women at home that made many working class British women and multipararous Asian women argue for hospital delivery. They wanted to go into hospital for a rest. Asian women living in nuclear households were particularly in favour of hospital confinement:

"I think I prefer to stay in hospital for a week, for a rest. It's alright in there, quiet, and no one to trouble you. Nothing to do but rest."

(Case No. 3A, primipara, living in nuclear household)

"Hospital is alright because it is very difficult to manage at home here (in Britain)".

(Case No. 25A, Parity 3, living in nuclear household)

All of the British women who said they preferred a hospital delivery because of the opportunity to rest were working class women with other children at home:

"I like going into hospitals really, it gives me a rest".

(Case No. 10B, Parity 3, WC)

"I'm looking forward to the rest like with these two (other children)"

(Case No. 13B, Parity 2, WC)

Other British women who had already given birth in the hospital made comments such as "it's just like a hotel", "everything's so hygienic and modern", "it's a fantastic hospital". These women were most impressed by the new building and the temporary relief they received from their domestic burdens.

One third (35%) of the British women said they were "worried", "frightened" or "depressed" by the thought of going into hospital, although they still accepted the hospital as the legitimate place of birth:

"A hospital's a hospital anyway. I don't think anyone's ever happy about being in hospital"

(Case No. 9B, primipara, MC)

None of the women were informed of the current debate in obstetrics about the safety of hospital deliveries. (Kitzinger and Davies, 1978) They accepted the dominant medical belief that the hospital is the safest place to give birth, and apart from the two women who wanted home deliveries, did not question the necessity of a hospital birth. The women were more critical of certain hospital practices than radically questioning whether they should have been in the hospital in the first place. Asian women who were vegetarian complained of the appalling diet available to them,<sup>1</sup> while other women criticised the hospital's

<sup>1</sup>Several of the Asian women in their previous delivery asked their husbands to take food in for them.

policy towards older children. These children were only allowed to visit in the afternoon which meant them taking time off school! Neither children nor fathers were permitted to pick up the baby while in hospital and those unaware of the hospital rules were told off for contravening them:

"I mean they won't even let the father's pick the baby out of the cot at Walsgrave.....I mean it's got to get used to its father's germs sooner or later.....I mean all these child psychologists say that a baby should have a close relationship with its parents, but why won't they let the father hold that baby?"

(Case No. 11B, Parity 4, WC)

None of these policies can/<sup>be</sup> seen to aid the woman's transition to motherhood.

A further obstacle in the status passage to becoming a mother is the isolation and separation women experience in the labour ward. For this reason some women (five, 19% Asian and twelve, 46% British) would like company in labour):

"I'd like my husband there. You're left on your own so you might as well have your husband there".

(Case No. 6B, primipara, MC)

On the other hand, some women would like to be alone in child-birth, regarding it themselves as a time of impurity:

"I like him (husband) to be there while I'm all nice and decent, but I wouldn't want him there after".

(Case No. 24B, Parity 2, MC)

A more systematic analysis of the support the women expect to receive from their partners at the time of delivery is detailed in Chapter Ten. The above examples provide a glimpse into how pregnant women, from two different ethnic backgrounds,

but now residing in the same country, react to the separation of childbirth from the rest of society.

RE-INTEGRATION OF THE MOTHER INTO SOCIETY

The "social return" of the woman from childbirth, the final ceremony in the "rite de passage" (cf. van Gennep 1908) seems to have lost some of its significance in Britain today. The ceremony of the re-integration of the woman back into her family now occurs at the entrance to the hospital where the maternity sister hands over the baby to the mother (or sometimes father) before they leave. The ceremony that used to be significant at this time was the "churching of women" in which the woman gives her thanks to God for delivering her from the "great pain and peril of childbirth" (Book of Common Prayer). It also marks the end of her period of potential pollution and is the final cleansing act before her re-integration into society. Although this ceremony has lost most of its significance, women who are in hospital the Sunday following birth are often invited to give thanks to God in the hospital chapel. Other religious women may go to their own church soon after discharge, though the numbers are likely to be few. (Of the sample only three (11%) British women interviewed said they intended to be "churched" or attend chapel or church soon after delivery).

"Me mum wants me to be churched, she's already mentioned it. I'll do it just to shut her up".  
(Case No. 3B, primipara, WC)

Another woman said she had received a prayer asking for her safe delivery through childbirth:

"During my first pregnancy my mother-in-law sent me a little card which I found upstairs a few weeks ago.....It was to Saint Anthony, a prayer that I might be spared the pains and agonies of childbirth, which I thought was the most tactless thing to send".

(Case No. 26B, Parity 1, MC)

The re-integration into society of the newly delivered woman in rural India is marked more clearly by rituals which are related to the period of impurity. The woman's period of impurity varies from ten days among the Brahmins to forty days among the lower castes. Traditionally, neither the woman nor the child should come out of the confinement room during this period (Chandrasekhar 1959). For woman of all castes the total period of confinement lasts for forty days after which the woman can resume her normal duties.<sup>1</sup> The extent to which Punjabi women in Britain observe the forty day period of confinement depends on the presence of other women in the household, particularly the mother-in-law, and the economic situation of the household:

"Mother-in-law, she won't let me out of this house for forty days anyway. Last time I went to bed for forty days...After forty days go to the Temple and take blessing from there - then you can go anywhere. Bless baby as well and baby's name chosen from the Holy Book".

(Case No. 11A, Parity 1, living in extended family)

"My mother-in-law tried her best to give me complete rest for six weeks, but I didn't want to give her too much burden with the housework. After the first delivery I did take six weeks rest, but after having other children I try to help my mother-in-law looking after the children. But in the housework, she did not let me help her".

(Case No. 25A, Parity 3, living in extended family)

---

<sup>1</sup>Pillsbury (1978) details the restrictions which apply to Chinese women for the first month after children.

Asian women who do not live in extended families (58% of the sample studied) found it difficult to arrange for help after they come out of hospital:

"It is difficult because there is no mother-in-law here (in Britain). It is difficult for my mother to come because she has to look after her grandsons - her daughter-in-law goes to work. My brothers are small too and father goes to work, so it is difficult for her. My mother wants me to go to her so that she can look after me, but I'm alright here, I don't want to go there".

(Case No. 14A, Parity 4, living in nuclear family)

This account shows how the traditional rituals surrounding re-integration of the newly delivered woman into society in Britain are breaking down. However, amongst the British middle class women new rituals seem to be developing; for instance, these women mentioned their own anxiety about how existing children would respond to the new arrival. They were therefore more concerned about the integration of the new baby into the original family:

"Well she's only twenty-one months (daughter), she knows, well she keeps saying there's a baby in here (points to bulge), but um...how much she understand I don't know. I've tried to let her see as many small babies as possible. She knows the baby's room, but how much she understands about it I don't know. I'm a bit apprehensive about how she's going to react, it's difficult".

(Case No. 22B, Parity 1, MC)

Another woman described an even more detailed ritual she had planned to aid the new baby's integration and avoid sibling jealousy:

"At the moment I'm in the process of getting her (daughter) a little doll with a bath and its own dummy, so that she can copy. She always wants to help....What I want to do with the doll and what have you, is to take it into hospital with me so that when she comes to visit me the first time to see the baby, I'm going to give it to her and say "Well this is your baby of your own and you can help me with this one at home". And hopefully we can stop any feelings of



jealousy".

(Case No. 19B, Parity 1, MC)

The working class women on the other hand, were more pragmatic about the integration of the new born into the family - this can perhaps be related to the larger family size and lack of funds to provide baby-substitutes! However, they did mention devising their own rituals:

"What I normally do to get over it (the fact that children are not allowed to touch the baby in the hospital) - when I get home I line them up, put them on the settee and as soon as I get home I give them the baby. Make them feel that it is their baby. I mean it is their baby, they've got to learn to live with it".

(Case No. 11B, Parity 4, WC)

It would appear, therefore, that the re-integration of the newly delivered woman (and the integration of the new-born baby) into the home and family need to be treated more sensitively. For example, those women who have had "unsuccessful" pregnancies, i.e. a miscarriage or a stillbirth, do not receive sufficient support or counselling which would help to allay some of their fears and aid their re-integration.

Lewis (1976) highlights the doctor's reluctance to console the woman who has had a stillbirth. He says there is a strong pressure on professionals, "to keep the crisis of stillbirth hidden away, thereby in fact hindering the mourning and healing process".

(1976: 619-620).

Moreover, women who experience a successful outcome to their pregnancy are still insufficiently prepared for motherhood - they may

suffer from puerperal depression, and those who want to breastfeed may experience difficulty and discomfort in doing so. This is particularly significant in British society where many women work outside the home until the birth of their first child, after the birth they feel isolated and may experience a "loss of self identity". Oakley (1980) refers to the "bereavement" newly-delivered women experience and how a:

"reorganisation of the 'assumptive' world has to take place, and new meanings have to be sought to replace old ones". (p.213)

#### Summary

The anthropological concept of status passage, combined with an interpretation of the women's experiences, is useful as it provides a dynamic framework for the analysis of the social transition to motherhood. For the woman, this social transformation involves change and uncertainty which is managed through rites and rituals, concessions and prohibitions. At this time women's status is ambiguous and tensions are felt between women's role as mother and as worker.

The inadequacies of the medical profession in dealing with the social meaning of pregnancy are outlined and the amount and nature of support pregnant women received from their social network is emphasised (a point developed in later Chapters).

CHAPTER SEVEN

PREGNANCY AS HEALTH

Introduction

The previous Chapter outlined some of the changes pregnant women experience in their transition to motherhood. Throughout the social transformation certain ambiguities and tensions became apparent which can in part be attributed to the change in social status, and in part to the tensions between a folk and a medical way of treating pregnancy. Some women (particularly those who live in extended families or have strong links with older women) subscribe to a folk model of health and illness which is based on prevention (or health maintenance) and traditional recipes; others who have been educated in the western scientific tradition may subscribe to a model of health which is based on curative medicine. These distinctions are crude but provide a starting point in the analysis of maintaining or restoring health in pregnancy. What happens in practice will be developed later.

What I intend to do in this and the following Chapter is to separate out the importance of the folk model of pregnancy and the medical model and gauge their importance to pregnant women at different points in time. The folk model of pregnancy as discussed in the previous Chapter is concerned with the rites and rituals performed to guard against the dangers of pregnancy and childbirth. However, there is another dimension to the folk model which is the belief that pregnancy is "natural" (cf. pages 44-48), this belief is particularly popular in those societies

where death is also regarded as a common occurrence (that is, societies with a high infant and maternal mortality). In the folk model of pregnancy, health is maintained and discomforts alleviated through fresh air, exercise and changes in diet. The medical model of pregnancy, on the other hand, is premised on the belief that pregnancy is a potentially pathological condition warranting scientific investigation. However, it must be pointed out that not all medical practitioners subscribe to this view - GP's in particular may view pregnancy as a state of health (see pages 363-365 and Chapter Nine).

The locus of treatment for the folk model is in the woman's home or familiar environment surrounded by those she knows, while medical treatment is provided in the clinic or hospital environment. In this Chapter I concentrate on pregnancy as health and the contribution of folk knowledge in maintaining this definition. In the following Chapter the focus is on pregnancy as a potentially pathological condition situated in the hospital environment with attendant medical procedures.

Throughout these Chapters there are areas of tension between the two models and other areas where they complement each other. One source of tension is the assumed superiority of medical knowledge, which the woman may question because of her own knowledge and experience. Another source of tension is the question of whether pregnancy itself should be viewed as a health, or illness, state. Functionalist sociologists in the past (Hern, 1971; 1975; Rosengren 1961-62; Goshen-Gottstein 1966) have examined pregnancy in terms of adoption of the sick role. However, these

analyses appear to ignore the experience of the women themselves and their perceptions of pregnancy. I shall argue therefore that although women have fears and uncertainties during pregnancy which relate to themselves and the child in utero and are managed through a complex system of prescriptions and prohibitions (see Chapter Six), they also view pregnancy as a state of health interspersed with non-life threatening illness episodes (commonly known as discomforts). To argue this case, I shall look at the women's perception of their health in pregnancy; measures they take to maintain their health (the particular importance of diet in maintaining health and tensions with the medical model); and how health is restored in the case of the discomforts of pregnancy (focussing particularly on who was consulted and the form of treatment offered).

#### PERCEPTIONS OF HEALTH IN PREGNANCY

At the first interview the women were asked to describe their state of health. Their responses were analysed in terms of whether they viewed their health state positively, or negatively (see Tables LI a) and b) ). In the initial sample 75.5% of all women responded in positive terms about their health and in the final sample 78% of all women responded positively. However, this is not to say that these women felt well throughout their pregnancy, but at that particular time they felt positively about their health.

Pregnancy, for some women, is a time when they feel healthier than usual:

"I've been marvellous all the way through, I've just got fatter and that's it. I'm the same as I am when I'm normal. I don't even get tired, you know, people say you'll get ever so tired, but in fact I think I've got more energy. 'Cos I can't sleep at night, you see, 'cos you can't get comfortable. So I'm up earlier in the mornings now and doing my washing and God knows what."

(Case No. 8B, Primipara, MC)

Although they recognise that not all women are so fortunate:

"I do everything, including mowing the lawn, but this would cause a miscarriage in others."

(Case No. 11B, Parity 4, WC)

Other women face daily changes in their health:

"I am fit now, but I don't know about tomorrow".

(Case No. 7A, Primipara, Sikh)

"I'm better now. I felt sick and had pains in the stomach early on."

(Case No. 10B, Parity 3, WC)

For most women these discomforts were temporary and of short duration (further details on the women's perception of the discomfort and the way they are treated is dealt with more fully later). Generally speaking, the majority of women felt they could control their health in pregnancy through preventative measures and these will now be considered more fully.

#### HEALTH MAINTENANCE IN PREGNANCY

At the time of the first interview forty-two women (81%) of all women (Asian and British) thought there were things they could do to remain healthy in pregnancy. The measures mentioned

were - plenty of exercise, fourteen (54%) British women and four (15%) Asian women; good diet, eleven (34%) British women and twenty-one (81%) Asian women; and plenty of rest, one (4%) British woman and four (15%) Asian women (see Table LII).

It is interesting to note that the majority of Asian women placed importance on diet, while the British women emphasised exercise and fresh air as their prescriptions for maintaining health in pregnancy. The stress on diet by Asian women is consistent with the traditional dietary prescriptions of pregnancy practised in India, which will be discussed later. Another point of interest is the way attitudes to certain prescriptions for health changed over the course of the pregnancy. These differences were most marked with reference to exercise and rest in pregnancy. For example, the British women considered exercise important early on in pregnancy, however, when they were eight months pregnant they thought rest was more important. The Asian women conversely, considered rest was more important in early pregnancy and exercise was seen to be more beneficial just before delivery. (See Table LII).

TABLE LII

NUMBER OF WOMEN WHO THOUGHT THAT EXERCISE AND REST WERE IMPORTANT AT THEIR FIRST AND SECOND INTERVIEW

	N = 26							
	British				Asian			
	1st <u>interview</u>		2nd		1st <u>interview</u>		2nd	
	No.	%	No.	%	No.	%	No.	%
Exercise	14	54	1	4	4	15	10	38
Rest	1	4	9	31	4	15	1	4

These figures reflect the dominant sources of advice women receive. The British women in the eighth month of pregnancy were more aware of the medical prescription for rest, particularly if they had high blood pressure. The women who had been hospitalised during the course of their pregnancy for high blood pressure, were most acutely aware of the emphasis placed upon rest:

"Yes I've rested a lot since, since I came out of hospital the first time I've really rested. My husband does nearly everything you know.....I was fine until I'd been in there and they sedated me a lot, and um..I didn't feel quite with it when I came out. And from then on I haven't just been able to do it. I've um..I think they must have tightened me up in hospital like, making me rest up. Until then I felt quite free to do, well, I could do mostly anything, you know. But since I've come out of there, everything's sort of tightened, you know, it just doesn't work."

(Case No. 2B, Primipara, WC)

"Well I...last week I really started in earnest (resting) because I thought 'Gosh I'm going back to hospital if I'm not careful, and I don't want to have to go in.'"

(Case No. 25B, Parity 1, MC)

Other women disliked the idea of resting because they felt bored, or "like an invalid".

"Down the hospital - I was having a bit of swelling around the ankles - and they kept saying, 'You've just got to sit in the afternoon, don't do anything, just sit, put your feet up.' But - well it's so boring...just sitting there with nothing to do."

(Case No. 8B, Primipara, MC)

"It's not normal to sleep in the day, but I do try and sit down."

(Case No. 12B, Parity 2, WC)

"I only have a chance to sit down with my feet up in the evening - then I feel like an invalid so I don't do it for long."

(Case No. 18B, Parity 1, MC)

As far as exercise was concerned, those women who prescribed fresh air and exercise at the beginning of pregnancy, tended to argue for more rest towards the end of pregnancy.



"I used to walk a lot, earlier on. I've just toned it down a bit now."

(Case No. 20B, Parity 1, MC)

"I played netball till I was five months pregnant, till when I began to show."

(Case No. 9B, Primipara, MC)

For the Asian women the traditional prescription for pregnancy is to continue domestic work all the way through, in the belief that "labour aids labour". Earlier in the pregnancy, four (15%) women advocated rest, but these women were those who had suffered badly with vomiting. However, by the time the women were eight months pregnant someone (usually the mother, mother-in-law or sister-in-law) had told the pregnant woman of the traditional prescription of moving around/walking about in order to aid delivery:

"My mother says if you move about, you will have a quite easy birth."

(Case No. 11A, Parity 1, Hindu - Educated)

"They (the ladies) say that if you keep moving about childbirth is easier."

(Case No. 26A, Parity 3, Sikh - Uneducated)

"If you carry on working you get easy to have a baby"

(Case No. 4A, Primipara, Hindu)

Only one woman was slightly sceptical of the prescription:

"I came to know (of walking about in pregnancy) when I had my daughter. I had her very quickly, but my son came slowly. But with these children I have to move about!... What can make a delivery easy?" (Emphasis in original)

(Case No. 20A, Parity 3, Muslim - Uneducated)

There did not appear to be any variation in belief of this traditional prescription by education, religion or parity.

Despite the fact that 81% of all women thought there were things they could do to remain healthy throughout their pregnancy, there was also a view expressed by the British women that whether you had a "good" or "bad" pregnancy was purely a matter of luck:

"I've never had any real problems, I suppose I've been lucky really."

(Case No. 12B, Parity 2, WC)

"Some people really go through it. A friend of mine felt terrible for nearly all the time, and she looked as miserable as sin nearly all the while. But I'm just lucky."

(Case No. 24B, Parity 2, MC)

It was only the British women who referred to being healthy in terms of "luck". The Asian women were much more likely to attribute health to traditional beliefs about health maintenance. To understand these traditional beliefs it is first necessary to take a brief look at the importance placed on diet in maintaining health in India. Throughout this thesis, diet and food are of fundamental importance - in Chapter One the sexual distribution of food was discussed; in Chapter Six the food prohibitions and concessions were referred to; and in this Chapter reference will be made to the traditional relationship between diet and health, dietary prescriptions for maintaining health; the importance placed on diet by health care workers, in particular the attention paid to weight increase in pregnancy; and finally, the importance of traditional recipes in alleviating the discomforts of pregnancy.

First, the importance placed on diet in maintaining health in India.

#### Importance of Diet in Maintaining Health in India

The traditional Hindu system of medicine (Ayurveda) views health as a state of equilibrium and disease:

"as a state of disharmony in the body as a whole... Hence, according to it, treatment should aim at not only the finding of appropriate internal remedies but the employment of all available means to restore the normal balance or equilibrium. This comprehensiveness of Indian medicine is further evident from the attention it gives to diet - both in health and disease".  
Report of Committee on Indigenous Systems of Medicine 1948)

The importance placed on diet by Ayurvedic medicine warrants further discussion, particularly in the context of how it relates to folk beliefs about the maintenance of health during pregnancy.

In the traditional Hindu system of medicine (Ayurveda) a person's constitution is made up of three humours - one of which is dominant and inherited genetically. The three humours are - vata (wind), pitta (bile) or kapha (phlegm). These three humours are called the tri-dosha and when they are in a state of balance the body is healthy. To maintain a balance between the dosha, Nichter (1977) argues the Indian villager will pay particular attention to what he/she eats:

"Villagers commonly speak about their health and general well being with reference to their appetite, diet and defaecation....they attribute most common illnesses to improper food digestion". (p.143)

Foods are classified in the Ayurvedic tradition into the effect they have on the body, or their after effect:

"Sets of bodily symptoms are associated with heating and cooling foods and subsidiary classifications have been assigned to foods causing specific symptoms such as wind or dizziness." (Nichter 1977, p.149)

The classification of foods into "hot" and "cold" qualities is not according to the temperature of the food, or the taste, but the effect produced within the body (a classification of some foods is provided in the Appendix E ).

Cooling foods include most dairy produce as they coat the alimentary canal with a fat which slows the digestion process and which results in a soothing and cooling feeling. Thus Nichter says, the prescription for heartburn is to eat butter (a "cold" food) this relieves the burning sensation:

"Villagers state that butter and its concentrated ghee form are very cooling and that buffalo milk products are more cooling than those of cow's milk."  
(p.149)

Excessive consumption of cooling foods can have a contrary effect and lead to constipation, headaches and chills. An anomaly in this classification is black pepper, which is "hot" to taste but causes the body to sweat and cool off and therefore classified as a "cold" food. (Nichter, 1977, p.150).

Illness may be caused by eating foods at the "wrong" time of year, or the "wrong" time of day. For instance, drinking butter milk cool on a hot afternoon is attributed as the cause of a headache. (Nichter, p.150).

The other kind of foods in this classification are heating foods, these are usually digested much quicker than "cold" foods, but this does not mean that they are more digestible:

"The over eating of heating foods may cause dry hard faeces, heartburn, diarrhoea, back pain, burning eyes, mouth sores, rashes and a specific burning sensation in the body." (Nichter, 1977, p.150)

Three criteria are used to classify heating foods - 1) hot to taste, for example, chillies, radish; 2) hot in the effect on the stomach and digestive system, for example, ginger; 3) foods which cause a hot reaction in the stomach because of their extreme coldness, for instance, ice. Ice is so cold it is said to cause a burning sensation in the stomach. This burning is due to the body's reaction of heat to the extreme cold nature of ice. Thus "cold is qualitative and a substance which is too cold will cause the body to react in an opposite manner." (Nichter, 1977, p.151).

Although most followers of the vedic tradition agree that the essence of a good diet is a proper balance between "hot" and "cold"

foods (Beck 1969, p.561), this does not mean most people consciously select their foods in order to balance their everyday diet. Often an excess of "hot" foods, for example ginger, chillies are eaten without thought of their consequences. There are times however, when people are more aware of the foods they are eating; these times are when "a family member is sick, in a transition stage such as pregnancy, or when a food is to be used in a ritual context." (Nichter, 1977, p.154).

The extent to which Asian women in Britain follow dietary prescriptions when they are pregnant was investigated in this study. As mentioned in Chapter Six, there is an almost universal prohibition of "hot" foods in pregnancy (page 297). This prohibition is most marked in the early months when it is considered that the foetus is easily dislodged by the excessive heat in the body:

"I've had everything except 'hot' things. In the beginning I didn't even have egg for two or three months, I also left fish and sundh (dry ginger)"  
(Case No. 6A, primipara, Christian)

Q. "Why don't you eat 'hot' foods?"

A. "Because they want to make sure that the child stays there. As you know our Indian women have so many complications and very often have miscarriages after two or three months."  
(Case No. 2A, primipara, Sikh)

Nichter (1977) provides us with an explanation for the accumulation of heat in the body during pregnancy in terms of the Ayurvedic tradition. He says:

"during pregnancy, a woman's womb is full of blood and heat. A woman's body should not become too hot or cold during this time or she will abort. For this reason, she is not allowed to eat extremely heating, cooling or gaseous foods." (p.94)

A Brahmin woman in the sample whose grandfather had been a vaid (a practitioner of Ayurvedic medicine) religiously followed the traditional Ayurvedic prescriptions instructed by her mother:

"My mother said not to have 'hot' things, not to sit in front of the heater, and not to have coca-cola... the body acquires too much heat and causes miscarriage. And not to go out in the cold, if its raining not to go out.

Q. Why can't you have coca-cola?

Because of the gas in it. In the beginning when the baby is not very secure it can cause miscarriage."

(Case No. 5A, primipara, Brahmin)

Other beliefs women held were that "hot" foods would burn the baby inside, while water and "cold" things were avoided in the belief that:

"the insides will clear out and become clean. They (older women) say don't give water because it will flow into their veins and their stomach will get bloated."

(Case No. 1A, primipara, Sikh)

Another time when a woman's body is full of heat is when she is menstruating, and consequently heating foods are avoided at this time. After menstruating for three days, the woman is given "hot" food to clear out the stomach - menstrual blood being regarded as poisonous and its elimination therefore being imperative. Similarly, after a woman has given birth she is given "hot" foods to ensure the womb is cleaned out and also at the same time produce heat in the body which generates energy for the nursing mother. After delivery the woman's body is considered to be excessively cool and "cold" foods and substances must be avoided to the extent that cold water is not even used to wash hands:

"If you touch cold water after birth you may have permanent aches, so you have to be careful."

(Case No. 4A, primipara, Hindu)

There is a special "hot" food called punjeeri given to women in India after delivery (sometimes it is also given to the woman immediately before delivery to give the woman strength). This food is prescribed for the parturient woman by her mother or mother-in-law. Gideon (1962) describes it as given to strengthen the newly-delivered woman in the rural Punjab in India:

"Punjeeri is made by browning atta (whole wheat flour) in a large amount of melted butter, then adding, sugar, raisins, almonds and tiny crystals of gur (crude sugar) .....Punjeeri has the reputation of giving great strength; almost every woman had a handful of it every day after her confinement." (p.1230)

A variation of this food women in the research were familiar with (and seventeen (65%) were going to eat) is dabra. This has the same basic ingredients as punjeeri and is made in the same way, but additionally, it contains sundh (dry ginger), juan (barley), saunf (aniseed), ground khaskhas (poppy seeds) and the magaz (kernals of seeds of water melon, sweet melon, cucumber, and pumpkin) are ground along with pista (pistachio nuts) and almonds. The ingredients tend to vary according to individual taste and the availability of them in Britain. Some women have their own variations and one ate bajāy:

"In that we put ghee (clarified butter), almonds and all the magaz (kernals of water melon, sweet melon, cucumber, and the pumpkin seeds), pista (pistachio nuts), sougi (raisins) - all this.....I'll buy all the stuff myself, my auntie says it gives strength."

(Case No. 16A, Parity 1, Sikh)

In addition to giving strength, dabra is also renown for curing the bachaches and headaches which often follow birth:

"It's good for your health after that! For your back, when you work you don't complain about your back".

(Case No. 13A, Parity 1, Hindu)

"Yes, dabra must be eaten. The backache and headaches get better with it. It's good to have these things in milk as well."

(Case No. 22A, Parity 1, Sikh)

Dabra is considered a special treat as it is made out of nuts and sweet foods not normally eaten. It is very expensive to make and other family members often like to taste it. Several of the first-time pregnant women had already tasted dabra when a relative was pregnant:

"I have tasted it and I like it very much. It's sweet and bitter and 'hot'.....My Mum she doesn't make it too 'hot', because my mother said if I had something too 'hot' it might damage something else. She said she'll make it for me, not now, but when the baby's born."

(Case No. 3A, Primipara, Hindu, living in nuclear family)

Women living with their mother or mother-in-law will almost certainly be given dabra, or one of its variations to eat. The preparation and consumption of food is closely related to notions of reciprocity which are well defined in the traditional Indian family. In the case of dabra, the pregnant daughter-in-law is obliged to eat the food which her elders have prescribed for her and which they believe is beneficial to her. A woman who does not like dabra and lives in an extended family is likely to experience some tension between herself and her mother or mother-in-law, who has prepared the costly food:

"Well I have to eat it - not yet (after the delivery). The last time before birth, but I didn't feel like it much. But this time they were forcing me. I says 'No, I don't want it at all, if you give it, it will only be wasted.' My Mum told me this time, I said 'I will waste it. I don't want it'.... and I said 'Well I won't eat it because I don't like it at all. It's alright afterwards, but I don't feel like eating it yet.'"

(Emphasis in original)

(Case No. 11A, Parity 1, Hindu, living in an extended family)



"After the delivery my mother-in-law and everyone on her side insisted I eat some semolina pudding with much healthy stuff in it. But I didn't take it because I don't like the greasy food." (Emphasis in original)  
(Case No. 25A, Parity 3, Sikh, living in an extended family)

Women living in nuclear families who do not like dabra because of its sweetness or greasiness, are advised by older female relatives to eat almonds, either whole or crushed in flour or milk:

"No I told her (mother) I don't want it (dabra). I don't like it...She said I should eat almonds, she said I should crush them and have them in my milk if I don't like them in flour."  
(Case No. 17A, Parity 1, Sikh, living in nuclear family)

"Almonds and sundh (dry ginger) - such things are given to drink to clear the system."  
(Case No. 23A, Parity 3, Sikh, living in nuclear family)

Even women with no female relatives in this country may receive advice from relatives in India or Pakistan:

"My mother wrote to me and she said you should eat almonds and things like that".  
(Case No. 10A, Parity 3, Muslim, no relatives in Britain)

Other foods considered good to eat after the birth, are yoghurt, "a cup of juan (barley) and saunf (aniseed) and make sandulha (a pudding) and give that." The amount of choice the woman has over what she eats seems largely to depend on whether or not she lives in an extended family, or whether her mother or mother-in-law will be staying with her after the delivery (as is the custom - see page 317).

Another dietary prescription women were familiar with was the taking of oil orally in the month before delivery. This is believed to lubricate the birth passages and aid the expulsion of the foetus and afterbirth. Five (19%) women said they would take either almond oil or ghee (clarified butter) in milk in the weeks prior to delivery:

"If there's more grease inside it's easier for the birth...almond oil keeps everything soft inside."

(Case No. 4A, primipara, Hindu)

"They (older women) say have oily foods otherwise it will be hard for you. Have this and have that - have more ghee in your milk."

(Case No. 18A, Parity 3, Sikh)

One woman had been told to eat a lot of ghee (clarified butter), but had not done so as she was unable to make it. Another woman feared the lubricating powers of oily and fried foods thinking they may cause a premature birth:

"I've heard of taking almond oil and ghee, but I've never done it because I think the baby might slip out."

(Case No. 3A, primipara - Hindu)

These traditional dietary prescriptions were widely known among the Asian women studied. Twenty-three (88%) women said they had been given specific advice on diet in this pregnancy. The main sources of information were the mother and mother-in-law; in their absence a sister-in-law would give advice. Of the three women who had not been given advice on diet in this pregnancy, two (8%) were Hindu women from Tanzania and did not have any relatives in Britain; the third woman had neither her mother or mother-in-law in Britain at the time of her pregnancy.

After the birth of the baby, in addition to the traditional dietary prescriptions such as dabra or punjeeri, many women observe further dietary restrictions. One woman said she would avoid red chillies for a couple of weeks "as it may hurt when I go to the toilet." Other women spoke of the dietary restrictions enforced on breast feeding mothers. Traditionally, in rural India all babies are breast fed and for the period of breast feeding women pay

particular attention to their diet which is prescribed for them by their mother or mother-in-law.<sup>1</sup> However, in Britain surprisingly few Asian women breast feed; of the initial sample eight women (32%) breast fed and of the final sample five women (20%) were breast feeding while they were in hospital. One of the reasons Asian women gave for not breast feeding was that you have to "take care of your diet."<sup>2</sup> Mother-in-laws and mothers often claim that young women in this country do not pay enough attention to their diet and for this reason they are unable to breast feed. As one mother-in-law said:

"Yes it's all very good (breast feeding) but only if the mother takes good care of her diet for one and a half years while she is feeding the baby, otherwise the baby will find it difficult to digest the mother's milk. It is difficult for me as mother-in-law to tell my daughters-in-law that if they are going to breast feed they must restrict their diet to certain foods. They might think their mother-in-law is stopping them from eating! .....Anything with resha (phlegmish) should not be taken, like yoghurt."

(Mother-in-law of first-time pregnant Sikh woman. Two daughters-in-law live with her)

The prohibition on "hot" foods, such as chillies, while the woman is breastfeeding is enforced because these foods are believed to de-hydrate the baby. Some women find these restrictions limit the spicy food they can eat and occasionally they may be tempted to eat some of the prohibited foods. In these cases the woman is reproached by older women who are present:

"If the baby falls ill, then they (older women) say that it must be because the mother ate something."

(Case No. 2A, primipara, living in an extended family)

---

<sup>1</sup>In certain parts of India there is widespread advertising of artificial feeding and it appears that there is a general move towards bottle feeding.

<sup>2</sup>Other reasons for Asian women bottle feeding are discussed in Chapters Five and Ten.

The relationship between food ingested and the baby's health is thus perpetuated after the baby is born. One woman who had been bitten by a snake in Pakistan said she would not breast feed her baby because it was believed the poison<sup>1</sup> was still inside her body.<sup>1</sup>

The presence of an alternative form of feeding babies in Britain (which the majority of Asian women use) means that the dietary restrictions for the post-partum period are largely ignored. This is in contrast to the traditional dietary prescriptions during pregnancy which have persisted on migration to Britain. These prescriptions are particularly important immediately before and after delivery, for it is then that the woman is seen to need strengthening foods. The Asian women were largely dependent on older "experienced" women for advice about diet. This advice is consistent with the indigenous system of medicine and lay concepts about bodily changes in pregnancy. Although some Asian women are questioning the traditional prescriptions, up to now, the majority of women observe them. Moreover, there are very few alternative sources of information on diet available to Asian women in Britain. The Parentcraft classes (which only two (8%) Asian women in this pregnancy attended) considered diet in terms of traditional British diet), while only seven (27%) Asian women said their GP had spoken to them about diet. Some foods recommended by doctors trained in allopathic medicine contravened the Ayurvedic restriction on "hot" foods during pregnancy. Eggs are one such example. The main foods the GPs

---

<sup>1</sup>Nichter (1977) says in South India, women with poisonous breast milk may have their breasts branded to "eliminate the poisons" (p.92).

advised women to eat were meat, milk, eggs, fruit and vegetables. Vegetarian women were not given special advice on what foods to eat:

"Well he knows (that I'm a vegetarian) I told him the last time anyway. He never told me about diet, nor did they at the hospital. They haven't told me anything."  
(Case No. 11A, Parity 1, Hindu, vegetarian with Asian GP)

The Asian women were therefore very dependent on traditional dietary prescriptions and familial advice. In contrast, the British women were not familiar with such a co-ordinated system of traditional beliefs about the importance of diet in maintaining health during pregnancy.

#### British Women's Knowledge of Diet During Pregnancy

The British women's knowledge of diet during pregnancy was largely premised on a belief in the science of nutrition, although this was class-based. The British middle class women believed that the concept of a "well balanced diet" was fundamental to maintaining health in pregnancy. Knowledge of what constituted such a diet was often learnt at school as part of biology or domestic science. The British working class women, on the other hand, were more likely to focus on which foods should be avoided during pregnancy, information which was usually provided by older women.

The sources of information about diet for British women were varied and the advice given was more fragmented than for the Asian women coming from school, GPs, Parentcraft classes, books, relatives or friends. The dominant response to questions about diet was that it was up to the individual to eat the "correct" foods and it was

assumed she would know what they were. This attitude is different to that held by the Asian women who saw diet much more in terms of a collective responsibility based on a co-ordinated system of traditional beliefs.

The British women were similar to the Asian women in that they did not find their GP very forthcoming on the question of diet. Only four (15%) British women mentioned their GP as a source of information on diet. Moreover, two women found the information provided by their GP was not consistent with advice gained elsewhere:

"The thing that I didn't ever get adequate information on, was over salt...My doctor said that...he saw no reason whatsoever why I should reduce salt intake, yet in the States they said cut out salt completely".

(Case No. 26B, Parity 1, MC)

The British women who attended the Parentcraft classes learnt about diet in the seventh month of pregnancy. The advice given was to eat "a good well balanced diet" consisting of meat or fish, eggs and cheese at least once a day. They were also told not to eat for two and to try and cut down on the amount of starchy foods eaten. The importance of foods containing iron, of fresh vegetables and of milk, was also stressed. After one of these classes, the Health Visitor commented that she felt she was "preaching to the converted....its only those people who are interested who come and they could get the information they need elsewhere anyway". She commented that often the women who come are teachers and sometimes she feels that they know more than she does. (Conversation, 22nd June, 1977). There is an assumption on the part of this Health Visitor that the women who attended Parentcraft classes do not really need to be given advice about diet in pregnancy. Two British women who went to the Parentcraft class on diet reflected this same assumption:

"They told us about it (diet) when we went down to the relaxation, what things to eat. But she (Health Visitor) says, - there's about eleven of us that go down there - she says we're alright, because we're about the right build anyway".

(Case No. 3B, Primipara, WC)

"We had a bit on diet and that there (Parentcraft class). But more on what to eat after the baby is born if you're breast feeding."

(Case No. 7B, Primipara, WC)

A woman who went to fee-paying National Childbirth Trust classes also expressed this view:

"They hand out leaflets on diet, so all the information is there, but not really a discussion about it (diet). I think its taken for granted these days that everyone knows about diet."

(Case No. 20B, Parity 1, MC)

Nine (35%) British women said they had not been given any advice on diet, and only one woman (4%) thought this was inadequate:

"No-one mentioned it (diet)...not a thing. I think its very important one should be given advice, they should have diet sheets which they hand out. I've been surprised at having no information at all....I seem to remember being given lots of literature the first time (in America)."

(Case No. 26B, Parity 1, MC)

The other women who had not been given any advice on diet in this pregnancy reflected the view "everyone knows" about these things; "it's taken for granted that you should drink milk"; or "it's one of those things that one knows about really."

"I did buy one or two books and I did go to the library and read what I could (about diet). I thought that if I just went along eating what I thought was a fairly healthy diet um..and a balanced diet, then I would be alright. And I do drink a lot of milk". (emphasis added)

(Case No. 20B, Parity 1, MC)

"You more or less know what you've got to eat, you've got to try and eat plenty of vegetables, drink plenty, perhaps plenty of water...I think you know anyway...I do try and eat plenty of nourishing foods if I can...It's up to you yourself - if you're responsible." (Emphasis added)

(Case No. 22B, Parity 1, MC)

What is interesting to note here is that all the women who expressed the view that "everybody knows about diet these days" were educated, middle class women. They were also the women who ate well when they were not pregnant:

"I eat a very varied diet anyway. I've always drunk milk and I eat an awful lot of cheese".

(Case No. 9B, Primipara, MC)

"We eat a good well balanced diet anyway". (Emphasis added)

(Case No. 25B, Parity 1, MC)

The working class women, on the other hand, were less likely to have read books other than the clinic leaflets on diet, and they were also less likely to have an adequate diet when not pregnant. One of the pregnant women whose husband was unemployed said that she often went all day without eating:

"Like Wednesday when I go out (to the clinic) - I never have much when I go out - I never bother eating or drinking...I never bother having anything till when I come back here about ten at night. That's when I really start eating."

(Case No. 13B, Parity 2, WC)

Another woman was in a Hostel for unmarried pregnant girls in her previous pregnancy and felt she was not given enough to eat:

"I said to me Mum 'Just bring us something up....I'm not getting enough here to eat to pass to the baby, never mind for me to eat'. One day she was stood there while I was having a meal and she said 'Your little brother could eat as much as that and there's ten years between us. So my mother started, well I was seeing her at least three times a week, so she started bring me stuff to keep me going. She said 'You need something inbetween meals if that's all you're getting'."

(Case No. 14B, Parity 1, WC, speaking of previous pregnancy)

The working class and unmarried women were far more likely to rely on advice given to them by their mother, than to obtain information on diet from any other source. The advice given to these women by their mother was most often in terms of the amount of food to be eaten, and specific kinds of food to be eaten:



"I just drink plenty of milk. My Mum's always said that if you can get milkdown, its the finest thing out you know."

(Case No. 3B, Primipara, WC)

"She (Mother) says 'Oh you'll have to keep off anything like the stuff which you know affects you, like fresh tomatoes.' ...."The skin on fresh tomatoes does. Well I mean I really get it bad (indigestion) at the best of times, that's without being pregnant, you know."

(Case No. 16B, Parity 1, WC)

Occasionally, it was a midwife who gave traditional advice on foods to eat, particularly if the woman was intending to breast feed.

(Note the similarity here with what the older Asian women said

page 337):

"Like no vinegar, I love pickled onions and that and I can't eat them...They go into your milk in your breasts, and they give the baby gripe or whatever you call it, I don't know. But its advisable not to drink sour, spicy stuff...The midwife did tell us that at the relaxation class."

(Case No. 7B, Primipara, WC)

This advice was more acceptable to working class women than the clinic literature which tends to deal with the question of diet in more "scientific" terms, and assumes a certain amount of knowledge:

"Do eat sensibly. This means eating iron-containing and high protein foods. It means eating little carbohydrate.... (p.22, You and Your Baby, Part One)

Although the middle class women tended to gain their information about diet from books and independent sources, while the working class women tended to rely more upon traditional advice from their mother, there is a sense in which both groups of women were beginning to question traditional knowledge about diet. Seven (27%) British women thought that iron, calcium, vitamins and protein were needed by the pregnant woman. This change in attitude to diet reflects a

greater dependency upon the doctor, who administers the prescription for the iron tablets, and the drug companies who manufacture the iron and vitamin pills. These pills were seen by four (16%) women as the panacea for all dietary deficiencies:

"I have taken multi-vitamin tablets as well, on my own initiative, especially when I thought I hadn't had a very good diet that week. Then I took a few multi-vitamin tablets."

(Case No. 20B, Parity 1, MC)

"You see you have iron tablets now, everybody has them, don't they? They fill you full of vitamins. If they (doctors) think you're lacking in anything they'll find out, through your water tests and things like that."

(Case No. 18B, Parity 1, MC)

There has been a recent shift away from the traditional dietary prescriptions as advocated by older women. This advice would often take the form of recommending special foods seen to be necessary for the woman and developing baby and were based on years of experience. One such traditional recipe a British woman mentioned was the prophylactic practice of drinking raspberry leaf tea.<sup>1</sup>:

"They (mother's friends) used to drink raspberry leaf tea. And that used to be, they say one of the finest things for pregnant women...With both me and me brother Dr. M. who's our doctor said when I'd first been born that I looked like a baby that was three months old or something. The skin, there was no redness or wrinkle with it - she (mother) swears that it was er... that it was a lot to do with this raspberry leaf tea - the fineness of the skin like you know, not being like a prune."

(Case No. 18B, Parity 1, mother WC)

These traditional prescriptions are now being replaced by medical prescriptions, i.e. pills that are prescribed for the woman by the doctor. Iron and vitamin pills were viewed by some British women as essential in ensuring a "good well-balanced diet" in terms of

---

<sup>1</sup>This tea is now patented and sold in health food shops.

nutritional theory. Conversely, the Asian women considered it essential that their diet should be "balanced" in terms of Ayurvedic theory. A few less traditional Asian women are beginning to conceptualise diet in terms of western nutritional science and incorporating this knowledge into their lay beliefs about "hot" and "cold" foods.

Surprisingly, little information about diet was given to both groups of women at the ante-natal clinic or by their GP, and often the advice given was when the woman was well advanced in her pregnancy anyway. Despite the lack of attention paid to diet by medical personnel, both Asian and British women were aware of the concern the same personnel placed on regular weighing of the pregnant woman. This weighing was performed in the belief that pregnant women have regular weight increases throughout pregnancy which are quantifiable and each woman will increase her overall weight by the end of pregnancy by a universal amount.

#### Tensions with the Medical Model - Weight Increase in Pregnancy

The dominant belief of the medical profession is that pregnant women should have regular weight increases throughout pregnancy and put on a total of twenty eight pounds in weight. The booklet women are given at the clinic reinforces this belief:

"During pregnancy a woman puts on about 28 lb in weight".  
(You and Your Baby, Part I, p.45)

This advice was often taken so literally (particularly by the British middle class women) that they kept to a strict diet in order not to exceed the required amount of weight increase. The traditional Asian women, on the other hand, were not familiar with the medical reasons for a specified weight increase. They were

more likely to control their weight gain in the belief that large babies are more difficult to deliver:

"During pregnancy I don't believe in taking rich food because it will make the baby very heavy. And the heavier the baby, the more trouble there will be in the delivery time."

(Case No. 25A, Parity 3, Sikh, living in extended family)

The British middle class women who attempted to regulate their weight increase, occasionally found themselves being reprimanded for having lost weight. For instance, one woman was advised by her GP to control her weight and later told off by the hospital staff for losing weight:

"As I said to the midwife 'My doctor told me not to put on more than one pound' and she said 'But he didn't tell you to lose weight.' So since then, I might add that I've been eating around to make sure next week because they really do flatten you in this way. And I had to do one of those urine things, oestriol tests."

(Case No. 25B, Parity 1, MC)

The women thus were caught between trying to ensure they did not exceed the required amount of weight increase and not losing weight, an indication in medical terms that "something was wrong". The women found the threat of having to do oestriol tests or be hospitalised for weight loss, were very effective forms of social control over the women:

"I didn't want to put on too much weight, because they say this is bad for you and all that....The doctor said 'Oh, you're not putting on much weight. Why's that?' and then he says 'Have you had a cold or diarrhoea, anything like that?' And I said 'No. Nothing like that'. Then he says 'Well you're certainly not putting on much weight lately' he said 'You'd better do some of these oestriol tests....you'd better do one for the next three days sort of thing'. Well that came as a bit of a shock ....so I said 'Well is something wrong, will you tell me?' 'No', he said 'we're just being careful'....I was pleased my weight's been kept down a bit, because two stone is

as much really as you want to put on, and I've put on two stone now...But people do put it on at different times - they seem to want everybody to be absolutely to standard, you know, size and shape."  
(Case No. 23B, Parity 2, MC)

"I'm so scared. Scared to go next time (to the clinic) that they'll keep me in. 'Cos I lost some weight and they told me to put weight on...They told me yesterday to put on weight, otherwise I'll have to go to the Walsgrave for the rest. Because last time they sent me as well when I lost the weight."

(Case No. 11A, Parity 1, educated)

The way that weight loss is treated by the medical profession tends to worry some women excessively, so that they either panic at the thought of being hospitalised, or they over-eat to make sure they do not lose weight. Working class British women were most likely to take the latter course of action:

"I was told to put on no more than two stone. But I was ten and a half stone before I started and I think I'm getting on for thirteen now. So I know I've put on over the two stone mark you know...But as I say, down the hospital if you lose weight, they don't like that. So you've got to try and sort of be putting a little bit on you know."

(Case No. 2B, primipara, WC)

Another woman found out through experience that to be hospitalised for weight loss was not as uncommon as she had been led to believe. In fact, she was surprised at the number of women who were unable to keep to the medical instruction of regular weight increases:

"I was amazed to go into M I and listen to the other girls talking. I wasn't there long enough to get to know any-one particularly, but er... there must have been twenty-eight to thirty beds on that ward and there was about twenty-three filled when I was there, and er...the biggest, a great percentage of them were in for weight loss. And I thought when I was first told with him that I'd lost weight, I thought - well I really did panic. I thought goodness me, you shouldn't lose weight, you should be putting it on. I thought it was something really rare, that I'd got something really wrong with me. But I see now that it's very common, I didn't realise how common it was."

(Case No. 18B, Parity 1, MC)

Despite the medical instruction of not putting on too much weight, nor losing it, the women were not given constructive advice as to how they could control their weight. This was a particular concern of the British women:

"Yesterday she (the woman who weighed her at the clinic) said 'You're overweight now, so you'd better start starving yourself', and that's the only advice she gave me."

(Case No. 22B, Parity 1, MC)

"I'm overweight in fact. I just put on a stone in the last three weeks. They just said I've got to watch what I'm doing now. Nothing specific - just watch."

(Case No. 6B, primipara, MC)

Another woman thought that advice about how to control weight in pregnancy was essential if women were to keep within the limits outlined by the medical profession:

"You need a strict control on your diet. You need someone to blast your head off if you're eating the wrong foods and you're putting on too much weight. Otherwise you're not going to make the effort."

(Case No. 19B, Parity 1, MC)

As most of the British women took the medical definition of "normal" weight gain seriously, they were surprised to find that the weighing procedure was not always accurate:

"One week I went and the doctor I saw said I'd had an excessive weight gain and I must go back next week. The next week I'd lost weight! That's another thing, I don't think they weigh you properly. I'd ate just the same. I know those scales that they weigh you on down the hospital, they're supposed to balance, aren't they? Well for instance this week, one was still going down when she'd got me weighing too much. But she still wrote it down."

(Case No. 9B, primipara, MC)

"They weight you on a pair of bathroom scales - they can't even get your proper weight."

(Case No. 7B, primipara, WC)

To compensate for the inaccurate weighing at the clinic or GP a few women weighed themselves regularly at home. They often found that their recordings showed a far more consistent weekly increase in weight than those taken by medical personnel. They were thus very sceptical of the fluctuations of weight recorded on their hospital record card. The suspected inconsistencies in weighing, the lack of advice about how to control weight, plus the fear of being either under or over weight all contribute towards a situation where the pregnant woman feels she just "can't win." The definition of "normal" weight increase appears to be so arbitrary that the woman can do little to maintain an ideal weight - for that "ideal" is always changing and does not take into account different body size at the start of pregnancy, or the parity of the woman.<sup>1</sup> The woman is therefore left with the doctor making the final decision about how much weight she should put on in pregnancy:

"Well the doctor said to me actually 'Stop the dieting' - I wasn't dieting as such, but I was as I thought being careful and sensible. But obviously you just can't win you see."

(Case No. 25B, Parity 1, MC)

This was the woman who earlier (page 346) said her doctor had instructed her not to put on more than a pound a week during the later stages of her pregnancy.

Another factor which is significant in any discussion of diet, yet ignored by health care workers, is the woman's social

---

<sup>1</sup>Moore (1978) claims that later-born children are usually heavier (page 6).

conditions. For instance, the interviewing was conducted in the summer and autumn of 1977 during which time there was a national bread strike. This strike altered the eating patterns of some working class British families as the following example shows:

"In fact there was a girl in front of me when we were being weighed and they said she'd lost weight. And she said 'Well there's no bread is there?' And the nurse said 'Are you starving then? You poor dear, you'll have to make yourself some!'"  
(Quoted by case No. 23B)-

This woman suggested that the bread shortage was the reason for her weight loss, a factor which she thought was outside her control.

This discussion of the importance of diet in maintaining health and the contrasting scientific view which sees diet as something to be controlled and regulated during pregnancy, illustrates some of the tensions pregnant women experience. On the one hand, there is folk knowledge about diet, which in the case of Asian women is closely related to the Ayurvedic theory of medicine. This folk knowledge is contained within the family and passed down through generations of women. The health of the individual is seen as a matter of collective concern and several female relatives may be involved in preparing dietary prescriptions. On the other hand, scientific knowledge about diet is primarily concerned with quantifying food, counting calories or specifying weights. The scientific model presupposes individual responsibility for health - it is up to the individual woman to regulate her weight during pregnancy and she is held individually accountable.



These tensions are also evident when women experience discomforts during pregnancy. The management of these non-life threatening illness episodes illustrates the importance of different health restoration agencies to different social groups.

#### HEALTH RESTORATION - THE DISCOMFORTS OF PREGNANCY

The discomforts of pregnancy are non-life threatening illnesses which occur frequently during pregnancy, for example, digestive disorders, aches and pains. These discomforts are distinct from medically defined life threatening illnesses peculiar to pregnancy, for example, toxæmia and high blood pressure. The discomforts are universal, while only five(10%)of all women in the final sample suffered from medically defined illnesses (see Tables LIII a) and b)).

An analysis of the discomforts in terms of: i) their incidence; ii) the women's perception of them; iii) the person consulted and their frame of reference, whether they subscribe to a folk model or one located in the allopathic tradition and the form of treatment they prescribed; enables us to tease out differences between the women studied and their varying degrees of dependence on certain forms of treatment.

##### 1) Incidence of discomforts

Earlier, it was stated that the majority of women (78%) viewed their health in positive terms at the time of their first interview. Although they experienced changes in their health throughout pregnancy, at the time of the interview they felt

positively about their health. As stated before, the women were all at different stages of their pregnancy and the complaints they suffered from varied - pains in the stomach, tiredness, giddiness, backache, feeling lazy, and trouble with walking.

When the women in the final sample were interviewed again at eight months, they were asked what discomforts they had suffered from during the course of their pregnancy. All of the women (Asian and British) reported experiencing at least one discomfort and 88% (twenty-three Asian and twenty-three British) women reported suffering from more than one complaint. The main discomforts for the British women were - heartburn 61.5%; sickness 58%; aches and pains 35%; and indigestion 31%. The Asian women suffered most from "weakness"<sup>1</sup> or tiredness 77%; vomits 58%; heartburn 15% and difficulty in moving 15%. For all women the most common discomfort was vomiting or sickness,<sup>2</sup> 58% of all women suffered with this; followed by weakness or tiredness 44%; and heartburn 38%. (See Table LIII a)).

These figures are comparable to those of Graham (1977) who says that over 90% of the respondents in her study experienced "secret" complaints during their pregnancy. However, these "secret" complaints were different in nature to the ailments outlined in

---

<sup>1</sup>The Asian women often referred to pregnancy in terms of "weakness", they would go to their GP saying "I feel weakness" rather than "I think I'm pregnant". The high incidence of osteomalacia among Asian pregnant women (of which weakness is a symptom) may provide an explanation for this phenomenon.

<sup>2</sup>The British women referred to what is commonly known as "morning sickness" in pregnancy, as "sickness", while the Asian women used the word "vomits".

Table LIII a), for they were constipation, piles, varicose veins, vaginal discharge and cystitis. Another study, that of Lennane and Lennane (1973), claims that nausea of pregnancy occurs in 75-88% of pregnant women. The difference between these figures and my own, is one of definition, the Lennane study referring to nausea which is a feeling of sickness, while my figures refer to the actual incidence of sickness.

Although all of the women in the final sample had experienced some discomfort in their pregnancy, most of the women still felt well throughout pregnancy.

ii) Women's perception of discomforts in pregnancy

The woman's perception of discomforts in pregnancy was found to vary considerably with the woman's own experience of pregnancy. For instance, the first-time pregnant women (both Asian and British) did not have experience of the body changes which occur during pregnancy and therefore had no yardstick to measure these changes by. They did not know whether the discomforts indicated "something wrong" in the pregnancy, and a few first-time pregnant women did not automatically associate the discomfort with the fact of being pregnant. This was particularly the case with those women who at the time did not know they were pregnant:

"I thought it was a haddock I'd had at college, it was horrible and I was being sick after it, and I blamed it (the sickness) on that. I had it for a few weeks, but I only started having it after that haddock.

Did you know you were pregnant then?

Well I thought I might have been, but I thought it (the sickness) was the haddock and it put me off fried foods as well."

(Case No. 7B, primipara, WC, unmarried at the time)

"My mother told me when I was pregnant. When I started vomiting - I didn't know - then my mother told me."

(Case No. 12A, Parity 2, Muslim)

Another first-time pregnant woman was very concerned about the change in her health while she was pregnant, she had not expected to experience discomforts and was surprised by the number of different complaints she suffered from:

"I've had morning sickness, heartburn, strain pains, (and that was before the baby turned!) varicose veins, aches, pains, swelling....I'm beginning to think I'm becoming a hypochondriac."

(Case No. 1B, primipara, WC)

Although this woman listed seven different discomforts she had experienced during the course of her pregnancy, she did not consider them all to be caused by pregnancy. Her husband had left her when she was three months pregnant and she attributed some of her ill-health to the change in her social circumstances.

Women who had been pregnant before and therefore knew what to expect in pregnancy, often compared the discomforts they experienced in each of their pregnancies. Differences between the pregnancies were often accounted for in terms of changes in social circumstances:

"I was at work before as well (in previous pregnancy) you see, right up to eight months, and that made a lot of difference 'cos you're with people all the time, with girls like. And you're not sitting thinking about how poorly you feel or how tired you feel...Once I'm on my feet and working I'm alright, its when I'm sitting down I start and feel tired and heavy and not much energy."

(Case No. 18B, Parity 1, MC)

"I didn't notice me pregnancy last time, 'cos I was busy".

(Case No. 17B, Parity 1, WC)

Women with young children often cited the children as the reason for their tiredness in this pregnancy:

"My husband often says to me 'Why don't you have a rest in the afternoon'...But what am I supposed to do with her?...I can't handle her...I'm tired, I could quite happily go to sleep...but I can't 'cos she's always there. Sometimes I'm so tired, I'm so worn out."

(Case No. 19B, Parity 1, MC)

"I do feel more tired (in this pregnancy) well, from six o'clock in the morning he's (eighteen month old son) like a little dynamo you see...He's on the go all the time."

(Case No. 18B, Parity 1, MC)

An Asian woman whose mother had recently died attributed her ill-health in this pregnancy to the bereavement:

"I do not keep well these days. I feel very weak. In the previous pregnancies I never felt like this. This time I am not feeling well at all...At first I felt quite well, but now I have started getting very weak. It's since my mother died."

(Case No. 26A, Parity 3, living in extended family)

There are thus social factors which affect a woman's well-being when she is pregnant and it is important to recognise the presence of these social factors when attempting to understand how women perceive their health in pregnancy.

Social factors are also important in determining the woman's tolerance of the discomfort she experiences. For instance, a woman who is in paid employment outside the home may find it difficult to continue her job while she is suffering from morning sickness.

As one woman said:

"I was very sick with Carol...well actually, I was a bit cowardly actually 'cos as I say I was working at the time and I was having to leave classes and be sick. Yeah, every day I was having it - it was all-right if you like, but it was getting a bit embarrassing."

(Case No. 25B, Parity 1, MC)

In this case, the woman found the sickness was preventing her from teaching (and was causing her embarrassment) so she sought relief

from the discomfort which she said she would have tolerated under other circumstances.

One of the main determinants of whether a woman sought relief for a discomfort was whether she thought it was possible to control the condition, or whether it was "all part of pregnancy". Generally speaking, the Asian women would consult an older woman about the discomfort and follow the advice she gave. This advice often involved a change in diet aimed at restoring health. Asian women with no female relatives near at hand were more likely to be dependent on their GP. British women who were concerned about the persistence of the discomfort tended to consult their GP, women who thought they could cure the discomfort themselves tended either to use traditional recipes, or purchase compounds at their local pharmacy. There was a definite social class variation in the way these different agencies were used.

iii) Person consulted and form of treatment prescribed

The people consulted about discomforts in pregnancy tended to be either a) an older woman with knowledge of traditional recipes; b) a medical practitioner who may give a medical prescription if necessary, or c) a chemist who would sell compounds over the counter. It is worth looking at these three areas in more detail.

a) Traditional recipes - it is usually the woman's mother or mother-in-law who has knowledge of traditional recipes for the alleviation of discomforts in pregnancy. These recipes, or the appropriate course of action to take, are part of what is commonly known as

women's knowledge, sometimes derogatorily referred to as "old wives tales" (rather than "wise old tales"). Traditional female knowledge of healing dates back centuries when wise old women were respected for their skills in treating everyday maladies (see Ehrenreich and English 1979). This knowledge has been passed down through generations of experienced women and in rural India it is still the older women of the household who hold knowledge of desi (home cures) and it is to them villagers go with minor ailments. Thakkur (1976) a vedic practitioner, recognises the skills of older Indian women:

"Old grandmas used to give, in early days of childhood, to a young infant or a growing child, in case of severe colic, pinch of Bishop's weed seed, rock salt and ginger, with a little lukewarm water and immediate cure was achieved - it was not merely relief but a cure. If the credit for such a cure goes to the particular ingredient, equal credit should be given to the knowledge which the grandmas possessed." (p.vi)

For some rural villagers, it is the desi (home medicine) which is the most readily available in times of need (cf. Homans, 1979).

In Britain, there is a much more fragmented body of knowledge about traditional recipes for certain maladies, and in many cases this knowledge has been undermined by western curative medicine (i.e. allopathy). The extent to which both Asian and British women in Britain use traditional recipes for the discomforts of pregnancy will now be determined.

Nineteen (73%) Asian women said they were familiar with traditional recipes for discomforts in pregnancy, compared with nine (35%) British women. For the digestive disorders, changes in diet were universally prescribed, while for other discomforts such as,

tiredness and giddiness, a certain course of action was prescribed. What is interesting to note is the similarity between some of the traditional recipes used by both the Asian and British women.

In the case of vomiting or sickness, both groups of women took particular care of their diet and watched the food they ate. Three (15%) British women mentioned the recipes they used for coping with the sickness:

"I had bicarbonate of soda - I mean everybody takes that".

(Case No. 15B, Parity 1, WC)

"I do my home cures. For sickness, I've got a basic thing I've used for years. I make it myself - it's a kind of soup with pasta, it's very thin and salty. And I drink chamomile tea and things like that, it has a sort of settling effect."

(Case No. 26B, Parity 1, MC)

"I watched the food I ate, and a cup of tea in bed and a biscuit in the morning before getting up helped with the sickness."<sup>1</sup>

(Case No. 1B, primipara, WC)

For heartburn the traditional remedy also lies in an alteration of diet. Both Asian and British women mentioned drinking milk as the cure for heartburn, though the reasons they gave for the ameliorative affect of milk on heartburn, came out of two completely different philosophies. Asian women saw the prescription of a "cooling" food such as milk to be essential in restoring the proper balance in the body and thereby reducing the burning sensation.

"Two months ago I had quite a lot of heartburn, and my mother told me to put some glucose in milk and drink it at night. It does help, especially at night if I have it before I go to sleep. It stops the burning."

(Case No. 3A, primipara, living in nuclear family)

---

<sup>1</sup>This woman reflected the advice given in the booklet given out at the clinic, except it was her mother who brought her the tea. "Don't begin to get out of bed until he (husband) has brought you a cup of tea and a biscuit, or something of that sort." (You and Your Baby, Part One, p.10).



British women on the other-hand, considered milk to be important in restoring the acid/alkali balance in the stomach:

"I drink the top of the milk - if you have it before you eat something, it stops you getting it (heartburn). Just take a teaspoon of cream.....it stops you making too much acid in your stomach. It does work."

(Case No. 4B, primipara, living with mother)

Both groups of women saw fried foods as causing the heartburn and they would try and avoid these foods. The British women mentioned eating late at night as another cause of heartburn, and would remedy this by eating earlier:

"You occasionally get heartburn if you eat too much late at night...I remedied it by not eating anything after tea-time...It was something I could control myself."

(Case No. 22B, Parity 1, MC)

"Funnily enough she'd (mother) been saying today with this heartburn, she'd been telling me one or two bits of pieces to keep off...She said avoid pastry um...a lot of fat foods, anything that's too fatty, like you know."

(Case No. 2B, primipara, WC)

They also mentioned taking bicarbonate of soda, lemonade and polo mints to relieve the heartburn:

"With the third one I had bad heartburn and I ate packets and packets of polo mints...My aunty was a nurse and when she was pregnant she used to have medicine from the doctor and there was mint in it. So I thought a packet of polo mints is cheaper, so I'll have that."

(Case No. 11B, Parity 4, WC)

Indigestion was also seen to be caused by eating the "wrong" foods, or eating at the "wrong time" of day.<sup>1</sup> The prescription for indigestion therefore involved a change in diet:

"I had indigestion when I was first pregnant, rather than sickness with this one. I tended to have indigestion with certain things, in fact cheese sauce. I suppose it's hard to digest anyway."

(Case No. 20B, Parity 1, MC)

---

<sup>1</sup>Note the similarity here with Ayurvedic medicine which claims certain illnesses are caused by eating foods at the "wrong time" of day (see page 330).

"I'd had some fish and chips the other Monday from the chip shop and I really enjoyed it at the time. But all evening I felt I was in labour almost.... It's as if I've got to stick rigidly to an earlier time."

(Case No. 21B, Parity 2, MC)

The other digestive disorder women suffered from during pregnancy was constipation. This condition was often aggravated by the taking of iron tablets and some of the women mentioned not taking the iron tablets because of this. However, most of the women would alter their diet in an attempt to alleviate the discomfort. The Asian women had several traditional recipes that they used as a cure for constipation, while the British women would try and eat more roughage:

"I've eaten a lot of vegetables and tried to eat more fruit and all things like that....I've taken a cereal in the morning which I really detest...I must try and keep myself regular. And having iron tablets, well, I don't normally have any problems like that. But I decided myself to take bran and Alpen, which I hate, but I push it down."

(Case No. 25B, Parity 1, MC)

"For constipation I will take banaksha only."  
(A herbal tea containing eucalyptus)

(Case No. 20A, Parity 3, Muslim)

"For constipation you can take sweet saunf (aniseed) or pahardi saunf (mountain aniseed) or put juan (barley) or the petals of rose flowers, or banaksha (herbal tea containing eucalyptus) - things like this, which are made into a kahra which is like tea. You can boil all these in milk and drink that."

(Case No. 26A, Parity 3, Sikh)

"In India there are three or four types of roses with a different smell - the most scented one they use with sugar inside and mash it up and eat it. And that's a cure for constipation."

(Case No. 11A, Parity 1, Hindu)

In addition to these traditional recipes, the Asian women had cures for bad blood, weakness, aches and pains, breathing trouble

and high blood pressure. Bad blood or bloodlessness, is a recognised illness according to Ayurveda and is caused by certain foodstuffs. Milk, for instance, is supposed to raise the quality of the blood. When a woman is pregnant she is more likely to suffer from "bad blood" or "bloodlessness" and feel weak:

"My mother said 'Your blood might be bad you know' for these itchings like (the woman had come out in a rash during her pregnancy) so she said 'eat some honey like'."

(Case No. 11A, Parity 1, Hindu)

"I feel very weak. Just look how dark and pale I look. I feel weak and breathless and I can't sit down comfortably and I can't walk, my legs feel weak and shaky. When I get up after a sleep I feel I'm going to fall down - when the 'heat' rises in me I feel faint and fall down."

(Case No. 18A, Parity 3, Hindu)

The Indian remedy for weakness and bloodlessness is eating strengthening foods such as almonds (see page 335)

"The people at home tell me to have almonds and butter for my health and to stop the weakness."

(Case No. 9A, primipara, Sikh)

The British women also suffered from weakness and "bloodlessness"<sup>1</sup> and had traditional methods of coping with these complaints:

"I seem to get giddy turns if I'm not careful. And I know I'm going a bit pale in me face, or perhaps I've been on my feet too long. I know I've got to sit down... Well I had it four or five times with Rebecca but I was always able to control it, because I always knew it was coming on, so I knew I had to sit down, just till it blowed over, just a few minutes."

(Case No. 17B, Parity 1, WC)

"I wasn't feeling very well and I went to the shop and the woman says 'Are you alright?' I don't know I just sort of went off, out like - so she sat me down in the chair and gave me a drink and all."

(Case No. 15B, Parity 1, WC)

---

<sup>1</sup>One woman said that she felt "bloodless" after two pregnancies and had no energy at all.

(Case No. 13B, Parity 2, WC)

Other recipes the Asian women mentioned as cures for discomforts in pregnancy were:

"When my back aches, I have sundh (dry ginger) in butter and with sugar."

(Case No. 23A, Parity 3, Sikh)

"Yesterday she (mother-in-law) was after me, because I said I've got a pain in my back.' And she said 'You've got to have almonds oil.'"

(Case No. 11A, Parity 1, Hindu)

"When I had the third baby I had some breathing trouble and I used to take the Indian treatment of having saunf (aniseed) and only then could I breathe at night."

(Case No. 14A, Parity 4, Sikh)

"Take cloves for blood pressure, with honey. Take a spoonful of honey with a clove in it - it's good for high blood pressure....I also purifies the blood."

(Case No. 22A, Parity 2, Sikh)

All of the women quoted above learnt about traditional recipes for the discomforts of pregnancy from older women. The Asian women had either learnt the recipes in India or since they had been in Britain. As one woman said:

"In India we seldom go to the doctor. Whenever anyone is unwell the elder ladies are consulted and they usually give something."

(Case No. 7A, primipara, Sikh)

However, it would appear that knowledge of traditional recipes is declining among those Asian women who do not have older female relatives to learn the skills from, and among some women who have been exposed to western curative medicine. Two (8%) Asian women said they did not use desi (home medicines) in Britain because the climate was different and the medicines might not work, and one woman had been told by her doctor not to use her own cures, but to take any illness to him for treatment. As medical treatment is free in Britain under the National Health Service, Asian people have been

able to use allopathic medicines without fear of not being able to afford them. A considerable number of Asian women consulted their GP with discomforts in pregnancy and used medical prescriptions either on their own, or in conjunction with home cures. The nine (35%) British women who used traditional recipes also consulted their GP if the discomfort persisted, or if they were worried that the discomfort indicated something was wrong.

b) Medical prescriptions for the discomforts of pregnancy. Most of the women who consulted their GP about discomforts in pregnancy did so when they went for their routine visit; only a few found the symptoms so bad they had to make a special appointment. The GP's reaction to these ailments fell into two main categories:

- 1) that it was all part of pregnancy and nothing to worry about,  
and
- 2) that it was a condition that could be alleviated with the prescription of a drug.

The former view was also expressed in the section on "Keeping Well" in the leaflet given out at the clinic (You and Your Baby, Part I, p.43-46). In this article Professor Rhodes says morning sickness "though unpleasant, is certainly nothing to worry about" (p.43); breathlessness is common and as "long as your doctor found heart and lungs normal....there is no need to worry" (p.44); palpitation "virtually only occurs in normal hearts" (p.44); and faintness and dizziness "are extremely common symptoms in early pregnancy". (p.44)

The women who were not convinced that the symptoms they experienced were a "normal" part of pregnancy, were those women who mentioned their ailments to their GP. In many cases they received answers closely resembling those in the clinic leaflet:

"I've just felt tired. I started getting bachache and I started getting palpitations. I didn't know what they were until I asked the doctor and he explained that it was nothing to worry about." (Emphasis added)

(Case No. 4B, primipara, WC)

"I just can't walk. I've told him (doctor).... I said 'I have a bit of trouble you know getting across (the road)' and he said 'If that's all that's wrong with you, you haven't got nothing to worry about.'" (Emphasis added)

(Case No. 10B, Parity 3, WC)

The doctor's emphasis on the "normality" of these discomforts did little to allay the fears of some women. Several women were upset that the doctor took so little interest in their condition which to them was unique:

"It was like a blackout really. I mentioned it to the doctor, but I don't think he was all that concerned."

(Case No. 17B, Parity 1, WC)

"I asked the doctor what caused the rash. He said that it often happens when you're pregnant. But last time I didn't get it. When I said this to the doctor, he said 'Not all pregnancies are the same, some take 38 weeks, some take 40 weeks....sometimes you have a girl, sometimes you have a boy. It doesn't mean to say you have the same thing.'"

(Case No. 11A, Parity 1, Hindu)

"I've got the same pain down my leg (as had in previous pregnancy....I did mention it to my GP in my visit last week. I mentioned it and he said 'You'll just have to bide your time. When you have the baby it'll go.' But you know I can see that I've got it for about ten weeks I suppose."

(Case No. 19B, Parity 1, MC)

Although these women were dissatisfied with the response that their ailment was all part of pregnancy, there was a further small group of women whose faith in the medical profession led them to

accept the doctor's definition of their symptom as "normal" and ceased to worry about it on the grounds that "they would have told me if anything was wrong":

"When I stand up a lot I feel dizzy....I think it's because me blood doesn't flow so quickly, because I always get a lot of pins and needles in my legs and arms. They took blood tests for haemoglobin and that, so if there was anything wrong there, they would have found it, so I didn't bother saying nothing. It's got 'well' on the card 'cos I had a peep at it."

(Case No. 7B, primipara, WC)

"Well I don't really ask him any questions really, I just let him get on with his job and that's it really. As long as everything's allright according to him."

(Case No. 17B, Parity 1, WC)

All of these women had GPs who were against the prescription of drugs and discomforts of pregnancy - these conditions were seen to be specific to the pregnancy and would disappear when the child was born.

In this context the GP neither prescribed a medicinal remedy or advised the woman how the symptoms could be alleviated. The women were simply told their doctor did not agree with the prescription of drugs in pregnancy:

"I told the doctor last time...He said 'No. You can't have any tablets while you're pregnant'. No-one had mentioned it before then."

(Case No. 13A, Parity 1, Hindu)

"My GP said he didn't think it was a good idea to take even Asprin in pregnancy."

(Case No. 3B, primipara, WC)

"I'm not sleeping at the moment you see and I went to see Dr. S....buthe wouldn't give me any(tablets). He said 'No' which was fair enough."

(Case No. 1B, primipara, WC)

Only one woman out of the total sample said her doctor had given her advice about how to ease the condition she was suffering from:

"I said to him (GP) that I couldn't sleep at all well, and he says 'Have a short walk and have a hot shower before you go to bed'. He said 'You have to start taking it easy now'. As I say, with him you do feel as you can ask him a little you know, whereas with the others I feel uneasy."

(Case No. 10B, Parity 3, WC)

British women who did not receive a satisfactory answer from their GP may ask several different health workers for advice, until they found a prescription which suited them:

"I've had constipation...I did mention it at the doctor's once, you know. They asked if my bowels were alright and I did mention that. And I did mention it at the hospital. And he did say there that I could take a mild laxative if I wanted to. This was when perhaps I was about five months, but I did mention it to the midwife up at my doctor's and I asked her if I could take things like Andrews Liver Salts or Enos. And she said 'No. Don't take anything like that. Just eat more fruit and prunes - eat foods. That'll get you better - foods that'll work it out'." (Emphasis added)

(Case No. 19B, Parity 1, MC)

Although this woman had asked her doctor and the hospital doctor about a remedy for constipation, it was not until she spoke to the midwife that she found an answer that was acceptable to her. Other women did not go to such lengths and would either take what was prescribed by their doctor or refuse medication.

The most frequently reported incidence of medication for a discomfort of pregnancy was for sickness or vomiting. Asian and British women alike went to their GP for a medical prescription to relieve the sickness. Eight (15%) women were prescribed tablets for sickness, that is, 27% of those who reported sickness to their GP. Only one woman found the tablets provided complete relief from the discomfort:



"I took them and it was just - I couldn't believe the difference really....But it was great not being sick, I must say it was great".

(Case No. 25B, Parity 1, MC)

Most women only went to the GP asking for a prescription as a last resort, when they could tolerate the sickness/vomiting no longer.

However, they did not always find that the medical prescription provided complete relief and often the women did not finish the full course of treatment:

"I used to vomit a yellowish, greenish liquid....I couldn't even speak for three months, then I went to the doctor. He gave me medicine, but there wasn't much difference with the medicine. But it automatically got okay after three months."

(Case No. 14A, Parity 4, Sikh, living in nuclear family)

"The medicine didn't do any good, so I left taking it"

(Case No. 4B, primipara, Hindu, living in nuclear family)

"He (GP) just gave me some tablets...I didn't like them, they made me feel ill. It (the sickness) only lasted about a fortnight and I was alright then. I only took the tablets for about two days."

(Case No. 22B, Parity 1, MC)

"When it was Easter time as I started being sick, I realised I was pregnant and I went up to the doctor's, you know, after so long as I could stand it. 'Cos some nights it used to be unbearable 'cos the pains and that I got in my stomach. And um...he gave me some tablets, but I didn't take many, about half a dozen, because they say you don't want to have too many. You don't know what it does to the baby - there's got to be something in it. So I thought I'm not taking any more, and I just put up with it after that." (Emphasis added)

(Case No. 10B, Parity 3, WC)

There are two main concerns expressed in the statements given by the women who did not complete the full course of the medical treatment prescribed. (It is interesting to note that none of the women who had taken traditional recipes for these same discomforts expressed any such concern). Implicit in the statements that the

women made were 1) a feeling that the medical treatment was not alleviating the ailment, and sometimes it was felt to aggravate the condition, and 2) a concern that the medical prescription may in some way harm the baby. Women stopped taking the medicine or tablets if they did not think it was effective or if they were aware of the recent controversy over the effects of drugs upon the foetus.

The women studied often found that the treatment for sickness/vomiting, and constipation tended to aggravate the initial ailment. One woman who had been prescribed tablets for constipation (rather than a change in diet) said:

"I couldn't go to the toilet (embarrassed). I did ask the doctor and he gave me something which took a long time to work, so I stopped taking it and haven't asked since."

(Case No. 13B, Parity 2, WC)

Additionally, the women spoke about the effects iron tablets had, either in making them constipated (as mentioned before), or making the woman feel sick, or sticking in the throat:

"I could never take them. If I took an iron tablet... it sticks, the tablet always sticks in my throat... So I don't take them".

(Case No. 13B, Parity 1, WC)

"I always get them stuck in my throat, so I didn't take them for the first four months."

(Case No. 14B, Parity 1, WC)

"They (iron tablets) weren't any good, they used to make me feel more sick afterwards. So I used to miss them sometimes you know."

(Case No. 7A, primipara, Sikh)

These women had mentioned to their GP that the iron tablets did not agree with them. The first woman had received iron injections in her first pregnancy and hoped to have the same in this pregnancy, but her GP ignored the request. The second woman was found to have a

low haemoglobin level and was instructed to have iron injections to raise the level. The third woman told the doctor that the iron tablets made her feel ill and he changed them to some others which did not make her feel sick. Both the medications prescribed for ailments, and also the medications which were seen to be a "normal" prescription for pregnancy (for example, the iron tablets) were not taken if they had any adverse effect.

The second reason for women not completing prescribed treatment was a concern over the potential effects of the treatment upon the foetus. The recent thalidomide scandal had made some women aware of the harmful consequences of taking certain pills which have been prescribed by medical practitioners:<sup>1</sup>

"I don't know what they'll do, so I won't take them (pills)...and I think it's just things published like the thalidomide, and that makes you worry."

(Case No. 20B, Parity 1, MC)

The impact of the publicity about side effects of drugs has led many of the British middle class women who are familiar with this literature to question the doctor's decision in prescribing certain drugs:

"I just wouldn't take anything. In fact I did have a very bad cold when I was about four months pregnant... you know, a really bad nose and throat. And it got me down and I didn't want to go up to the doctor's and I didn't get anything myself because I didn't want to take anything. But it got so bad that in the end I did go up to the doctor's....and she gave me some tablets to take, I think pencillin, or something like that. Anyway I got them home and never took one of them. I thought 'Oh no. She might not know what she's doing'. I thought 'I'll suffer' so eventually it went away of its own accord."  
(Emphasis added)

(Case No. 19B, Parity 1, MC)

---

<sup>1</sup>Sjöström and Nilsson (1972) argue that in the case of thalidomide, doctors were at the mercy of the drug companies who provided information about the safety of the drug. In 1961 Distillers issued an advertisement which stated that "Distaval can be given with complete safety to pregnant women and nursing mothers without adverse effect on mother or child". (p.195)

"At the beginning of pregnancy I had a lot of migraine and he (GP) says 'These tablets are safe'. But when I got home I thought about it and I thought 'No', I'd rather not take anything because of the possible dangers, especially in the early months".

(Case No. 24B, Parity 2, MC)

Other women had made decisions about not taking drugs in pregnancy based on the experience of others:

"I wouldn't take anything anyway, even if prescribed by the doctor. I'm funny like that...Even for sickness, if I had it, I wouldn't take anything. My sister had a lot of trouble with sickness and she was on tablets galore. She was due as now is, more or less, and she lost hers at six months. It was born normally. I don't know what the trouble is with her I'm sure, she's taken so much. She's pregnant again now, once again she's sick a lot. I said to her 'Are you taking tablets?' and she said 'No', I'm not going to bother this time'. I think it's best let alone if you can cope with it".

(Case No. 18B, Parity 1, MC)

Ten (38%) British women said they would not take any drugs at all in pregnancy (only one Asian woman (i.e. 4%) said that she would not take drugs in pregnancy).<sup>1</sup> The reason these women gave for not taking drugs was the effect they may have on the child. They would often suffer during pregnancy under conditions which they would have taken pain-killers had they not been pregnant (see earlier discussion page 298 ).

"I was frightened about drugs and things. I won't even take an Asprin or Paracetamol or anything. Sometimes I wish, if I have a bad headache or something, I wish I could take one. But I couldn't, I'm quite firm about that".

(Case No. 20B, Parity 1, MC)

The women who said they would not take any drugs at all in pregnancy faced a dilemma when they encountered a painful illness episode. When this happened to one of the women, she presented at the doctor and was prepared to take the doctor's word that the drugs prescribed were "safe":

<sup>1</sup>The Asian women were more likely to rely upon traditional recipes, and the women who took pills were unaware of the recent literature and controversy surrounding the taking of drugs in pregnancy. Also the Asian women were less likely to challenge their GP's decision in prescribing.

"I had an ear infection a few weeks ago and they gave me a course of antibiotics, some ear drops and some painkillers. That set up a vaginal infection, with the antibiotic, so they gave me some more tablets to combat the antibiotics which were causing that. So now I'm taking about seven lots of tablets at the moment...He (GP) in fact got out his medical book and said 'I'm going to prescribe a new course of antibiotics, let me just check that everything's alright'... I'd literally taken nothing not even an Asprin...I know well enough that I shouldn't so I've avoided taking anything really."

(Case No. 22B, Parity 1, MC)

This last example should perhaps be seen in the context of the recent belief that there is a pill for everything. This woman, while not prepared to take Asprin for a headache considered that an ear infection was a justifiable cause for medication. As Klass (1975) says:

"We are inclined actively to seek medication for everything we confront, and what we seek we get from the doctor or from over the counter in a nearby drugstore or chemist."  
(p.45)

While the belief is that there is a pill for every occasion, it might also be stated "every occasion but pregnancy". Women who receive medication in pregnancy therefore find themselves in the centre of a medical debate about prescribing practice in pregnancy. In the sample studied it became apparent that most of the GPs were reluctant to prescribe drugs for pregnant women; as stated before the discomforts of pregnancy were seen to be "normal" and "nothing to worry about". This contradiction is heightened when the pregnant woman no longer suffers from a discomfort but an acute illness, as when a pregnant woman is hospitalised. In these instances, women were very confused by the fact they received medication in hospital which was subsequently denied to them on discharge:

(When in hospital) "All they did was fill me full of drugs as I said, which is something you always avoid. You don't take drugs when you're pregnant like. Everybody knows that. From the moment I was there, I was on those tranquilizers - they've got some real good ones like, they make you sort of dizzy!"

(Case No. 18B, Parity 1, MC, hospitalised for blood pressure)

"They give you tablets in the hospital and when you go to your doctor, he doesn't give you none. It's funny isn't it? I suppose they don't want to take on any responsibility in case anything happens or something, perhaps that's why....."

(Case No. 11B, Parity 4, WC)

It seems as if the distinction is between being pregnant and at home under GP care, which is "normal" and being hospitalised which is not "normal". One woman who suffered from sleeplessness in pregnancy worked out her own means of bridging this contradiction when she was hospitalised:

"In hospital...they come round and say 'Do you want any sleeping tablets?' And they give you two, and two painkillers as well, and two iron tablets - so that was six tablets I had. But I didn't take them all, I kept some for the next day, then if I had any left over I brought them home. I knew he (GP) wouldn't give me none over the road, so I kept 'em."

(Case No. 15B, Parity 1, WC)

Given the dominant medical belief that discomforts are "normal" in pregnancy, there is a further contradiction in terms of the prescriptions available for the discomforts. On the one hand, drug companies have invested large amounts of money into trying to develop anti-sickness pills, while on the other hand, we are faced with the situation where very little can be done to alleviate the pain caused by varicose veins in pregnancy. The form of relief available for varicose veins is very limited and consists of wearing elastic stockings. Something which is not without problems:

"I was told to wear elastic stockings - you can get the stockings on prescription, but not the tights, so I have to buy my own tights. Hence I haven't got them on at the moment - you can only afford one pair at a time. I can't afford two pairs....(She did wear the stockings once). They gave me them and I shall never forget it as long as I live! That was the first and only time I ever wore a pair of elastic stockings (went out and), the elastic stockings had come down to me knees and they'd pulled the suspenders down to me knees! I never felt so embarrassed before....They tell you not to wear anything too tight - but it's basically got to be an iron corset to keep those things up."

(Case No. 11B, Parity 4, WC)

Another woman had to wait for three months to obtain a pair of these stockings, while an Asian woman was given an elasticated bandage instead:

"I asked for a prescription (for the stockings) and he (GP) gave me one like and he said it would be three months before I could get a pair. Three months - it sounded a long time to wait. But I couldn't get them on anyway 'cos me ankles were all swelled up."

(Case No. 15B, Parity 1, WC)

"They've (GP) given me two bandages. First they gave me one which I had to tie around the leg, but it would come down. Then they gave me an elastic one which I can tie to the top and feel comfortable with it."

(Case No. 14A, Parity 4, Sikh)

These three women suffered considerably with varicose veins and had little relief for the condition. Unlike the other discomforts of pregnancy which were transitory or pregnancy-specific, varicose veins are much more permanent and some of the women had been suffering from them since a previous pregnancy. Varicose veins are more enduring than the pregnancy itself and they are extremely painful. The doctors say "nothing can be done about them during pregnancy" (Rhodes, 1975, p.46) though there are injections which can be given after pregnancy. Out of all the discomforts the women suffered from, varicose veins were the only ailment which affected women differentially, they occurred in one particular group of

women - those of a lower social class and higher parity. None of the middle class women suffered from this complaint although they were equally susceptible to it. The other discomforts mentioned did not appear to be class or culture specific in their incidence,<sup>1</sup> but in terms of the treatment followed there were considerable variations. The third source of treatment was the chemist shop which only the British women used.<sup>2</sup>

c) The Chemist's shop - Twelve (46%) British women mentioned buying drugs at the chemist for the discomforts of pregnancy. They bought remedies for specific discomforts - heartburn, indigestion, aches and pains. For example, half of the British women who suffered from heartburn obtained some form of relief from the chemist, the other half of the women used traditional recipes as outlined previously. The most popular remedies obtained from the chemist were Rennies, Settlers and Milk of Magnesia, though other compounds were mentioned:

"I just take a little Morland or something like that. They're just indigestion, heartburn tablets - we've always got some in the house. I just take them."  
(Case No. 24B, Parity 2, MC)

"Once when I had it very bad I did take some, I think it was Boots make of um..Alka Seltzer stuff, you know. I did take some of that once because it was so bad you know."  
(Case No. 21B, Parity 2, MC)

---

<sup>1</sup>The high reported incidence of weakness among the Asian women is a possible exception to this.

<sup>2</sup>Asian women mentioned using Aspirin for children's ailments, but none said they used them for discomforts of pregnancy.



For indigestion the women mentioned taking Rennies or Settlers four times more often than they mentioned altering their diet to prevent the indigestion. Some women also mentioned the large amount of these tablets that they consumed:

"I'm Rennies mad! I eat a packet of twenty-four Rennies every week...perhaps more...I eat them like sweets I'm afraid.

(Case No. 1B, primipara, WC)

"I've taken about twenty tablets in the last two days."

(Case No. 12B, Parity 2, WC)

Other women were slightly more cautious of taking these tablets and only took them as a last resort:

"I try and go as long as I can actually, then I take Rennies or Settlers. I do take them, that is something I do take occasionally, but it's very rare.....And I feel as though they are safe to take." (Emphasis added

(Case No. 17B, Parity 1, WC)

Twelve (46%) British women mentioned going to the chemist to buy products advertised as providing relief from indigestion, heartburn and aches and pains. It is interesting to note that four (15%) of these women were those who had said they would not take drugs in pregnancy; they seemed therefore to be making a distinction between what was medically prescribed and what could be bought over the counter. The latter were assumed "safe" because of their accessibility. The women who used compounds bought at the chemist were more likely to be working class women (31% of these women used the chemist and 15% of the middle class women) who found it more convenient to go to the chemist's shop than to make an appointment to see the doctor. Also, they did not consider their

discomforts serious enough to warrant a special visit to the doctor, when the chemist stocked everything they needed:

"There's nothing you can't get now, there's a marvellous array of stuff at the chemist. And the chemist at the Co-op Mr. M. is a marvellous man, I've never known a pharmacist like him. He'll come out and explain all about the drugs to you and you can ask him about side effects and he'll get his sheet out....He'll tell you anything. Almost as good to tell you the truth as going to the doctor."

(Case No. 16B, Parity 1, WC)

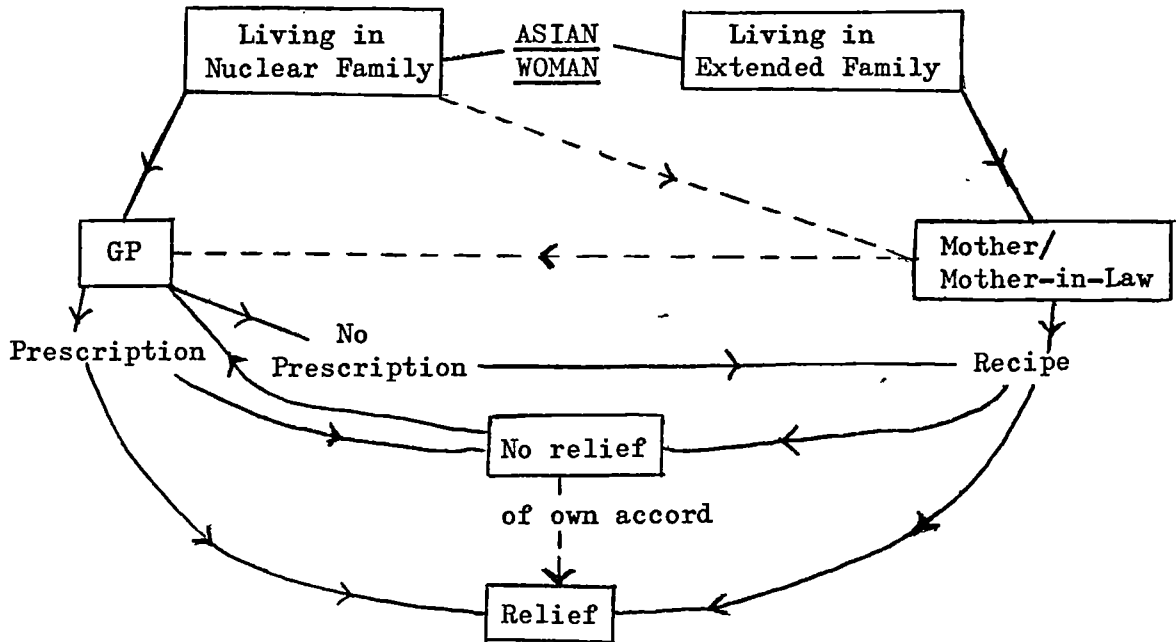
The reasons women gave for going to the chemist were of a pragmatic nature - the chemist was more convenient, and the visit short compared with the GP.

#### SUMMARY

This Chapter has looked at the women's perception of health in pregnancy, how health was maintained and restored (when suffering from discomforts). There are distinct differences between the Asian and British samples in terms of their patterns of consultation. Moreover, there are significant differences within each sample between Asian women living in a nuclear family without older female relatives to provide advice on traditional recipes and those Asian women who live in extended families or have female relatives living nearby; and for the British sample the main difference was one of social class. It is possible to portray the consultation patterns of both samples through using a diagram, and this helps to conceptualise what has previously been stated.

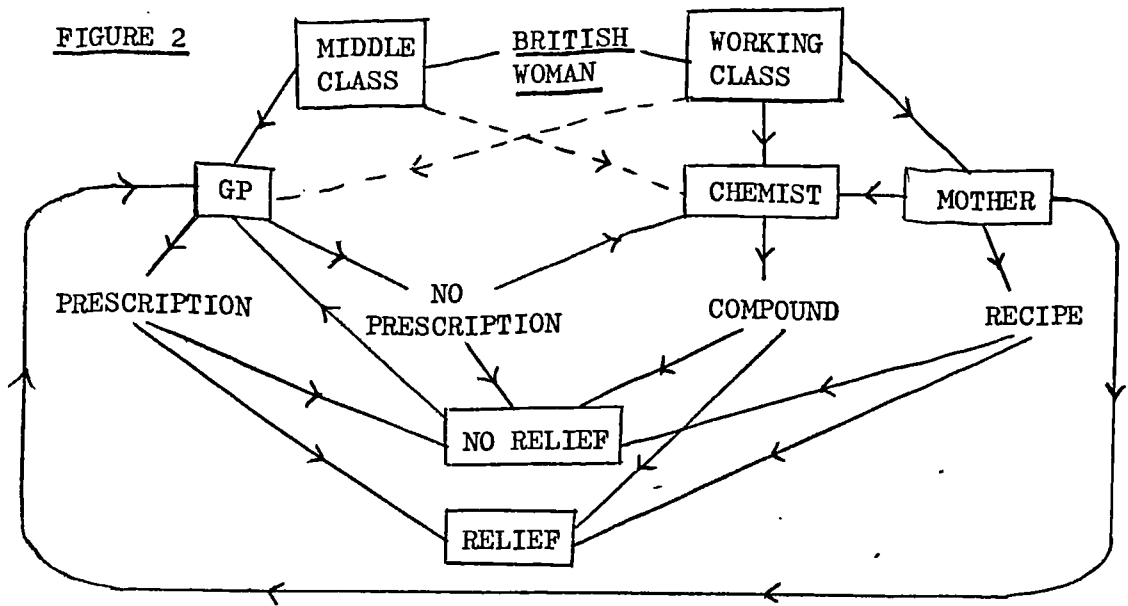
Figure 1 shows the path the Asian woman takes in her attempt to alleviate the discomforts of pregnancy. The woman living in an extended family is likely to consult her mother or mother-in-law, who will prescribe a traditional recipe (under some circumstances she may refer the woman to her GP).

FIGURE 1      CONSULTATION PATTERN OF ASIAN WOMEN FOR DISCOMFORTS  
OF PREGNANCY



The traditional recipe may or may not provide relief for the discomfort, if it does not, then the woman will probably consult her GP. The Asian woman living in a nuclear family (without older female relatives at hand) will go to her GP in the first instance. GP's may decide to prescribe to alleviate the discomfort, although not all GPs consider this necessary. If a medical prescription is provided relief does not automatically follow, nor can it be assumed that all women take the complete course. In many instances, the discomfort was found to right itself after a certain time interval (see page 367).

The consultation pattern for the British women was similar to that of the Asian. The main differences being those of social class (working class British women tending to act in a similar way to



CONSULTATION PATTERN OF BRITISH WOMEN FOR DISCOMFORTS OF PREGNANCY

Asian women living in an extended family, and middle class women resembling Asian women living in nuclear families); the British women also used the chemist in their search for relief of certain discomforts in pregnancy, which the Asian women did not. A further difference between the two samples was the way they used their GP. The British women (particularly middle class women) would consult their GP, but be very wary of any prescription they were given. Often the full course of treatment was not taken. The Asian women, on the other hand, were more likely to take drugs prescribed by their GP.

The GP's themselves altered the course of some women's consultation pattern. GP's who thought discomforts were "all part of pregnancy" did not offer relief for the symptoms and the woman may go elsewhere for relief, or simply tolerate the discomfort.

Some women who spoke of traditional recipes, qualified their statements with "but its only old wives tales" as if to say they should be treated with suspicion because they were not very "scientific". This reflects some lay people's attitude towards, and dependence on, curative scientific medicine as the only legitimate body of knowledge. We are therefore faced with an interesting dilemma whereby "non-prescribing" GP's consider discomforts cannot be "cured" and some women who view medical prescriptions as the most "advanced" form of treatment. The distinction between doctors subscribing to and defending "scientific" knowledge, and lay people subscribing to and seeking out "folk" knowledge is by no means a clear one and what happens in practice is that people are muddled, subscribing to both belief systems (cf. Helman, 1978).

## CHAPTER EIGHT

### PREGNANCY AS PATHOLOGY

#### Introduction

In the previous Chapter the part played by folk medicine in health maintenance and restoration during pregnancy was examined. However, despite the women's general perception of well-being during pregnancy, they experienced a medical regime designed to detect and cure pathology. Constant screening of the pregnant woman is advocated by medical personnel, in an attempt to ensure the birth of a live, healthy baby to a fit mother.

Medical intervention in pregnancy and childbirth has increased dramatically since the widespread hospitalisation of childbirth and the concomitant concentration of finance in the hospital sector.<sup>1</sup> Although care during pregnancy has become increasingly hospital based, the largest component of ante-natal care is the routine screening of a seemingly well population of pregnant women. Recently, the preventive aspects of ante-natal care have been stressed in the Health Education Council campaign which encourages women to attend their GP early in pregnancy and be involved in routine screening, to prevent complications developing.

The clinical model of pregnancy is predominantly concerned with detecting pathology and preventing death, while the social aetiology of disease is accorded less significance in the clinic

---

<sup>1</sup>The publication of Government Reports (Guillebaud, 1955; Cranbrook, 1958; Peel, 1970) strengthened the argument for hospitalisation of births.

setting. Much research has however shown the importance of social factors in affecting the successful outcome of pregnancy. For instance, women who are malnourished, of low social class and high parity, are more likely to be susceptible to complications of pregnancy and childbirth. Richards (1978) and Ashford (1978) among others, have argued that there is a strong correlation between perinatal mortality and low birth weight babies, and Moore (1978) and Baird (1975) draw attention to the correlation between social class and perinatal mortality. Other writers have looked at the low birth weights of Asian babies born in Britain (Warnes, 1962; Stroud, 1971; Arthurton, 1972; Roberts et al., 1973).<sup>1</sup> Further studies suggest that toxæmia of pregnancy can be attributed to malnutrition (Our Bodies Ourselves, 1978, p.358).

Furthermore, although the medical model of pregnancy claims to be scientific, there is reason to doubt the rationale behind the present organisation of ante-natal care. Recent research at Aberdeen shows that there is no scientific foundation for the present number of ante-natal clinic visits. Often women are receiving consultant care at times when the possibility of detecting pathology are slight.<sup>2</sup> However, an increasing number of women are receiving consultant care and fewer GPs are considered specialised enough to

---

<sup>1</sup>The differences in birth weight for all babies born in Coventry in 1976 by country of origin of mother are shown in Table XXXVI. The birth weights of babies born to the women in this study are illustrated on Tables XXXV and XXXVII.

<sup>2</sup>A paper entitled 'The Scope and Limitations of Ante-Natal Care' given by Dr. Marion Hall at the Human Relations in Obstetric Practice meeting, University of Warwick, 21-23 March, 1980, develops this point further.

be fully responsible for all a woman's ante-natal care, and home births are generally regarded as "unsafe".<sup>1</sup>

Women have come to depend on constant screening during pregnancy and associate this, together with medical intervention at the time of birth, as contributing towards the alleviation of pain in labour and the successful outcome of their pregnancy. Moreover, women may compare the services available to them with those their mother received, or the conditions in rural India:

"He (doctor) says 'You've got very small hips for the size of you, you know, for the height'. So I think it's good (that she might have to have a Caesarian section) 'cos it's better to be safe than sorry, because my mother had an interlocked pelvis - her bones were locked together and she was in three days labour, you know. And if she was pregnant now-a-days they wouldn't have let her do that. They would have said Caesarian section, you know".

(Case No. 8B, primipara, MC)

"In India many babies die".

(Case No. 8A, primipara, Punjabi)

First-time pregnant women were seen to be particularly dependent on clinic based ante-natal care, although, as will be discussed later, women in the clinic setting were treated as patients and their social status as mothers-to-be was ignored. Lack of privacy and treatment by different personnel were cited as depersonalising and restricting communication. Multiparous women complained that the clinic was not geared to the needs of their other children, in terms of provision of facilities and timing of the clinic.

Multiparous women who have previous experience of medical care in pregnancy and childbirth tended to be the most critical. Their own experience may have indicated that medical knowledge is not able to

---

<sup>1</sup>A more detailed discussion of the safety of home births is contained in Kloosterman, 1978; Mehl, 1978; Richards, 1978. The women's attitudes towards hospital and home confinements are detailed on pages 311-315.



successfully control and cure all conditions. One woman was hospitalised ante-natally for pre-eclampsia and subjected to various different treatments. She began to feel very despondent when the doctor said:

"Well we tried that and it didn't work, we had better think again".

(Case No. 18B, Parity 1, MC)

The limitations of medical knowledge are clearly shown in relation to the cause of miscarriage (as will be discussed later).

Furthermore, many women were perturbed and/or confused by the conflicting advice given them by different medical personnel. Women who considered medical knowledge to be a uniform body were the most disconcerted by conflicting information. These tensions become apparent in this Chapter and are dealt with in more depth in Chapter 9 which looks at the division of labour among health care workers and their different conceptualisations of pregnancy.

In this Chapter though, I focus on 1) the women's reaction to advice to attend their GP early in pregnancy and how this varies according to parity, social class, ethnic background and feelings of well-being; 2) the women's expectations and experiences of the consultant clinic and their perception of the patient status conferred on them; 3) the medical procedures experienced during pregnancy and at delivery. The women's knowledge of them and attitudes towards them and how this varies depending on the women's faith in medical knowledge and lack of confidence in themselves; 4) areas where medical knowledge is limited will be briefly examined with reference to an underlying fatalistic belief in "whatever will be, will be" subscribed to both by women and some health care personnel.

1. FIRST ATTENDANCE AT G.P.

One of the pre-requisites of present day ante-natal care is that pregnant women attend their GP early for confirmation of pregnancy and to make arrangements for subsequent care. When pregnant women first attend their GP may indicate the extent to which the women perceive pregnancy to require medical attention. Early attenders are usually women who are keen to become pregnant, or have a history of previous complications (for example miscarriage) or those wanting a termination. Variations also exist between primiparous and multiparous women and women of different social class and ethnic background (Tables XI and XII detail when the women studied first attended their GP).

Three quarters of all women went to their GP of their own volition ( Table LIV). The eight Asian women and four out of the five British women who were advised by someone else to consult their GP were primiparae. The woman's husband was most frequently cited as the person who advised visiting the GP ( Table LIV). The lay support women received during pregnancy is detailed in Chapter Ten. Six out of nine first-time pregnant Asian women and seven out of the nine first-time pregnant British women attended their GP in the first trimester of pregnancy. On average, first-time pregnant women were likely to visit their GP earlier than multiparae, but unmarried women (unless wanting an abortion) and shy Asian women, were likely to delay in attending:

"When I was expecting the eldest I went down to the doctors when I was seven months pregnant..."

(Case No. 13B, Parity 2, WC, unmarried when first pregnant)

"The first time I went to the doctor in the fifth month because I was very shy. This time I went in the second month."

(Case No. 16A, Parity 1, Sikh)

When the women were asked if they thought there was a "correct" time to attend the GP during pregnancy, twenty three (88%) Asian women and twenty-two (85%) British women in the final sample said "Yes". Twenty-two (85%) Asian women and nineteen (72%) British women thought the "correct" time was in the first three months of pregnancy ( Table LV).

However, some multiparous women tended to think there was no need to consult the GP straightaway, unless they were feeling ill:

"You need to go early with the first. After you've had a couple you know what you're like. Also you know - you don't need a water test to tell you that you are pregnant". (Emphasis in original)

(Case No. 11B, Parity 4, WC)

"I first went when I was five months pregnant....I didn't have any trouble before that otherwise I might have gone earlier. Because I didn't have any trouble I went only in the fifth month."

(Case No. 14A, Parity 4, Sikh)

Another multiparous British woman who was familiar with the antenatal arrangements said she delayed her initial visit so she did not have to make so many clinic visits. While one British woman in her second pregnancy said she waited until she was absolutely sure she was pregnant before going to the doctor's as she had had a "false alarm" before:

"I did leave it a bit late. I don't go until I'm four months, when I'm absolutely sure. Whereas most girls start going before, perhaps they've only missed one or two periods. Whereas I'd missed about four before I started going....You can miss periods for other reasons, not always pregnancy, and I did once miss three in a row and I'd never in my life been irregular. I'd always been as regular as clockwork, so I thought that must be it, and it wasn't. I wasn't. There was no explanation, it just started again on its own..."

With my mind going back to missing three before - I couldn't help harping back to that - that's why I never told anyone 'Cos grandma's can get upset if they think you're going to have another little ray of sunshine and then you tell them it's all a sad mistake sort-of-thing. So that's why I kept my mouth shut about it."

(Case No. 18B, Parity 1, MC)

Early attenders at their GP tend to be those women who have longer education. For instance, British women who received education over the age of sixteen attended the GP on average at seven weeks pregnant, those women who had not received education beyond sixteen attended the GP on average twelve weeks pregnant. Asian women with secondary education and above, attended the doctor at an average of eight weeks pregnant, while those with less than secondary school education went to their doctor at an average of thirteen weeks pregnant.

Women who had not received formal sex education were also likely to report later to their GP when first pregnant. The Asian women were less likely to receive formal sex instruction than the British women (pages 242-243) and were less likely to recognise their pregnancy as soon as women who had received formal sex education:

"When I was two or three months pregnant I came to know from the ladies and the doctor".

(Case No. 12A, Parity 2, Muslim)

Other women who had received formal sex education reported to their doctor much earlier. For instance:

"It was at about one and three-quarter months. Actually eight days after missing my period."

(Case No. 5A, primipara, Hindu)

"I thought I was pregnant after missing a period, so I went to the doctor".

(Case No. 3A, primipara, Hindu)

It was not only the Asian women though, who reported to the doctor late through ignorance. One British woman who was unmarried at the time of her first pregnancy did not realise cessation of the menses was an indication of pregnancy:

"I used to hate having a period like, it used to get on me nerves. And I never used to know about - well, I couldn't be all innocent when I was having the first - but I never used to know that you'd stop having the period like you see. And I used to think it was great half the time because I used to feel all...er bored and everything (when having a period) it used to get me down. Then me husband, well I was going out with him then, he says that I looked like I was expecting like...He actually told me at the first 'cos I never used to know that you'd stop having the periods at the start...His mother told me I was putting on weight and everything and she took me to the doctor the first time, to her doctor and he says that I was expecting."

(Case No. 13B, Parity 2, WC)

As far as this woman was concerned, the cessation of menstruation made her feel healthier, rather than indicating that something was amiss, and she did not see a doctor until the seventh month of pregnancy.

For the women who considered there was a "correct" time to attend the doctor during pregnancy, there was often a discrepancy between what the women thought should be done and what they actually did. For some women this discrepancy was accounted for by the fact that they did not know they were pregnant. Four (15%) British women were already receiving treatment from their doctor for other complaints (vaginal warts, previous miscarriage, anaemia and depression) and although the women had mentioned the possibility of pregnancy, this was not diagnosed immediately by the doctor:

"We weren't absolutely sure in the beginning. 'Cos he (GP) was treating me for anaemia you know, 'cos once I did go five months without having anything."

(Case No. 10B, Parity 3, WC)

"Well I'll tell you what it was like with me like. I was mixed up for a couple of weeks like you know. (Was treated for depression) And I don't think they can tell for fourteen days or you can have a pregnancy test. I was so eager to find out, I'd been to the doctor and it was Dr. S. and he didn't put my mind at ease. He didn't even send me for one (pregnancy test) 'cos if he had sent me for one then I would have known, you know. 'Cos as I say, he didn't know nor did I. So I went and had a private one at the chemist and I was. So I knew before him and I was chuffed...When I did see Dr. S. again and I told him I was pregnant, he says 'Why did you do that?' (Emphasis added)

(Case No. 16B, Parity 1, WC)

This last woman was disappointed the doctor was unable to diagnose her pregnancy straight away and it led her to question his ability as a doctor. During the course of her pregnancy she changed to another doctor in the same practice. Another woman who expected the doctor to be able to diagnose pregnancy, was taken aback when the doctor told her she was six months pregnant. She had consulted the doctor four months earlier, suspecting that she was pregnant, but the doctor had said "No". She had therefore believed in his expertise, rather than her own cues about the changes taking place in her body:

"I didn't know I was pregnant till I was six months. I was going to the doctor's (I've got a daughter in care as you know) and I says 'I haven't come on'. 'Oh don't worry' he says 'it's through you being worried you know'. Well after Christmas I began to believe I was pregnant. 'I can't be - he told me I'm not' and that went on for months and I went to the doctor again and he goes 'Did you know you're about six months pregnant?' I could have dropped through the floor". (Emphasis in original)

(Case No. 14B, Parity 1, WC)

Although 86.5% of all women felt there was a "correct" time to go to their GP when they were pregnant, and 95% of these women thought this was in the first trimester, 38% of all women said they didn't think it made any difference to their health if they went later to their GP than they had done.

TABLE LVI

RESPONSE TO QUESTION: DO YOU THINK THAT IT MAKES ANY DIFFERENCE TO YOUR HEALTH IF YOU GO TO THE GP LATER THAN YOU DID?

Final sample N = 52

	<u>Asian</u>		<u>British</u>		<u>Total</u>	
	No.	%	No.	%	No.	%
Yes	18	69	11	42	29	56
No	7	27	13	50	20	38
Don't know	1	4	2	8	3	6

Most of the women who advised early attendance at the GP, had consulted their own GP for some form of medication. They either wanted iron or vitamin tablets, or more rarely, needed hormone injections to prevent a threatened miscarriage.

Despite the recent arguments for early ante-natal attendance (DHSS 1977;<sup>1</sup>, Zander, et al., 1978, Ashford, 1978, Health Education Council Campaign 1980) some women felt their GP did not pay sufficient attention to them at their initial visit:

---

<sup>1</sup>The DHSS document argues that "the first visit made by a pregnant woman to a doctor is often the most important". Zander et al., (1978) argue that the first ante-natal visit is important and its objectives are 1) to make a general assessment of the patient in physical, psychological and social terms; 2) to establish a plan of management for the pregnancy and 3) to establish a relationship between the patient and her doctor and midwife (p.119)

"The first time I went to him (GP) I told him that I'd missed my period and all that, and I think that I'm pregnant. Well I said 'I want to go to the hospital for the test', so he just gave me the bottle like you know, so I went there for the water test and that's all. So then I asked him what the result is and he says 'Positive' - I phoned from here and then I went to see him afterwards, you know, when he says it's positive."

(Case No. 11A, Parity 1, educated)

This woman was dissatisfied with her GP's lack of interest in her pregnancy and stopped going to him and continued attending clinic appointments only. Another woman in her first pregnancy was surprised at the casual treatment she received:

"When I thought I was pregnant I went to another doctor in the same practice and he said 'Come after two or three weeks, then we'll take your test and see if you are'. So after three weeks I went there but he was on holiday so I had to go to Dr. A. - he just wrote a letter and told me to go to Warwick hospital and get the test. And when the test came back I went and he said 'You are pregnant'."

(Case No. 3A, primipara, educated)

Often the women were bemused by their doctor's lack of interest in their pregnancy. Many of the women were familiar with the aim to get pregnant women to their doctor as early as possible in the pregnancy, yet their doctor did not always seem to welcome them. In fact, several of the women were told to return to their doctor a few weeks later as they had gone too early! These women then went elsewhere for a pregnancy test, either to a chemist or to the BPAS (British Pregnancy Advisory Service).

When the women first attended their GP and how she/he responded, often affected the timing of their first consultant ante-natal clinic visit, although GP referral practices varied considerably (see page 189) and not all GPs were committed to the pathological definition of pregnancy, (cf. pages 476-488).



## 2. WOMEN'S EXPECTATIONS AND EXPERIENCES OF CONSULTANT CARE

### a) Expectations of the ante-natal clinic

About 80% of all pregnant women in Coventry receive some of their ante-natal care from the consultant clinic. This is not through choice, but a result of the local policy which emphasises continuous screening and monitoring in pregnancy (see pages 149-150).

The women's expectations of the consultant clinic were shaped by their previous experience. Thus women with no experience of the maternity services have less specific expectations of them. The Asian women were less likely to have been to a clinic before in this country than their British born counterparts. Nineteen (49%) Asian women in the initial sample said it was the first-time they had been to the consultant clinic, for fourteen women (36%) it was their first pregnancy, and for the other five (13%) it was their first pregnancy in this country.

The Asian women's knowledge of the management of pregnancy was firmly located in the context of what happens in the country they grew up in. There is little up to date ethnographic evidence about the management of pregnancy in the Punjab; however, Morpeth (1979) argues most births still take place in the home and little has changed since Gideon's (1962) detailed account. According to the reports of women who recently gave birth in India, the major change is that the dai (traditional midwife of barber caste) may now have received formal midwifery training. The first-time pregnant woman is still expected to return to the home of her mother when she is six to seven months pregnant, and the pregnant woman's behaviour is very much prescribed by older women (particularly the mother or mother-in-law); she is told what to eat, what foods to avoid, and instructed in the correct behaviour for a pregnant woman.

The birth at home is still women's business and the labouring woman is attended by the village dai, her mother (or mother-in-law) and possibly her būa (father's sister-in-law). Only the very rich or those women having complications in pregnancy, give birth in hospital where the treatment has to be paid for. Only four (15%) women studied had previously given birth in Asia, and all of these women had a home delivery. Their accounts of the birth were very similar - at home with women they knew and no medical intervention.

Only one Asian woman had been into hospital in India for treatment, she had gone when she was five years old and could hardly remember her visit. Two other women had accompanied relatives to the nearest hospital, one had been with her grandmother when she had her eyes tested, the other woman had visited her younger brother when he was hospitalised. Therefore the Asian women studied had very little experience of hospital care before they migrated to Britain. Their comments about the hospital services in India always referred to the fact that care had to be paid for:

"The treatment in the hospital costs money".  
(Case No. 18A, Parity 3, Punjabi)

"There is a difference as you must know - they (medical staff) look after you better here (Britain) and without money".

When faced with hospital ante-natal care in Britain these women have very little idea of what to expect, although they are very grateful that the services are free under the National Health Service.

The Asian women were less critical of the medicalised model of ante-natal care than the British women, they saw it as contributing to the birth of a live child. Only one third (33%) of the Asian women in the initial sample had criticisms of the ante-natal clinic

studied, compared with thirty (77%) British women.

When the Asian women were asked if the clinic was as they expected it, nineteen (49%) women in the initial sample said they had no idea what to expect as it was their first visit; eight (21%) did not expect it to be so "rushed and packed" as it was, while the others thought there would be an interpreter or Indian doctor, a play area for the children, and "drinks facilities". At the later home visit, eighteen (69%) Asian women said they thought there should be a "lady" doctor for internal examinations (see pages 257-258).

The Asian women had therefore lower expectations and were less critical of the ante-natal services than the British women. This can be related to: i) their low status as migrants. They feel they should be grateful for the "free" services, rather than complain they are not suited to their needs; ii) their low status as women in Asian patriarchal society. They are not used to questioning decisions made by men:

"It's alright both places (GP and clinic). It doesn't make any difference to me....It's alright wherever they call me."

(Case No. 24A, Parity 2, non-English speaking)

"I was taught to go to the doctor first and now to the clinic. They ask me questions there also and here also. It doesn't make any difference to me where they take me."

(Case No. 2A, primipara, non-English speaking)

"Well you can't say nothing you know".

(Case No. 4A, primipara, English speaking)

Not all of the Asian women responded in such a passive way to the ante-natal services, some of them with more experience made their own evaluations:

"If you have any complaints then it's alright if they call you so many times. But if you have no complaints(at the clinic) then what is the use of going?"

(Case No. 14A, Parity 4, non-English speaking)

On the whole, the British women had more idea of what to expect from the clinic, either from previous visits or because they had resided in the city longer and had friends who had been to the clinic before. However, six out of the eight British women who had not been before did not expect to wait as long as they did. Women who had previously attended the clinic, remarked that it had changed little over the years:

"It don't seem to have changed from six years ago"  
(Case No. 10B, Parity 3, WC)

"It hasn't changed since last time". (In this case fourteen years ago)  
(Case No. 16B, Parity 1, WC)

Some of the middle class British women were very explicit in what they expected of the clinic:

"They didn't ask when the baby first moved. And I didn't have a cancer smear."  
(Case No. 19B, Parity 1, MC)

"It would help if there was a resident dietician to offer advice".  
(Case No. 26B, Parity 1, MC)

The women who had definite expectations of the clinic are the experienced ones - they have experienced pregnancy before and have concrete ideas of what procedures should be carried out at the clinic. They compare the treatment they receive in their current pregnancy with that received in the past:

"He (doctor) came in, he just had a quick feel of my stomach, then he put the - you know, you're supposed to be able to listen to the baby's heart beat - he just put it on and took it off. 'Cos I thought: 'Well, that's quick'. With the others they've listened in two places and they have felt the stomach properly you know....'  
(Case No. 11B, Parity 4, WC)

For some first time pregnant British women, their attendance at the clinic actually raised their expectations during the course of their pregnancy. One woman who listened to the baby's heart beat at one clinic visit considered this should be made available to all women at every visit. Her response is worth quoting at length:

"I heard its heartbeat for the first time last week - it was marvellous...that little machine they put on. There was workmen drilling outside the hospital or something and he (doctor) couldn't hear a thing you know, and..when he first done it I was beginning to get a bit worried you know, because he was putting it here and putting it there and couldn't find it. And I thought: 'Oh God, there's something wrong!' you know. Anywayhe put it - it right up here (points) it's heart was you know, and he says 'Oh it's lying funny'. And I just sort of heard it go pump, pump, pump, then he took it off and he said that's alright you know. But I think they should let women hear that, because it's so reassuring because all the way through you're wondering is it really alive in there, you know, because sometimes it goes quiet and you think: 'God is it dead?' 'Cos if he could have heard it with the trumpet he wouldn't have done that, he wouldn't have let me hear it you know. I think everybody should have it, for the time it takes them - it doesn't take any time whatsoever and they could put women's minds at rest."

(Case No. 8B, Primipara, MC)

b) Women's experiences of ante-natal care

When we look more closely at the women's comments about the ante-natal clinic it appears that they relate closely to i) the structure of the clinic<sup>1</sup> and ii) the "patient" status of the pregnant women in the clinic setting. Both of these factors reinforce

---

<sup>1</sup>The division of labour in the clinic is discussed in Chapter Nine.

the medicalisation of pregnancy and the enforced passivity of women in the medical setting. These two areas will now be discussed in more depth.

i) Structure of the clinic - Architectural features. The architectural features of the ante-natal clinic play a significant part in determining the nature of the social relations within the building. This point was also made by Rosengren and De Vault (1963) in their observational study of time and space in an obstetric hospital. They argue that:

"The dominance of the ecological setting, through spatial segregation, symbolic segregation and temporal organisation might qualify normative patterns, the forms in which they might be expressed, and their relative importance in the conduct of the participants." (p.287)

I would want to go further than this and suggest that the structure of the clinic (and organisation of wards) - both architecturally and socially - do have a definite effect on the users and providers of the service. The small size of the clinic studied meant that it was often overcrowded, hot and noisy.

The effect of having a large number of people in a crowded space adds to the difficult working conditions of the staff. At one ante-natal clinic session the Sister complained of a migraine which she attributed to the noise in the waiting area. The women, on the other hand, considered the clinic conditions caused their blood pressure to rise. This happened particularly when a woman was waiting in a small wooden cubicle before being examined by the doctor, as these cubicles are hot and claustrophobic.

"My general opinion is that the cubicles are too hot - dreadful. Then they wonder why your blood pressure has gone up."

(Case No. 18B, Parity 1, MC)

"And I don't like being shut in those little rooms, you know before you go into see the doctor. I just don't like being shut in them at all. The very first time I was in there three quarters of an hour - just shut in one of them little rooms. And it was so hot. I was so hot and by the time they called me in to see the doctor it was sky high - my blood pressure. I know that."

(Case No. 2B, Primipara, WC)

The design of the clinic and equipment is such that preference is given to the needs of the medical staff, particularly the doctors, rather than the comfort of the patients. For example, the women are unable to obtain refreshments at the clinic, although they may be there all afternoon, the doctors on the other hand, have a ten to fifteen minute tea break while the women are kept waiting. The following sarcastic comment indicates one woman's annoyance at this:

"I had just chosen to get on the couch while it was the doctor's tea break. That was my hard luck, so I just had to lie there till they came".

(Case No. 11B, Parity 4, WC)

Another example is the size and shape of the examination couch:

"You go in and you sit on the bed which is a very high bed - obviously because it's more comfortable for them not having to bend down. But it's quite a strain to get up on the bed, and then they take your blood pressure almost immediately...." (Emphasis added)

(Case No. 25B, Parity 1, MC)

This woman continued to say she thought it was the high bed and the effort it took to climb onto it that caused her blood pressure to rise. According to the women prone to high blood pressure, the clinic environment aggravated their condition.

The design of the building is such that it is not possible to expand the facilities to cope with the number of women attending the clinic. It is therefore the <sup>physical</sup> structure of the clinic which largely determines the number of medical personnel who work there. For example, the number of examination couches limits the number of doctors

who can practice at any one session. The lack of space also reduces the efficiency of the clinic and women often complained about it being disorganised:

"The clinic at times seems a bit jumbled, no proper system. There's a constant flow of people".  
(Case No. 20B, Parity 1, MC)

"What I can't understand and have been trying to work it out, is how they (midwives) work out the files. That I don't understand in terms of how long you have to wait. They don't always keep them in order, instead of being put under sometimes they seem to be put over. And there's always seems to be more than one person (dealing with them), this gets the whole thing muddled."

(Case No. 26B, Parity 1, MC)

Additionally because the clinic is constantly busy, women do not feel they have time to ask the staff questions. The busyness of the clinic therefore plays a significant part in determining the quality of the social relationships between the users and providers of the service:

"They (doctors) just kind of whiz in and out that you really don't feel like asking questions."  
(Case No. 24B, Parity 2, MC)

"The trouble with the ante-natal clinic is that it's always so rushed. The staff also are glum - they never smile or make you feel that you can approach them or ask them questions."  
(Case No. 19B, Parity 1, MC)

Lack of organisation coupled with extremely rushed conditions, were often given as the explanation for inadequate examinations. Under these circumstances it is possible to question the validity of screening large numbers of pregnant women for pathological conditions, when screening is hurried and incomplete.



"Last time I went to the hospital they didn't even take my blood pressure and they didn't even fill my card, which I didn't even realise till I got back and looked to see what they'd said....I've always thought it to be important that, the blood pressure bit....It was a bit strange that last time, very, very quick - you were in and out last time, rapid."

(Case No. 12B, Parity 2, WC)

"On one occasion the doctor did not feel the baby or feel my ankles or anything. That was the thirty second one..."

(Case No. 22B, Parity 1, MC)

The staff seemed aware that patients sometimes were not properly examined and occasionally women were re-called for a more complete examination. One woman attended the clinic on Friday afternoon and received a 'phone call from the sister on the following Monday, asking her to return to the clinic:

"She said 'This often happens Mr. X (consultant) stays behind after clinic on Friday and looks through the notes and as you know, it was a very busy clinic'. And she says 'This often happens, on a Friday Mr. X will realise that he's forgotten something, or that he wants to see a patient again' and she says 'He hadn't read your past history' - which I suppose he wouldn't have had time to, they just whiz in and out."

(Case No. 25B, Parity 1, MC)

Six (23%) British women felt they were incompletely examined at the ante-natal clinic, while none of the Asian women complained of this.

Workers in the clinic would probably claim that the structure of the clinic and lack of facilities contributed to the poor quality care received. This is in fact suggested by the local paper in an article addressing the conditions in the ante-natal clinic.<sup>1</sup>

---

<sup>1</sup>Coventry Evening Telegraph carried a half page article titled "Can they expect a better deal?" (24th February, 1977). The Community Health Council were also aware of the complaints women were making about the ante-natal clinic and they conducted their own survey in the summer of 1977.

"But it will remain a fact of the lives of pregnant women and of the doctors and midwives that the premises are too small to cope comfortably with the workload. Even space for essential storage is at a premium."

Although the architectural features of the clinic play a significant part in determining the standard of care women receive,<sup>1</sup> it would be incorrect to assume that it is only the physical structure of the clinic which determines the social relations. For implicit in the clinic organisation is the notion that the women attending are "patients", they are ascribed low status and their social needs are ignored.

ii) Pregnant women as patients. The pregnant woman in the clinic setting is defined as a patient, a medical status which ignores her social status as a woman, and mother-to-be. As a patient, the pregnant woman is constrained by the same factors as all other patients. Her ante-natal care is located in the clinic, she is denied access to information concerning her condition and she is relatively powerless in any encounter with members of the medical profession. All of the women were defined as patients while in the clinic itself and during their hospital stays, but even in these situations some women had greater access to knowledge and information than others. The women who had been pregnant before realised what the medical transition to motherhood entailed and in some instances were in a position to question procedures. Additionally, doctors are in a position to

---

<sup>1</sup>Women who had attended ante-natal clinics in other parts of Britain compared them with the one in Coventry. And one woman said:

"If you want to have a baby, go to Blackpool"

(Case No. 1B, primipara, WC)

Moreover, Coventry ante-natal clinic is not given a favourable report in The Good Birth Guide, (Kitzinger, 1979, p.132).

define some pregnant women as being more "at risk" than others. This labelling procedure serves to undermine women's confidence even further, and they are obliged to seek consultant care:

"I'd prefer my doctor all the way through really. But I think I'm under the doctor at the hospital because I haemorrhaged last time. I can't see that it makes any difference really, because they do just the same as the doctor does."

(Case No. 20B, Parity 1, MC)

"I think the hospital makes you feel old...Because I did read my doctor's notes that he'd written, it was in the file and the file was open...and it had got this bit about elderly primigravidae. And I thought 'Oh gosh!'"

(Case No. 19B, Parity 1, MC)

Increased medical intervention and regular screening during pregnancy has made women more aware that they are potentially at risk and they gain a negative reassurance from the continual screening they receive. This is particularly so for first time pregnant women:

"I'm pleased with going every fortnight because I'm frightened with my history. I'm pleased they've looked after me so well, kept me going regularly./

(Case No. 1B, primipara, WC, two previous miscarriages)

"I quite enjoy going down (to clinic) um...as far as when I walk out I know everything's alright. It sort of puts your mind at rest, you know, that."

(Case No. 6B, Primipara, MC)

Women who have been pregnant before are slightly more sceptical of the screening process, although they still see them as necessary:

"I mean, if anything I complain about having to go so often...but I think, obviously it's necessary because people may have sugar in their water and blood pressure and all sorts of things that need attention. But when you go time after time and everything's all right - all that for nothing! ...I should think you should know when you've got high blood pressure, swollen ankles and sugar in your water, it's quite self-evident."

(Case No. 21B, Parity 2, MC)

"And you keep doing it because you think 'Well it's  
formy own good."

(Case No. 15B, Parity 1, WC)

The Asian women almost universally agreed that the hospital clinic with constant monitoring of pregnancy was for the best. Apart from the woman who was married to a doctor and two other more critical women, most of the women did not understand enough about the clinic procedures to be able to question their efficacy. (This was particularly noticeable in relation to high technology medicine, a point which will be developed later). Despite the Asian women's lack of knowledge about the routine screening, they considered that the doctors' "know best"<sup>1</sup> and were generally pleased about having access to hospital services:

"It's (clinic) all right, the doctors' know best".

(Case No. 13, Parity 1, Hindu)

"In the hospital (clinic) there are so many doctors.  
If they find anything wrong they can send me to the  
hospital straightaway."

(Case No. 26A, Parity 3, Sikh)

While some women welcome the clinical approach to pregnancy, there are others who consider it unnecessary. They recognise the contradiction between feeling well and at the same time being treated as a patient. These women are those who have experienced a previous uneventful pregnancy and childbirth, and those who are critical of the thoroughness of the screening received:

"They (doctors) are making me go somewhere I don't want to go - there's no medical reason why I should be going there (clinic). What benefit are they gaining? I'm certainly not gaining any benefit."

(Case No. 11B, Parity 4, WC)

---

<sup>1</sup>The clinic booklet You and Your Baby, Part I, strongly argues that the doctor does know best (p.21), a belief which is discussed further in Chapter Nine.

"It's up to one's well-being. If you feel well, there is no need (to go to the clinic)."  
(Case No. 17A, Parity 1, Sikh)

"Some of those visits that I had to the hospital (clinic) were a waste of time because of the doctors I've seen."  
(Case No. 9B, Primipara, MC)

The women's experiences at the clinic reinforced their patient status (as expressed by impersonal procedures and lack of power in the medical encounter), while at the same time failing to recognise the woman's social status as wife, mother, worker, and the duties this status entails. Women with children, or those in full-time paid employment tended to find the clinic visits most inconvenient. Some women were in a better position to negotiate the terms of their clinic encounter and were able to manipulate the clinic conditions to their advantage. This ability is strongly correlated with the woman's social class position and/or her previous experience of pregnancy. Two areas where differential treatment was seen to operate were a) the length of wait at the clinic; b) the attitude towards children in the clinic, and these will be discussed in more detail for clarification.

a) Long waits. Generally speaking the women were very tolerant of the long waiting times (67% of all women waited over one and a half hours (see page 194). This tolerance can in part be explained by the transitional nature of pregnancy - the women see it as a phase in their life which they do not anticipate repeating too often.

"Obviously they haven't got much staff down there. They could improve it I suppose if they wanted. I'm not really bothered, it's not as if I'm going to go every year."  
(Case No. 16B, Parity 1, WC)

Those with low expectations of the clinic like the Asian women, were the least critical of the long waiting periods. In India, any hospital service they may have used would involve long waits of up to a day before being examined, and sometimes having to return the next day to queue again. It was the middle class multiparae in the British sample who were most critical of the long waits involved and 78% of them complained:

"The day you were there, crikey, it was terrible wasn't it? To me that was my impression of the ante-natal was always, you know, big long waits and that you know."  
(Case No. 25B, Parity 1, MC)

"The trouble is, it's a whole afternoon. There was one occasion when it went on so late that I couldn't collect the child at the right time."  
(Case No. 26B, Parity 1, MC)

The first-time pregnant were not totally uncritical of the system:

"The time I was down there the Tuesday I saw you, I could have cried the time I was waiting. We were there at a quarter to two and I didn't get home here till quarter to six that night...I appreciate it's not the hospital - they're understaffed and this, that, and the other."  
(Case No. 1B, Primipara, WC)

The British women were more critical of the length of wait involved although those with experience of the clinic system were in a better position to manipulate the time of their appointment. The negotiated with the receptionist appointments early in the session or turned up late for their appointments, knowing from experience that the clinic always ran late. One woman who complained bitterly at the long wait she had at her first ante-natal clinic visit later said:

"Well strangely enough, you know, when I first spoke to you down the Coventry and Warwick it was a bad day, wasn't it? It was a long wait. Well strangely enough I've never been so quick down there as recently. You're just in and out literally yeah. In fact I was quite sad the last couple of times. I thought: 'Crikey I don't even have time to sit down and recover after getting in, kind of thing.'"

(Case No. 25B, Parity 1, MC)

The explanation for the woman's short wait was that a clinic midwife was also a neighbour and gave her, the woman, preferential treatment. Something which caused the woman some embarrassment:

"I hated it, in fact, and I felt terribly embarrassed by it. She said: 'When are you coming down?' And I said: 'Friday afternoon' and she said 'What time is your appointment?' She said 'I'll see that you get through you know...'"

(Case No. 25B, Parity 1, MC)

This woman managed to be seen quickly because of her relationship with one of the midwives; other women tried to negotiate the length of their wait on previous experience, either their own or of friend. For instance, one working class woman in her second pregnancy said:

"When I had my daughter I had to wait hours just to be seen. Well this time I've been lucky I haven't had to wait very long."

(Case No. 14B, Parity 1, WC)

"Luck" was not the reason for her short wait as she arrived thirty minutes late for her first appointment and said:

"Just between you and me, I came late so that I wouldn't have to wait so long."

(Case No. 14B, Parity 1, WC)

Three (11%) other British middle class women tried to cut down on their waiting time by altering the time of their appointment. They attempted to gain some control over the clinic conditions by negotiating an appointment to suit themselves. It was only the

experienced women who did this, that is, those women who had been pregnant before:

"I used to think that the first appointment at two was probably the better one - although I have sat down there till five or ten past two before the doctors have even come....My friend who's just had her baby - she tended to get late appointments, I don't know why - and she seemed to get through far more quickly you know. She'd be there and back in no time at all."

(Case No. 19B, Parity 1, MC)

"I always like to get there early in case I get called early, but it very rarely happens."

(Case No. 17B, Parity 1, WC)

These differential waiting times do seem to indicate that women with experience and those of a higher class position are in a more favourable position to circumvent the clinic time-table.

b) Children in the clinic. Children were generally not welcome in the clinic, yet for two-thirds of the women attending the clinic this was not their first pregnancy. There were no special provisions for children, such as, a play area or toys, and because of this and the long wait involved, many children became very bored:

"They (sons) get fed up and they don't want to sit down - and they did have to wait you know...And of course I've got to entertain them and think of games. Then they wanted a drink, they were thirsty, then they wanted to go to the toilet. So it's easier if I go without them."

(Case No. 24B, Parity 2, MC, two school aged children)

"I felt she was a nuisance, but it wasn't her fault really. It was just sheer boredom with sitting and waiting."

(Case No. 17B, Parity 1, WC, one child under school age)



In addition to the lack of facilities for children, they were actively discouraged from the clinic by one member of the staff's attitude towards them:

"Gosh she (Sister in charge) went mad one day, she really did. I mean she nearly went beserk about the children. And quite honestly these children were just playing and they weren't making a lot of noise at all. And she made themothers take them and make them sit besides them. Well that upset the children then. They were far worse after that you know."

(Case No. 25B, Parity 1, MC, one child under school age)

This form of discouragement was particularly effective for the British mothers with under school age children, for only one British woman regularly took her child to the clinic, while seven Asian women did. Seven Asian women living in nuclear households left the children at home with their husband(most of whom worked nights), for those living in extended families, the mother-in-law or sister-in-law was likely to help with child care (see Table LVII). Only two British women left the children with their husbands (one worked nights and the other man was unemployed); the other people involved in child care were the woman's mother, mother-in-law, grandmother, sister-in-law, friends and neighbours (see Table LVII).

The Asian women tend either to take their young children with them to the clinic or leave them at home with relatives. The working class women tended to live nearer their mothers than middle class women who preferred to call on friends and neighbours for help with child care.

TABLE LVII

SOURCE OF CHILD CARE FOR UNDER SCHOOL AGE CHILDREN AT TIME OF CLINIC APPOINTMENT

Initial sample N = 39	Asian	British	Total
Taken to clinic	7	1	8
Looked after by			
husband	6	2	8
mother	-	5	5
mother-in-law	5	2	7
sister-in-law	3	1	4
grandmother	-	1	1
friends	-	3	3
neighbours	-	4	4
	—	—	—
Total number of women with under school aged children	21	19	40
	—	—	—

The women with school age children found the time of the ante-natal clinic session inconvenient for collecting children from school. The sessions ran from 1345 hours to 1700 hours, and as Coventry junior schools finish between 1500 hours and 1600 hours it was almost impossible for women to meet their children:

"Last time it was, I have to collect my little boy at four o'clock and I didn't get out of there (clinic) till half four. And I was ever so worried you know, 'cos he hadn't long started and I did like to pick him up on time. And it was about ten to five when I did pick him up and he was waiting and he was the only one left and it's not very nice really."  
(Case No.12B, Parity 2, WC)

Three Asian women took a school aged child with them to the clinic to help interpret, in these instances the child took time off school to accompany his mother (all three children were boys).

The absence of facilities for children is much more likely to affect the Asian children who accompany their mothers, the British women tending to take their children only as a last resort. Another aspect of clinic organisation which affected the Asian women in particular was that of communication.

Communication in the clinic

The particular language problems the Asian women faced are dealt with in Chapter Four (pages 205-207). These problems were also recognised by two British women studied, and one made the following comment:

"They have quite a lot of Asian women down there (clinic). Well if you're sitting next to one of those, there's no point in trying to strike up a conversation, because they don't seem to speak much English do they?...I think some of them perhaps bring a husband who sits outside, but that's not really very satisfactory...You see the nurses trying to get them to understand something and it's quite obvious that they don't...But in an ante-natal clinic like that, where there's a high proportion of Asian women I would have thought it would have been well worthwhile having an interpreter there, every day even."

(Case No. 22B, Parity 1, MC)

The possession of a common language was not the sole determinant of good communication. All the English-speaking women encountered some difficulty with communication in the clinic. The main factors affecting communication were 1) the lack of privacy; ii) the lack of continuity with staff; iii) the medical hierarchy; and iv) the sexual division of labour.

- i) Several of the British women complained about the lack of privacy at the clinic. Women were examined by the doctors in an area which is separated from the next couch by a curtain. All conversations can be overheard and this acts as a deterrent to women:

"You know if you're talking to the doctor, if you ask anything, that the girl next door can hear, you know. Because the other week when I was in, some woman was in there and she must have been asking about sterilisation. And he (doctor) was talking to her about this you know. And I thought 'Well it's not very nice to be able to overhear'. It's a personal conversation she's having with the doctor you know. And you can overhear everything ....then he comes to you and smiles at you and it's 'Come on let's get on with it, let's get another one out'."

(Case No. 8B, Primipara, MC)

In the room where medical histories are taken, the shortage of space was a constant source of tension. Women were asked to discuss their social status and obstetric history in a room with other people present. For unmarried women this can be acutely embarrassing:

"I wasn't married at the time....I was a bit embarrassed 'cos there was somebody over the other end of the table, I didn't like to talk about it you know, not just to anybody, you know."

(Case No. 16B, Parity 1, WC)

Although many women complained that their conversations were overheard, it was the women who deviated from the desired medical norm of wanting to be pregnant and married, who were more intimidated by the environment. Women who wished to obtain an abortion or sterilisation found the presence of other people undermined their confidence to be more forthright with the doctor.

- ii) Some women found it difficult to communicate with unfamiliar people. Seeing a different doctor at each clinic session means that these women never acquire the confidence to ask questions:

"I've been (to the clinic) three or four times and there are always different doctors down there. And I mean if there is only one doctor down there all the time then you feel more confident and you feel like talking...but if there's different ones, you don't know whether to ask or not."

(Case No. 3A, Primipara, English speaking)

"I'd rather have kept continuing with one (doctor), you know, because then you build up a relationship with one instead of swapping over."

(Case No. 25B, Parity 1, MC)

At the women's first clinic visit six (22%) British women asked the midwives questions, and one English speaking Asian woman did. The British women were more likely to direct their questions to the doctor and ten (39%) women asked the doctor one or more questions, while only one Asian woman did. It was the multiparous British women who asked the questions. Given the lack of continuity of staff throughout the pregnancy, many primiparous women did not have enough confidence to ask questions about their pregnancy, and no information was volunteered:

"I've been given no information what-so-ever at the clinic, nothing - very unhelpful."

(Case No. 9B, Primipara, MC)

"There's no reassurance down that hospital...You're just in and out. And if they (women) were scared anyway, obviously they're not going to be the type that'll ask questions. So they go through the whole pregnancy and they don't know a thing. Nobody tells them anything - especially girls that are a bit nervous of it anyway."

(Case No. 8B, Primipara, MC)

The lack of continuity of staff also meant women were given conflicting information (a point which is discussed more fully in Chapter Nine):

"They all seem to have different opinions and they all seem to say something different every time you go."  
(Case No. 2B, Primipara, WC)

"I think I've only seen the same doctor about once. I'd like to see the same one 'cos of the fact you never know who you're getting. And it's um...you see that many and they all tell you different things and you begin to wonder 'Do they know?'"  
(Case No. 6B, Primipara, MC)

Conflicting information was most confusing for women who expected the doctors to subscribe to a uniform body of knowledge.

iii) The well defined medical hierarchy at the clinic, with the consultant at the top and the midwifery staff (and auxiliaries at the bottom,<sup>1</sup> tends to have the effect of restricting communication between the consultant and those women who are unfamiliar with speaking to professional people (that is, working class women, the majority of Asian women and some of the first time pregnant women):

"I can't really (speak to the consultant)...I daren't. I think being a consultant he's a very quiet man, he doesn't say a lot you know and I don't like to ask".  
(Case No. 2B, Primipara, WC)

Conversely, some middle class women and those who had been pregnant before would only speak to the consultant because they felt other members of staff were not qualified enough to be a reliable source of information. Women who had been pregnant before and knew who their consultant was felt slight more at ease with him:

"With Mr. Y. (consultant) I feel better you know, but with the ones you don't know, you've only seen once or twice you know, it's probably not so easy to speak to them...I sort of want to have a chat with him because as I say I haven't seen him for quite a while"  
(Case No. 23B, Parity 2, MC)

---

<sup>1</sup>The distinctions between the hospital medical hierarchy are developed in Chapter Nine.

The number of women who do ask questions at the clinic is very small (as previously stated) and often the clinic is so rushed it is not possible to speak to the consultant even if they want to.

iv) In many instances women felt it was easier to talk to the midwife as she was more readily accessible and some women preferred to speak to another woman:

"I always ask the nurse who accompanies the doctor - usually before the doctor arrives - I take advantage of that time to ask questions".

(Case No. 20B, Parity 1, MC)

"I think there's always a nurse down the hospital hovering about if you're feeling sort of lonely as you lay on the couch waiting. There's some-one there you can have a little chat to if you wanted to, probably a pupil midwife."

(Case No. 19B, Parity 1, MC)

Though the majority of women found the midwives more approachable than the male doctors, the rushed conditions in the clinic reduce the amount of personal attention each woman can receive:

"They (midwives) just walk in, take your blood pressure, say 'Fine, fine' and out again.... Some of them do (talk to you), let's be fair, I suppose it depends on how busy they are".

(Case No. 11B, Parity 4, WC)

This woman compared the midwives at the clinic with her domiciliary midwife; she found communication with the clinic midwives very difficult while she had an easy relationship with her "own" midwife. She considered it was the working conditions in the clinic which determined the nature of the social relationships and made communication so difficult.<sup>1</sup>

<sup>1</sup> Walker (1976) refers to the difference between midwives and obstetric nurses. The women's perceptions of the variation between hospital and domiciliary workers is detailed in Chapter Nine.

In addition to the restrictive conditions at the clinic, there were examples where women had been denied information when they asked:

"I was told I was reading too many books a fortnight ago when they turned the baby (breech presentation). Because I didn't know how it could be turned...I didn't know how it could be done. On asking 'Well how exactly do you do it?' I was told 'You've been reading too many books'".

(Case No. 26B, Parity 1, MC)

The doctor is the expert and the ideal patient is one who is passive and does not ask any questions. Some women found it disconcerting that the doctors would either talk amongst themselves or speak in a manner that women could not understand:

"Actually they tend to talk about you as if you're not there....They talk among themselves when you're on the bed."

(Case No. 21B, Parity 2, MC)

"I couldn't make out what he was talking about. I had to keep saying 'Pardon' and you know, asking him to repeat things and I wasn't really all that clear what he said".

(Case No. 15B, Parity 1, WC)

Difficulty in being able to understand what the doctors said was experienced by both the middle class and working class women, but the working class women reported more incidents of difficulty in understanding what was being said.

The long waits, lack of facilities for children, lack of continuity of care, and difficulty with communication, coupled with the spartan environment of the clinic, no flowers, magazines, refreshment facilities, all combined to make the pregnant woman feel de-personalised.



Depersonalisation in the clinic

The women often expressed annoyance at the arbitrary attention they received, they considered that their pregnancy, which to them was unique, was treated brusquely. This lack of attention has also been recognised in official reports (Royal College of Midwives, Preparation for Parenthood, Report, 1966):

"Perhaps it is not sufficiently realised how important it is to a woman to know if she is pregnant or not, and how she appreciates being regarded as a person, and a rather 'special' person at that". (p.71)

The assembly line conditions which predominate were remarked on by many of the British women. Conditions were such that the Coventry ante-natal clinic was commonly referred to as the "cattle market".<sup>1</sup>

"They (the clinic staff) don't treat you like a person, they don't seem to have time for you... I've come to loathe going there...I find the ante-natal clinic very impersonal. I'm hoping the baby arrives so that I don't have to go there again".  
(Case No. 19B, Parity 1, MC)

"I always feel you lose some sense of identity down there, I'm not Mrs. B. I'm number....I'm just another mother who's pregnant and this is her fifth pregnancy."  
(Case No. 11B, Parity 4, WC)

"They see so many there don't they? Oh dear, it's a proper production line there."  
(Case No. 18B, Parity 1, MC)

---

<sup>1</sup>Sheila Kitzinger (1979) in a study of maternity services in Britain uses the same language in describing this clinic.

"When you go down the hospital it's just like a cattle market, you know, you're in and out and that's it, sort of thing...Cos I don't like it down the hospital, no I think it's horrible.... you don't get a personal relationship with your doctor or anything you know."

(Case No. 8B, primipara, MC)

The humiliation of women in the clinic was only referred to directly by British women. The Asian women expressed a similar problem though they expressed it in terms of the lack of relationship between the woman and one doctor (see earlier discussion, page 411).

The lack of concern for a sustained doctor-patient relationship in the clinic setting is very indicative of the treatment of pregnancy like an assembly line with shift workers. The women are not treated as mothers-to-be, in a social sense, or given support and encouragement in their transition to motherhood. The clinic is not a place where information is disseminated, it is rather the location of routine checking and screening. While most women on the one hand feel that this screening is necessary, they are annoyed that in the process they are reduced from a person to a hospital number.<sup>1</sup> The management of pregnancy as potentially pathological overlooks the social aspects of pregnancy and in so doing tends to make women more dependent on members of medical profession and more susceptible to clinic induced illness. As one woman succinctly said of the clinic:

---

<sup>1</sup>Goffman (1971), p.28, records the de-personalisation process that takes place when inmates are admitted to total institutions and thereby lose their name.

"I've nothing to say apart from knocking down the place and starting again. There's just not enough facilities for mothers-to-be or children. The whole system needs re-organising. It's very impersonal - you're just kept waiting and it makes you annoyed. It raises your blood pressure".

(Case No. 11B, Parity 4, WC)

A further aspect of medicalised pregnancy and childbirth which erodes women's confidence in their own skills, is the increased use of high technology medicine. Although medical procedures during pregnancy may militate against the women's sense of well-being, she is unlikely to refuse these procedures because of her lack of knowledge of the techniques and her faith in whatever the doctor prescribes. There are considerable areas of tension though, as the following section illustrates - these tensions vary depending on the woman's parity, social class and ethnic background.

### 3. MEDICAL PROCEDURES DURING PREGNANCY AND CHILDBIRTH

Over the last twenty years, technological intervention in obstetrics has increased at a previously unprecedented rate. One of the most controversial changes in obstetric practice has been the rapid rise in induction of labour from 15% of deliveries in 1958, to 40% in 1974 (Huntingford, 1978, p.241). This increase in induction led to criticisms of obstetric practice from both within and outside the medical profession (Chalmers 1978; Cartwright 1977; Clayton 1974; Richards 1975; Robinson 1974; 1975; Oakley 1976). It can be argued that these criticisms have had an impact in changing, or at least questioning

the criteria used for selecting women for induction of labour; and the induction rates in some hospitals do seem to be falling. (Table XXXIX shows the fluctuation in induction rate between 1966 and 1976 for Coventry Maternity hospital).

Although induction rates appear to be declining, there has been an increase in the number of deliveries by Caesarian section, forceps and epidural anaesthetic. The Caesarian section rate almost doubled between 1958 and 1970 (Chamberlain, et al., 1975) and by 1973 it had increased even further so that 5.2% of all women having babies were delivered by this method (Department of Health and Social Security 1976). The rate for Caesarian section at Queen Charlotte's hospital has increased at a greater rate than the national level (Craft 1976). Forceps delivery has risen from 4.7% of all births in 1958 to 7.9% in 1970 (Chamberlain et al., 1975). Epidural anaesthesia also appears to be on the increase, in Queen Charlotte's Hospital in 1970, 3.7% epidurals were performed while in 1974, 58.5% of babies involved an epidural (Craft, 1976, comments on the unusually high rate of epidural anaesthesia in this particular hospital).

Table XXXX shows the outcome of delivery of the women studied, the induction rates of the samples being lower than those of the maternity hospital (Table XXXIX see also page 219). Although the initial sample size is small (78) and it is difficult to draw substantial conclusions from this, it is interesting to note that the induction rate for the Asian women was 29%, compared with

41% for the British women; Asian women tend to have more "small for dates" foetuses and lower birth weight babies. This finding is therefore of some importance. It is also consistent with the findings of Cartwright (1977) which showed that fewer social class V women were induced. The reason why social class V women and Asian women (who predominantly fall into the lower social class categories) have a lower induction rate would seem to warrant further research.

Generally speaking, the Asian women studied received less medical intervention at the time of birth than the British women.

(Table XXXX shows the different medical procedures Asian and British women were exposed to at the time of delivery.) In the initial sample 36% Asian and 68% British women received medical intervention. These figures do not include the incidence of episiotomy which was 31% for the Asian women and 34% for the British women. The Asian women tended to have a higher Caesarian section rate than the British women. This can be related to a higher incidence of pelvic disproportion in the Asian women, which may be attributed to smaller stature or variations in diet. The incidence of the use of forceps is higher in the British women which is probably related to the higher induction rate among these women. From these statistics it would appear that a much more detailed analysis of obstetric practice by country of origin of the women is needed, coupled with more research into the differential access to certain procedures.

All of the women in the final sample were asked whether they were familiar with the medical procedures carried out during pregnancy and at the time of birth. Many of the women had experienced

medical procedures such as the ultra-sonic scanner or X ray during their pregnancy: eleven (42%) Asian women and twelve (46%) British women had experienced these procedures. However, the women's knowledge of them, how they worked and what their purpose was, varied tremendously. The Asian women were particularly ill-informed, only three of them having any comprehensive knowledge of these medical procedures. (All three were well educated and English speaking). The British middle class and experienced women were the most knowledgeable. The following section thus has an under-representation of data from Asian women and an over-representation of data from British middle class or experienced women.

The use of medical procedures in pregnancy and childbirth reflects certain values which are implicit in the medical treatment of pregnancy. To fully understand what these values are, I shall look in more detail at the way medical procedures i) serve to undermine women's confidence; ii) are used without women having full knowledge of what they entail; iii) depend on a faith in medical knowledge; iv) are differentially accessible to women depending on hospital policy; v) have limitations which become acute when women a) have experience, b) subscribe to a belief of pregnancy and childbirth as "natural" or c) hold fatalistic beliefs.

i) Undermining women's confidence - medical procedures tend to undermine women's confidence during pregnancy. What the woman thinks or feels tends to be regarded as feminine intuition, which is not regarded as comparable with scientific knowledge. The use of the ultra-sonic scanner is one such example. The scanner

is claimed to determine the exact size and position of the foetus and may be used to dispute the woman's "dates", that is, her expected delivery date. When doctors challenge the woman's accuracy, the tension between knowledge derived from scientific technology and women's knowledge, becomes accentuated:

"They (doctors) were sending me for scans because he (baby) seemed small, and that's the Walsgrave. I had loads - I seemed to go every week from twenty-six weeks onwards. I should think I went eight times or so. Every time I went they said 'Come back in a week' or 'Come back in two weeks, we'll do you again'. It was just as if - I looked small so they said - they were placing me about four weeks earlier on. And I was quite sure because I'd had a pregnancy test early on and they can't do them before six weeks. So I couldn't be wrong about it."

(Case No. 10B, Parity 3, WC)

"And I've been to the Walsgrave twice for the scan test because they thought my date was wrong. They (doctors) were saying 'the baby's too low'. The first time I went they told me, they says that you're telling the dates wrong, the baby's too low".

(Case No. 11A, Parity 1, English speaking)

In both these cases the women had been correct in their "dates", the first woman's baby was born one day earlier than her expected date and the second baby was born two days after the Asian woman's forecasted date.

Epidural anaesthesia<sup>es</sup> and induction of labour also serve to undermine the pregnant woman's confidence in herself. They reinforce the view that women are unable to give birth without medical intervention. The lack of knowledge women have about how these techniques work, reinforces their dependence on the operators, that is, members of the medical profession.

ii) Lack of information - earlier, the problems women encountered with communication in the clinic setting were discussed (see pages 410-412). One result of poor communication, is a lack of knowledge about procedures. Thus women may agree to procedures in the belief they are for their own good and that of the baby, yet they have little knowledge of what the procedures entail.

The Asian women were less well-informed than the British women. Their lack of English prevented some of them finding out about technological interventions in pregnancy; and also, having originated from a country where it is not practised in the rural areas, they were less familiar with high technology medicine. Asian women were often very compliant, even those who could speak English and did not ask the staff about the procedures:

"The doctor just told me 'Your baby's low - we want to see if your date's right or not'...They didn't tell me anything (about the scan), they just said 'We're going to see if the baby's in the right place or not'. They didn't tell me nothing about how it worked".

(Case No. 11A, Parity 1, English speaking)

"When the small one was born they had tied this machine (foetal monitor) on me and I was conscious at that time...They had used that machine, I don't know what they were checking, maybe for the breathing of the child".

(Case No. 14A, Parity 4, non-English speaking)

Many of the British women would have welcomed detailed information about the procedures carried out, but they often did not feel in a position to ask what was happening and thus complied with what they were told to do:



"I'd like some explanation for everything they're doing to you, you know. Like what these oestriols are - I've been having them - these bottles to test this hormone or whatever it is...nobody's ever explained to me what it is".

(Case No. 18B, Parity 1, MC)

"I didn't know what was going to go on. I only went in for blood pressure like and a few days later they said that they were going to induce me like, you know. It's very worrying really 'cos nobody explained".

(Case No. 12B, Parity 2, WC)

Some of the women learnt about the medical procedures after they had been performed, either from friends, books or television.

In some cases the women were amazed they had succumbed to such treatment, particularly when they realised that it was not entirely straight forward:

"It was by no means painless (giving birth with epidural analgesia). Oh crikey I can assure you! And...I thought at the time in ignorance, I thought it was a bit stupid that only a doctor or a Sister could top you up. Which I couldn't understand then, but I've since learnt that it's quite a delicate thing. I must confess it was only after I really realised - in fact I was watching a television programme - that I really realised what the epidural really was. And I saw it and thought 'crikey' to think I had that...Several of my friends were amazed, and they said 'Oh I'd never let anyone tamper with my spine, kind of thing."

(Case No. 25B, Parity 1, MC)

"The nurses told me, they said that you won't feel anything in your legs (if you have an epidural). So you'll know what we're doing, but you won't feel it...They told me afterwards it didn't go right. It was all wrong anyway. No wonder I had all those pains you know... They didn't tell me anything at all, at night they says we'll tell you in the morning".

(Case No. 11A, Parity 1, English-speaking)

These women submitted to medical procedures without knowing the medical reason for the procedure, the techniques of the procedure

itself or any possible side effects. Other women who asked about medical procedures were often silenced by a response in medical terminology which they could not understand:

"I had something done and I can't remember what it was now. He (consultant) said, you see he was using these big words, I don't understand them".  
(Case No. 13B, Parity 2, WC)

"Oh I don't know what it was for (given injections at the clinic). He (doctor) said something, but I couldn't understand what it was".  
(Case No. 3B, Primipara, WC)

Often in these cases the medical personnel think they have provided a satisfactory answer without realising that the woman is not familiar with the terminology:

"I asked her (Sister) if she thought I would have the baby any earlier. She read my notes and said that you can tell by the height of the fungus, is it?  
(Case No. 16B, Parity 1, WC)

Some of the more articulate women were not content with medical terminology they did not understand and would keep on asking what words meant until they received an answer they could comprehend:

"If they find anything at all in the urine, one nurse will ask another...this time they said something about albumen content. So I said 'What does that mean?' .. At which point the one nurse said 'Nothing to worry about, everything is perfectly alright'. And I thought 'Well I'll be damned if I settle for that'. So when I got to the next stage, I said 'Well what exactly does this mean?' and they went on about kidney infections... the doctor then explained that you could have symptomless, urinary infections and not know about them....It meant asking and asking."  
(Case No. 26B, Parity 1, MC)

It was not only the terminology used by medical personnel which mystified the women, but also hieroglyphics or signs that were

were written on their record cards. The British middle class women expressed particular concern about not being able to decipher these markings:

"This is what I think they ought to explain - what FH or HB mean. What that is. What does FMF mean?  
(Case No. 19B, Parity 1, MC)

"Like this time Mr. X (consultant) had put a little thirty-seven with an arrow going down. And I thought 'Now what does that mean?' 'Cos I was in at thirty-seven weeks with Carol.<sup>1</sup> Now I didn't look at that card (Co-operation card<sup>1</sup>) till I got home, and er... I sat there thinking 'Is that because he's going to have me in?'"  
(Case No. 25B, Parity 1, MC)

These women were annoyed that the card they carried around with them was unintelligible to them. However, this did not deter some women from finding out the meaning of the signs on the card:

"I think that what they should do with that Co-op card is explain. I made a point of finding out about the blood pressure, how exactly it works, how they take it etc. What is high, what is low, what is normal? But I had to find out from my own experience, through nursing and people that I knew....I made a point of finding out myself. You've got to be hungry for information to find out anything. And you don't always ask the doctor there, you ask around, people that you know."  
(Case No.20B, Parity 1, MC)

This last woman assumes everyone has friends who are associated with the medical profession and can therefore understand the procedures sufficiently well enough to be able to explain them. Not all women are so fortunate, and it was only the middle class British

---

<sup>1</sup>Co-operation card is the record card that the woman takes with her to the ante-natal clinic and GP, it is used more as a record of weight and blood pressure than a source of information to the woman of her well-being.

women who had friends who were medically trained and the Asian woman married to a doctor:

"I had to ask the radiologist how the baby was doing inside and she said 'Fine, it's growing and you can see the head'. But you have to ask them. If you sit like that quietly they won't tell you".

Found out about the oestriol tests?

"From here (hospital) Mr. Y (consultant) he told me, I asked him. And from Dr. S (Registrar)....I asked my husband as well".

(Case No. 10A, Parity 3, married to doctor)

The purpose of taking the scan was not explained to one woman, so she:

"asked Violet, she was the hostess in the maternity, if she knew what a scan was, what it meant. The second time I want the woman who did it was a friend of my mother-in-law's, because my mother-in-law works in the hospital as well. She said to me that we get the general size of the baby and this sort of thing. But then again you have to make the effort to ask". (Emphasis in original)

(Case No. 19B, Parity 1, MC)

For those women who did not have friends who were medically qualified, their information often came from their own experience, from television, or from friends who had recently given birth. In these instances, the women did not always understand the medical technique, but they were at least familiar with its effects. In the following example a woman found out about pain relief in labour by asking other newly delivered women what they had been given:

"This is talking to patients afterwards about what they've had, or what they didn't have....And it's only listening to other patients afterwards that you realize...you've got to be able to know about it to be able to ask. When I went in with him (previous child) I asked for pethedine. I hadn't got a clue what pethedine was, but I asked."

(Case No. 11B, Parity 4, WC)

Whatever the source of the information about medical procedures, it is perfectly clear that this information is not volunteered "you have to ask". Women who were not intimidated by the hospital environment or the medical staff were able to find out certain information through enquiry and then pass this on to other women who did not feel so confident asking questions:

"The lack of information at the ultra-sonic unit is even worse than the ante-natal clinic....Nobody explained a damn thing, so I said to one of the women 'Where do I go?'....And the second time of course I knew exactly where to go and did everything and provided a lot of information for the other women who didn't know where to go.....And when you do go in (to have scan), again, total lack of information. The first time I went I took my daughter with me and I'd read an article, so I knew what was going to happen. So I put here where she could see what was going to happen and I asked a lot of questions. But when you sit in the waiting room, you can hear over the tannoy system, everything that's going on in the room. And I've been struck by the fact that virtually no information is handed out. Also by the fact that so few women ask".

(Case No. 26B, Parity 1, MC)

In this instance it is hardly surprising that "so few women ask " questions, for everything they say can be overheard by the other women in the waiting room. There are therefore the same constraints at the ultra-sonic unit as there were at the ante-natal clinic, when women said that they did not ask questions because of the lack of privacy. The women are caught in a double-bind situation, those who do not ask questions remain ignorant of the medical procedure, while those women who do demand information, do so at the risk of being given a curt reply from the medical staff (see page 414).

A possible explanation for some of the medical staff's reluctance to provide information to women is that the knowledge may cause anxiety in the woman. Some medical personnel claimed that it was in the woman's interest, not to know the full details, and to leave the worrying to the doctor. This advice is clearly expressed in the clinic leaflet (see further discussion, pages 504-512 ):

"You are going to have to answer a lot of questions and be the subject of a lot of examinations. Never worry your head about any of these. They are necessary, they are in the interests of your baby and yourself, and none of them will ever hurt you".

(You and Your Baby, p.12)

For some women the withholding of information may serve this purpose; their faith in the doctor's judgement being sufficient for them not to question further. One woman wanted to know why her blood pressure was being taken every half hour when she was in labour with her first child. She was concerned something may be wrong because she had "deep thrombosis", and she continually questioned the staff as to what was wrong:

"But they wouldn't tell me, in case yer get, you know, well when you're in labour you see, you're in a very bad way like, and if they tell you anything then it may make you worse like."

(Case No. 15B, Parity 1, WC)

On the one hand this abstract shows the concern of the medical staff not to raise anxieties in the labouring woman. Knowledge was withheld from her "for her own good". On the other hand, the idea that women in labour are emotionally unstable, is implicit in this protectionist attitude. This belief legitimates medical personnel making decisions on behalf of women.

At the same time, women in labour do not feel particularly confident in challenging what is being done to them:

"You get to the stage where you don't argue, you let them just carry on and you let them just push you around and you don't argue. You don't give a damn what's happening any more. They just came up and said 'We're going to give you pethedine, turn over".  
(Case No. 18B, Parity 1, MC)

Another affect of withholding information from some women is that they still continue to worry, their fears are not allayed. This was the case with one woman (Case No.11B) who was worried because she had been exposed to X rays during pregnancy (see page 303). This woman's previous experience of giving birth to a slightly retarded child, coupled with the knowledge gained throughout her previous pregnancies, made her more demanding of the services and also made her more sceptical of the consultant's expertise. After all, it was the woman who was going to bear the consequences of his action, or inaction. Although several other women questioned the doctors' decisions and also the effectiveness of high technology medicine (see pages 437-440 ), most of the first time pregnant women put themselves completely in the hands of the doctors, on the grounds of the doctors' superior knowledge.

iii) Faith in medical knowledge

a) "They must know". Primiparous women almost universally held the belief that "doctors know best". They put their faith in the doctors and high technology medicine hoping this would ensure a successful outcome to their pregnancy. The lack of knowledge some

women had of the medical procedures (particularly those used at the time of birth) heightened their dependency on the doctor.

They thus said:

"It's all right (whatever they do) - the doctors know best".

(Case No. 9A, primipara, non-English speaking)

"I think you should just leave it to them (hospital staff) you know, when you're in hospital. I think they just give you drugs as they think necessary. I think that you just put yourself completely in their hands. I think that if it's your first I don't see how you can judge really, perhaps if it's your second you can say 'Oh I don't want anything at all. I want a completely natural birth.' But you can't say that with your first, because you don't know what's going to happen."

(Case No. 8B, Primipara, MC)

"They (hospital staff) said 'If you have it (epidural), it will be good for you'. So I said 'All right, if you say I won't feel any pain, so better than that I will have it.'"

(Case No. 11A, Parity 1, recounting her experiences in her first pregnancy - English speaking)

These women unquestioningly accepted what medical personnel said in the belief that nothing would be prescribed if it in any way affected the baby.

"Well I don't really know what the pethedine<sup>1</sup> is. I've heard of it...it's a relaxation thing. Well if it doesn't hurt the baby, which obviously it doesn't else they wouldn't give it to you."

(Case No. 6B, Primipara, MC)

First-time pregnant women who would like a "natural" birth said they would agree to medical intervention at the time of birth if medically advised, either for their safety or to reduce pain:

---

<sup>1</sup>Pethedine is a narcotic which Richards argues can have a serious depressant effect on foetal respiration and may reduce the sucking response in the baby. (Richards, 1977).



"I wouldn't like that (epidural), I would like a natural birth, if it's not so painful, but if it is, I won't mind anything".

(Case No. 3A, Primipara, English speaking)

"My doctor said that if I have any trouble with my fits during pregnancy, then I might have to have one (epidural)....I don't think I'd like it, it paralyses you from the waist down and you don't feel anything - no, I don't like that. I would prefer for a natural birth, but if the doctor said I had to have it, then I would".

(Case No. 3B, Primipara, WC, previously suffered from epileptic fits)

Although it was predominantly the first-time pregnant women who said they respected the advice of the doctor, multiparous working-class woman were also prepared to do as the doctor (or consultant) said, because of his expertise:

"I would prefer to go into labour naturally (rather than be induced), but I would take the advice of the consultant." (Case No. 10B, Parity 3, WC)

"Well I don't really ask him (doctor) anything really. I just let him get on with his job, and that's it really. As long as everything is all right according to him".

(Case No. 17B, Parity 1, WC)

An Asian woman in her fifth pregnancy did not know what was happening when the ultra-sonic scanner was used. She did not question the procedure for she felt sure that "they must know":

"They (staff at ultra-sound unit) put lots of grease on my stomach. They had given me their own clothes. There was a big machine and then like a picture on television. I couldn't understand it, but they must know".

(Case No. 14A, Parity 4, non-English speaking)

Another factor which is important in contributing to the women's faith in the medical profession and high technology medicine, is that all decisions are made "for the sake of the baby". This is clearly stated in the clinic leaflet:

"You owe it to your baby to give him or her the best possible start in life." (p.26)

And this means "ask your doctor" (p.26)

b) "For the sake of the baby" - Women continually expressed the response that they would agree to medical procedures if it was "for the sake of the baby". British women more often expressed this view than Asian women, though this is not to say Asian women did not care about their forthcoming child. They did very much so; but they were less likely to understand the procedures or need to be convinced of their efficacy - they were more prepared to comply with whatever was prescribed. Whereas, British women were more sceptical of medical procedures, and the doctors used the argument "for the sake of the baby" to convince them of the necessity of these procedures. None of the women felt confident enough to argue against procedures which they had been told were essential for the well-being of the baby.

"They've told me they might induce me if this baby is in danger....If the oestriol level goes very low, or the baby's heart beat alters, they will induce me".

(Case No. 10A, Parity 3, speaking while in hospital for high blood pressure and weight loss)

"I know there's a lot of talk about this nine to five inductions for the doctor's convenience, but I suppose when you're ten days overdue it's a different matter. I don't think I would let them take me in early without a very good reason. If I had high blood pressure and there were other serious complications where the baby was at risk, and they said 'We feel we ought to take you in at thirty-nine weeks and deliver for the baby's sake', - then that's fine, not just for their convenience."

(Case No. 21B, Parity 2, MC)

First-time pregnant women who were less confident in asking about the necessity of certain procedures, expressed the view that they did not mind what techniques were used, as long as the baby was all right:

"I don't mind (having an induction), I'd rather have it over with now really. And I think that the blood pressure as well, I think it's better off that way, for the baby's sake".

(Case No. 2B, Primipara, WC)

"I'm not bothered (about having a Caesarian section), as long as the baby's all right. I would have liked a natural birth you know, with it being the first you know, because it's all an experience. But well, if it's got to be done, it's got to be done and that's it."

(Case No. 8B, Primipara, MC)

These women were confident that the medical procedures were necessary for the safe delivery of their baby. They were prepared to forego their own desire for a "natural" birth, if the doctor recommended intervention. Women who had experienced some of these techniques in previous deliveries and found them not to be fully effective had considerably less faith in high technology medicine (as will be discussed later).

To date the discussion has tended to assume that the medical procedures cited were universally available to all women and that they were only prescribed if necessary. However, there is evidence to suggest that access to procedures was not equal, nor was there a universal hospital policy about who should be entitled to certain procedures.

iv) Access to medical procedures - Earlier (pages 418-420) the difference between the amount of medical intervention Asian and British women received was mentioned.

Women who knew of the existence of certain procedures were in a position to ask for them, while others were led to believe they had to have them. An example of this latter point is the epidural anaesthetic, which some women felt they had to have because it was the "modern method" of delivery. This confusion was caused by the distribution of leaflets on epidural analgesia at the ante-natal clinic:

"The way I read it, it looked as though you had to have one. I thought this must be the way they do it these days, this must be the modern method".

(Case No. 16B, Parity 1, WC)

"I heard a woman talking about the one (leaflet) on epidurals and she said 'Do I have to have it?' and I thought well, if she can get mistaken about it... This woman thought she's got to have it, she thought everybody was having it, but the midwife explained that she wouldn't have to have it."

(Case No. 19B, Parity 1, MC)

Other women who would have liked an epidural were told it really depended on the hospital staff and the time of day they went into labour:

"She (midwife at the Parentcraft class) says it's up to them. You can have one (epidural) as long as it's in the weekdays and office hours. 'Cos they're not open afterwards unless there's special cases."

(Case No. 7B, Primipara, WC)

"They've (midwives) told us they're not doing them till after the holidays (summer)."

(Case No. 4B, Primipara, WC)

The question of choice in obtaining or refusing medical intervention in pregnancy seemed to be an arbitrary one, depending on the availability of staff and routine of the hospital. Women with previous experience of hospital delivery frequently referred to the management of labour being out of their control.

The multiparous middle class British women considered they had either, been unable to gain access to drugs they wanted in labour, or experienced difficulty refusing treatment while in hospital. They encountered hospital routines which prevented access to drugs, or universally advocated a certain type of delivery.

"I asked the Staff nurse, I think, for an injection (pain killer) and she said 'Oh we can't give them up here. You have to be down in the labour ward before you get those.' I said 'Well can't you send me down there?' and she said 'we can't send anyone down there before twelve o'clock'. Well by twelve o'clock I was feeling quite desperate...It was just as if they had to hang on to twelve o'clock, they didn't want anybody down there before twelve o'clock. Now to me that's all wrong, we were there for their convenience if that's the case."

(Case No. 21B, Parity 2, MC)

"When I went in for my first pregnancy there were three of us waiting to be induced, and the other women were waiting to have their second child...And he (doctor) came along and asked us individually if we wanted an epidural the following morning. And I was quite adamant and said 'No'. And the other two ladies having their second babies were quite adamant in that they said 'Yes'. And I began to worry a little bit then because he (doctor) turned round to me and he said - I don't know whether he was joking or, I suppose he was joking, he said - 'Aren't we the brave one then?' Which completely demoralised me in a way because I thought 'What am I in for now, you know?'"

(Case No. 19B, Parity 1, MC)

In other instances, it was not the hospital routine that guided whether or not certain procedures were available, but the whim of the woman's consultant.<sup>1</sup>

"I think it depends on the doctor as well. My last consultant, he didn't believe in giving pain killers while you were in labour."

(Case No. 11A, Parity 3, married to doctor)

Although women considered they lacked control in deciding when and if, certain techniques should be used, there was no doubt in the minds of some British women<sup>2</sup> that they did not want high technology medicine available to them during pregnancy and childbirth. They felt all women should be entitled to make use of certain procedures and resented the fact that all women were not given equal access to certain medical procedures.

"They only usually send you for a scan if they think anything's wrong or if they think you might be having twins. But it's something that they can find out at an early stage if there's something wrong - but I've never been for anything like this. I didn't have a blood test till I was six and a half months. By the time I was six and a half months I was getting quite worried 'cos I hadn't had anything done at all....I think I was a bit late having a blood test and I think it would be a good idea for everybody to have a scan."

(Case No. 9B, Primipara, MC)

"I asked for one (negative of scan) and she (radiologist) said she wouldn't give me one. She says 'We're not doing this for you to take home, it's for our information'. Right ratty she was...My friends had been given one, that's why I asked."

(Case No. 23B, Parity 2, MC)

---

<sup>1</sup>Women who had given birth either in another hospital or in the GP Unit, found considerable variations in practice based on the policies of different doctors.

<sup>2</sup>The Asian women were not sufficiently well informed about these procedures to argue for their use.

"I think that the test that Princess Anne has had (amniocentesis) every woman (and women over forty) should have that test if she wants it...It's unfair to bring a deformed child, mongol or whatever it is, into the world. That's why I think every woman should be given that test...all they have to do is tell you whether that child is normal or not."

(Case No. 11B, Parity 4, WC)

Although these more experienced women wanted equal access to high technology, diagnostic procedures in pregnancy, they seemed wary of arguing for medical intervention in childbirth.

v) The limitations of medical intervention. a) Women with

experience. As argued earlier, lack of knowledge of medical procedures, how they work and their side effects, can lead to an overdependence on the doctor. On the other hand, women who have some knowledge of high technology medicine (gained either through their own experience, or that of others, or read about in current literature) tend to be more sceptical of these procedures.

Several of the British women and one Asian woman had experienced instances when the medical procedure was not fully effective.

In these instances, the woman (or her husband) was often unduly worried that something was wrong with the baby, rather than being prepared for equipment failure:

"You've probably been told before - the machine they monitored my contractions (and they put electrodes on Karen's head to monitor her) - and the machine monitoring Karen did pack up. And I was unaware of this, but my husband wasn't. And he panicked thinking, you know...Well I've since heard - we thought it had just happened to us, you know, that this machine monitoring Karen's heartbeat had packed up - but I've since heard other women say 'No, It's just sort of...well it must be temperamental or something, it's just stopped.'"

(Case No. 19B, Parity 1, MC)

The procedure most commonly quoted as liable to fail, or not be completely successful, was the epidural analgesic . One group of experienced women had unsuccessful epidurals themselves (see page 423), . while another group had heard from friends about women with unpleasant experiences caused by incorrect administration of the epidural. Instances of knowing some-one who had suffered from the side effects of medical intervention in childbirth, were widespread among the British women. This knowledge derived from hearsay, constituted an important informal source of information:

"I've heard lately of somebody who it's affected (the epidural) paralysed. It's put me off completely....she had her baby three or four months ago and she still can't stand up now without being dizzy. And anyway, before that I'd never really fancied it, because I think there's so much er...they've got to get it in just the right place. And there's only so many can do it, you've got to be really experienced. I think I'd rather suffer."

(Case No. 23B, Parity 2, MC)

"They inject you, yeah, I have heard that it can sort of paralyse you for a few days, doesn't it? It's only what friends or people have told me. I know one or two said they wouldn't advise it because as I say it does sort of numb you, so you don't know when to push and all that."

(Case No. 6B, Primipara, MC)

Other procedures which were not considered as effective as the women imagined them to be, were induction of labour and the pain-killing drugs administered in labour. Women were unprepared for the side-effects of pethedine or annoyed when the gas and air machine was empty or difficult to operate.



"I had two drips (when induced)....I thought 'Gosh this is going to be a real kind of speedy job. I think it surprised them actually, but I suppose there again the baby just wasn't ready."

(Case No. 2B, Parity 1, MC)

"She (midwife) gave me a lot of injections. I didn't know what was going on. I thought I was drunk and everything..."

(Case No. 15B, Parity 1, WC)

"I did ask for it (gas and air), but they'd got to change the bottle or something, it had run out. And by the time they'd done that it was too late!"

(Case No. 17B, Parity 1, WC)

Most of the information about inductions and epidurals (gained either from the woman's own experience, or from hearsay), served to deter women from these medical procedures. The main source of information about these procedures for the British women was gained through watching television (see Table LVIII). The Asian women were generally much less knowledgeable about these procedures and only the three English-speaking Asian women fully understood what these procedures involved. They gained their information from 1) their own experience; 2) attending Parentcraft classes; 3) watching the television programme on these subjects, and 4) from talking to husband who was a doctor (one woman mentioned two sources of information).

TABLE  
LVIII

SOURCE OF INFORMATION ABOUT INDUCTION AND EPIDURAL,  
BRITISH SAMPLE ONLY N = 26

	No.	%
Own experience	6	21
Friends	5	17
Television	7	24
Parentcraft classes	4	14
Books	5	17
Doctor	2	7
	<u>29<sup>1</sup></u>	<u>100</u>
No information	6	23

<sup>1</sup>Nine women quoted more than one source of information.

Knowledge of these procedures gave women confidence to say they would refuse them. This was most prominent with epidurals, as the women were most likely to be consulted about whether or not they wanted one:

"I wouldn't have an epidural - they drill a hole in your back. I would refuse it."

(Case No. 16B, Parity 1, WC)

"Well I decided right from the very beginning that I wasn't going to have it (epidural) you know."

(Case No. 9B, Primipara, MC)

The effectiveness of the epidural analgesic was also questioned by the woman's GP, who in two instances played an active role in discouraging women asking for one:

"They (midwives) said that it doesn't always work and that sometimes they (women) have chronic backache and that, which is worse than going through the actual thing. It's as if your back's breaking in half. And I did ask the doctor this you know, if it was true, like, and he says 'Oh well, nothing works one hundred per cent.'"

(Case No. 10B, Parity 3, WC)

"He's (GP) not in favour really of them (epidurals)... He said for the risk there is attached to it it's not really worth it. He's of the opinion that in childbirth, the most natural way, without any aid if possible, is the best way."

(Case No. 18B, Parity 1, MC)

These two doctors reflected a distrust of high technology medicine and the second doctor expressed a belief in "natural" childbirth, a concept some women also adhered to.

b) Pregnancy and childbirth as "natural" - Earlier reference was made to the attitude held by some GPs towards prescribing drugs for discomforts in pregnancy (see pages 363-371). The same GPs who were against prescribing drugs during pregnancy were those who

considered childbirth should be a "natural" event. The different frame of reference of GPs and hospital doctors will be developed more fully later (Chapter Nine), but it is evident that GPs place more emphasis on the normal, or natural, in pregnancy and childbirth.

Although the women studied agreed to technological intervention in pregnancy as a diagnostic aid, they also expressed the desire to have a "natural" birth, that is, one located in the hospital without medical intervention. Eight (31%) Asian women and seventeen (65%) British women expressed such a desire. This ideal is held by primiparous women and those who have given birth before, and is most marked among the educated women:

"I think it's better to go naturally you know. Instead of they starting you off."

(Case No. 11A, Parity 1, English speaking)

"Well I've heard so many people saying about this (epidural) that they've had it and had to have a Caesarian and it's never natural birth really. They seem always to use forceps or they end up having to give a Caesarian. Well, I think if they freeze the bottom half of your body, how can you use it to bring the baby you know? You can't, and the baby's got to do all the work."

(Case No. 8B, Primipara, MC)

"I saw the programme on induction on television.... you know, you come in the morning and you will have a baby in the evening. But I don't believe in induction and things, they're not natural."

(Case No. 10A, Parity 3, English speaking)

Women who advocated "natural" birth most strongly were those

who had experienced a previous birth involving medical intervention,<sup>1</sup> these women considered they had in some way been deprived of the kind of birth they wanted. Also, they argued that medical intervention at the time of birth affected the quality of the mother child relationship.

"This is the only thing about having a Caesarian, you don't get any maternal instinct. Some-one comes and gives you this screaming bundle and says 'This is yours'. 'Oh thanks. Are you sure?'"  
(Case No. 19B, Parity 1, MC)

Another view expressed is that a woman who has medical intervention in her delivery, has not really given birth. She has not brought the baby into the world by her own effort but has been robbed of the experience by medical personnel and high technology medicine.<sup>2</sup> One woman was extremely upset by the comments of some men, who suggested because she had an epidural anaesthetic in her previous delivery, she had not really given birth. (Other men's comments about childbirth are detailed in Chapter Ten):

"I'd much rather thave a natural birth. I mean, it annoys me intensely actually, men who say to me 'Well, of course you don't really know what it's like to have a baby'. Not that it's because of that reason I want to, but I mean, I didn't want to have it (the epidural) I'd much rather have had it the nature's way". (Emphasis in original)  
(Case No. 25B, Parity 1, MC)

This woman recognised the double-bind situation she was in, she did not want the epidural anaesthetic, the decision was made for her by the doctor. After having the epidural she was accused of not

---

<sup>1</sup>Cartwright (1977) argues a similar point in relation to induction. She says "Only 17% of themothers who had an induction said they would prefer to be induced if they had another baby."

<sup>2</sup>See Shaw (1974) Forced Labour; Haire (1972) The Cultural Warping of Childbirth.

experiencing a "real" birth. Women are thus bound up in the contradiction between fulfilling the "most essentially female function of all" (Callaway, 1978) and being in a hospital where their potentially pathological condition is medically monitored and controlled. Knowledge of pregnancy and childbirth as something other than a pathological event tended to make women more sceptical of medical intervention. Another factor which militates against the pathological definition of pregnancy is limitation of medical knowledge in certain areas and a consequent resort to fatalistic beliefs.

c) Fatalistic beliefs - Although the clinical model of medicine purports to diagnose and cure, there are areas where medical knowledge is incomplete. One such area is miscarriage in pregnancy. Women who had experienced a miscarriage asked their GP why this had happened, but none of them obtained a "scientific" reason for the cause of the miscarriage.<sup>1</sup> In fact, the GPs resorted to a naturalistic explanation, which the women interpreted as them not knowing the cause:

"The doctor said he didn't know what caused it."

(Case No. 7A, Primipara, Sikh)

"He (doctor) just said 'These things happen, probably it (foetus) wasn't formed properly and it was nature's way of getting rid of it'. The doctor did say 'Oh this happens in a lot of first pregnancies, you know, and there's no reason why it should happen again sort of thing...'"

(Case No. 24B, Parity 1, MC)

---

<sup>1</sup>The middle class British women's attitude towards miscarriage was discussed earlier ( page 296 ) in the context of the women not wanting to save the foetus.

"My own GP just said that he thought that it (foetus) was probably malforming in some way and it was probably nature's way of getting rid of it....He just said 'Well it was probably a blighted egg, and you know, it's best to have got over it and forgotten about it'."

(Case No. 19B, Parity 1, MC)

"No. As he (GP) said nine times out of ten when this does happen there doesn't seem to be any apparent reason why I should have miscarried. It was just nature, nature saying 'I haven't done a perfect job.'"

(Case No. 25B, Parity 1, MC)

These examples indicate that there are some areas over which GPs do not feel they have control. Freidson (1970) argues that to compensate for areas where medical knowledge is deficient, doctors are trained to cope with "uncertainty" (p.169).

The GPs in this instance subscribed to a belief that Nature determines. Similarly, women of different social class and ethnic background expressed a fatalistic belief in "whatever will be, will be" and the outcome of pregnancy will be determined by Nature (or in the case of Muslim women, God). These fatalistic beliefs are still adhered to because medical knowledge and scientific application cannot control all aspects of health and illness, nor provide a supportive framework for areas of uncertainty. Two medical procedures were mentioned as being pointless because they contravened Nature (or fate) - they were the induction of labour and "turning" a breech presentation foetus.

"And whenever the baby has to be born, it will be born."

(Case No. 19A, Parity 5, Muslim)

"I'm not really worried about it being breech. I'm not very keen on the fact that if it should go back the other way that they'll keep turning it. I suppose I think that if it's meant to be breech, it'll be breech."

(Case No. 22B, Parity 1, MC)

"I pray to God the baby will be born as always".

(Case No. 20A, Parity 3, Muslim)

Even though the women subscribed to fatalistic beliefs which provided support during their transition to motherhood, these beliefs were not strong enough to supersede the realities of the delivery room and their concern to "get it over with" and return home:

"To be honest, you get to the stage where you don't care if they induce you, because you just want to get it over and done with. It's been hanging on and hanging on for so long...This is why a lot of people don't complain about inductions, because you think 'Just get it over with..I just want to have a baby and get home."

(Case No. 19B, Parity 1, MC)

"They've got the people so brainwashed on that M1 (consultant ward) that the girls are almost crying to the doctors to be induced. They can't wait for the baby to be born, they know that the doctors' have the power to start them off."

(Case No. 18B, Parity 1, MC)

#### SUMMARY

The data suggests that women find it difficult to resist the dominant concept of pregnancy as potentially pathological, involving hospital based ante-natal care, high technology medical

intervention, and the hospitalisation of birth. These procedures are extraordinarily pervasive, but many women do have independent ideas about pregnancy and childbirth as natural, social events rather than pathological crises. Consciousness of an alternative to the clinic model is weakly articulated by the women as a whole, but educated and experienced women were most likely to be critical of their treatment. Significantly, the Asian women for a number of reasons were most dependent on the hospital service.

Moreover, while clinical medicine attempts to be scientific, medical practice is an art which varies according to the practitioner. Some medical practice may be infused with lay knowledge (which is derived from experience) and may be more tangible to lay people than "scientific" medicine which tends to be elitist and removed from everyday experience.



CHAPTER NINE

EXPERIENCE vs EXPERTISE

EXPERIENCE - The division of labour among the experts

Introduction

In the previous Chapters a basic dichotomy emerged between the experience of the pregnant woman and the expertise of the medical personnel. "Experience" in this context is taken to be the knowledge acquired about the social and physiological conditions of pregnancy by living through the transition to motherhood rather than from formal learning. A woman who has gained experience through having been pregnant before will tend to have different expectations when she is pregnant again, while the first time pregnant woman may gain experience as she proceeds towards motherhood. The women's experience, their knowledge of what it is like to be pregnant, is contrasted with the expertise of the medical personnel. By "expertise" is meant the possession of specialist knowledge within the allopathic medical tradition which has been acquired through formal education and verified by examination. Having expertise does not imply an understanding of pregnancy in anything other than clinical terms.

The woman's experience is based on subjective knowledge of her body and what it feels like to be pregnant and treated by experts. On the other hand, medical expertise is gained through the acquisition of objective knowledge which is grounded in specific theories of the physiology of reproduction and of disease aetiology. There is often a tension between the woman's intimate knowledge of her body and the knowledge doctors possess about what is "supposed to be". This is clearly expressed in disagreements about the woman's expected date of delivery:

"I think it's the way I carry them, I carry them very low...I stop low down and I think this tends to confuse (the doctors). I mean, I said February with him (fourth child), one doctor said March, another said April. He was born in February, so I was right....I think women know more about her pregnancy and her body than the doctors - especially if she's been through it before".

(Case No. 11B, Parity 4 WC)

This woman knew how she carried her babies which the doctors at the clinic did not for they had not seen her in previous pregnancies. Nor was she examined by the same doctors at the clinic throughout this pregnancy. Women who have not been pregnant before, but are familiar with their previously regular menstrual cycle, begin to doubt the doctor's expertise (or experience) if they are challenged about the accuracy of the date of their last menstrual period:

"He said this to me, that I was very small for my dates and was I sure I'd got my dates right. But this seemed to me a doctor who hadn't got enough experience".

(Case No. 9B, Primipara MC)

The tension between the male doctor and female patient over the expected date of delivery is echoed elsewhere in the literature (see Oakley and Graham, 1977) and there appears to be a recurrent theme in which women's accuracy in these matters is questioned.<sup>1</sup>

The dichotomy as outlined so far between experience and expertise is considerably over-simplified. For instance, the actual experience of being pregnant and giving birth (an educative experience in itself) is not the only means by which women learn how to become a mother. Other ways in which knowledge is gained include: i) personal observation, either by being with a friend or relative when she was pregnant, and/or ii) by engaging in certain pursuits, e.g.

---

<sup>1</sup>In the Oakley and Graham paper (1977) there is a reference to an incident when the doctor questions the woman's dates. She confirms that she is sure of her dates and even knows the date of conception. The doctor laughs at this in a manner which suggests that he is sceptical, whereupon the woman proceeds to inform him that it is an artificial insemination baby.

reading, watching television programmes, attending Parentcraft classes, or by seeking knowledge from friends and/or relatives who either have experience or expertise. It is therefore possible for women to build up a body of knowledge about pregnancy and childbirth, without directly experiencing it. A first time pregnant woman may know in theory what changes will take place in her body, but in practice, the reality may be different from her expectations:

"At the clinic they says 'Are you having a lot of movement?' Well, if it's your first, how do you know? You expect to have some movement, but you don't know if it's a lot do you?"  
(Case No. 8B, Primipara MC)

This woman knew she would feel the baby move and she expected this to happen in the fourth month of pregnancy, what she did not know was what constituted a lot of movement. She did not have experience to provide a yardstick to measure the amount of movement.

Access to knowledge about pregnancy and childbirth which is not gained by direct experience often depends upon the woman's resources and can be closely related to her class position and ethnic background. Of the first time pregnant woman, it was the middle class, educated woman who had the most knowledge about pregnancy and childbirth in western scientific terms. These were the women who had greater access to books (and were more likely to be able to read), were more likely to have a television, attended the Parentcraft classes and had friends or relatives who were members of the medical profession.

The women who gain knowledge from the experiences of other women, particularly older women such as their mother or mother-in-law, tend to refer to a body of knowledge which is traditional, based on years of experience. This knowledge often conflicts with that held by members of the medical profession who claim that for something to be valid it must be scientifically proven. The experts subscribe to

knowledge which is scientific<sup>1</sup>, whilst the women may be familiar with this approach but more sceptical of it because of their closer contact with older experienced women at home. There are two things that need stating here: i) those women who have been educated in the western scientific tradition are more likely to understand the principles involved and may be more sceptical of some of the practices (the use of high technology medical procedures in labour is a good example of this). Those women who have not been brought up in the western scientific model, that is, the majority of the Asian women, are more likely to be unquestioning of the experts and their procedures because they do not understand why they are done. ii) Knowledge of western scientific medicine is acquired in the public sphere, at school, college or university. Traditional knowledge on the other hand is gained within the home, the private domain of women. Those who rarely venture outside the home are likely to be unfamiliar with the thought and practice of western scientific medicine.

Another facet of the dichotomy between experience and expertise, is that those who are the experts are paid workers, while those who provide advice and support for pregnant women within the home are unpaid, they give this information pro gratis. The paid workers are usually seen in an institutional setting (clinic, hospital or surgery) though occasionally they do make home visits.<sup>2</sup> In the instances when a woman is married to an expert, or has a friend who is medically qualified, then this person may provide information outside the institutional setting. Although the experts

---

<sup>1</sup>Some of the experts also hold traditional beliefs, a point which will be developed later.

<sup>2</sup>Midwives, Health Visitors and General Practitioners are most likely to make home visits.

are paid for their services, they are not all paid at the same rate, nor do they have equal status within the medical hierarchy. (This point is developed further on pages 454-459)

A further dichotomy between the expert and the pregnant woman is that their area of concern is different. The experts are predominantly concerned with detecting pathology in a population of pregnant women. The pregnant woman's focus on the other hand is individual, she is interested in her body and the changes it undergoes during the course of her pregnancy:

"Well it's like er...you're not an individual, you're just a pack of fat ladies and that's it! ... I suppose they get sick of looking at women all day anyway, you know so...But it's too impersonal, because I mean every woman's pregnancy's her own pregnancy, you know what I mean. But they might see a hundred a day".

(Case No. 8B, Primipara MC)

"I says I feel so weak and all that. And when I tell him (GP) I've got a pain here, he says 'Well you've got to have it!' And I said 'Well I didn't have it the last time'. He said 'All the pregnancies are not the same, so you've got to suffer this time'. He said 'Ill give you these tablets, if they help it's all right, otherwise you've got to stay like this'."

(Case No. 11A, Parity I Hindu - educated)

As stated in the previous Chapter, the woman views her pregnancy as "special"; the expert is looking for abnormalities, or "interesting" cases.<sup>1</sup> There is a difference in perspective between the woman and the expert about the nature of the visit to the expert. The woman seeks reassurance that her pregnancy is progressing normally; the expert is looking for pathology.

It is possible to construct a broad framework of the basic differences between the knowledge and perspective which constitutes the experience of the pregnant woman, and that of the medical expert.

---

<sup>1</sup>Oakley and Graham (1977) also make this point, they state that the doctors in the London research project "openly declared their preference for working in the 'special clinic' where high risk cases were seen, as it 'makes life a bit more interesting'." (p.9)

(See Figure 3) The experience of the woman is largely composed of knowledge which is traditional in origin and has been acquired in the private sphere from persons who are not paid for providing this information. The woman's concern about her pregnancy is individual in nature, and she consults the experts to be reassured of the normality of her pregnancy. The expert, in contrast, is more likely to draw upon knowledge which has a "scientific" base and which has been acquired in a public institution. The expert is paid for services rendered and focusses on detecting pathology in a population of pregnant women. This comparison is very crude but provides a starting point for furthering an analysis of the division of labour between the different medically qualified experts and the sources of knowledge which constitute part of the woman's experience of pregnancy.

FIGURE 3                      DIFFERENCES BETWEEN KNOWLEDGE AND PERSPECTIVE OF PREGNANT WOMEN AND MEDICAL EXPERT

	Women Experience	Medical Expert Expertise
Knowledge base	Traditional	Scientific
Sphere of gaining knowledge	Private	Public
Remuneration for gaining knowledge	Unpaid	Paid
Focus of attention	Individual subjective	Population objective
Purpose of visiting expert	Reassurance of normality	Detecting pathology

## DIVISION OF LABOUR

Much has been written on the division of labour in modern industrial societies. These works appear to fall into two main categories: i) the increased specialisation which has taken place in the occupational system and ii) the social differentiation of tasks in the home. This latter category also includes the care and socialisation of young children and the provision of support and advice, factors which are difficult to define as tasks but certainly constitute what is expected of women within the home.

An analysis of the division of labour in pregnancy would therefore focus upon the women's experiences of the professional management of pregnancy, the advice and information they receive from lay and family members, and the other sources of independently acquired knowledge, e.g. the media. In order to develop this analysis further, I shall look at who does what in the management of pregnancy, how the women perceive what they do, the accessibility of these sources of knowledge, and finally, what knowledge they impart. To do this I shall focus in this Chapter on i) the division of labour among the experts in a) the hospital setting, b) the community, c) the media; and in the following Chapter on ii) the division of labour among the social network of family and friends a) who performs which household tasks to alleviate the load of the pregnant woman and b) who provides what kind of support and advice for the pregnant woman.

### 1. The division of labour amongst the experts

The concept "division of labour" has been used by many theoreticians as a tool for the analysis of the increasing occupational

specialisation in modern industrial societies.<sup>1</sup> The use of the concept in this manner can either apply to increased specialisation and fragmentation of tasks within the factory,<sup>2</sup> or amongst the professions<sup>3</sup>; although the outcome of increased specialisation within the professions is different from increased specialisation within industry which results in workers losing control over their skills (Freidson 1977).<sup>4</sup> It is the division of labour amongst professionals that we are concerned with here, and specifically members of the medical profession.

In the previous discussion of experience and expertise there was a distinction made between the pregnant women and the members of the medical profession, that is, the experts. However, there is not simply a dichotomy between women with varying amounts of experience and a homogeneous body of experts. Each of these experts has a well-defined place within the medical hierarchy, with specific tasks which are based on the amount of training they have received and the degree of specialisation they have obtained within

<sup>1</sup>Marx considers that the emergence of class societies "is dependent upon the growth of the specialisation of tasks" (Giddens, 1972, p.229). For Durkheim the growth of the division of labour is seen "in terms of the integrating consequences of specialisation rather than in terms of the formation of class systems". (Giddens, 1972, p.229)

<sup>2</sup>Braverman (1974, p.85-121).

<sup>3</sup>Freidson (1970; 1971); Johnson (1972).

<sup>4</sup>Freidson (1977) states that specialisation within the established professions enables the workers themselves to specialise and negotiate organised control over their work. However, specialisation within the factory involves a "superior authority" which "breaks a task down into its simplest units, requiring the least possible skill to perform, and then hires, trains and supervises workers to perform them in a division of labour it creates". (p.27)



obstetrics. Moreover, there is a very definite bias in favour of white, upper class, males at the top of the medical hierarchy which has persisted to the present day. Acceptance at medical school has been largely determined by class origins<sup>1</sup>; and while 34% of first year admission medical students in 1974 were women (UCCA 1975), there is a marked absence of women (and blacks) in the higher status specialties and at the top of the medical hierarchy (see Elston 1977, pp.124-128). Despite the fact that white men dominate the top of the medical pyramid, about 75% of health workers are women and a sizeable proportion of them are coloured.<sup>2</sup> The division of labour in the medical profession is predicated upon a set of social relations which accords superiority to white male doctors, while among health care professionals women are largely subordinate to men, performing tasks akin to domestic labour.

In addition to the allocation of tasks in the medical profession on a sex, class and racial basis, there is also a distinction between the hospital and community based services. In terms of the prestige accorded to certain aspects of medical care, it is the hospital based curative services involving high technology medicine which holds a higher status than the domiciliary and general practitioner services.<sup>3</sup> In view of this distinction it is proposed to look at the division of labour in the hospital setting separately

---

<sup>1</sup>The Royal Commission on Medical Education states that in 1961 34.5% of final year medical students came from social class I and in 1966 39.6% of the first year medical students came from social class I. As social class I represents only 2.8% of the population there is a gross over-representation of medical students from professional families.

<sup>2</sup>Gish (1969) states that 26.8% of nurses in training in Britain in December 1966 were from overseas and most of them came from the Commonwealth and New Commonwealth.

<sup>3</sup>See Waddington (1977) 'General Practitioners and Consultants in early nineteenth century England : The sociology of an Intra-Professional Conflict' for a discussion of the historical background to the GP/specialist split.

from the division of labour within the community, although it is impossible to view the two as independent entities.<sup>1</sup>

a) The division of labour in the hospital setting

The prime concern of the hospital staff is to detect pathology in pregnancy. The ante-natal clinic is particularly geared to this end, with each member of staff having a specific set of tasks to perform.

i) Who does what? In the ante-natal clinic there are clear boundaries between the different experts based on their rank, sex and class and these are immediately recognised by other health workers, but not so obvious to those unfamiliar with the medical hierarchy. What was immediately apparent to the users of the service is that all the regular doctors were male and the other clinic workers were female (eight midwives, one staff nurse, seven trainee midwives, two auxiliaries and two receptionists). The ratio of male to female staff in this clinic was 1:5, the men occupying the top positions.

Apart from the two Sisters-in-charge who make public statements and assume an air of authority, it is difficult to distinguish between the different levels of nursing staff. Yet they all have particular duties and wear different coloured belts. The two full-time Sisters are trained midwives and they play a key role in the "public" area of the clinic. Part of their duty is to ensure the smooth running of the clinic and to maintain order. It is the Sister-in-charge who asks people who are not patients to leave the clinic on days when it is over-crowded. The Sisters take it in turn to supervise the "public" and "private" areas of the clinic. The Sister whose turn it is, organises the flow of patients

<sup>1</sup>It is appreciated as Dartington (1979) points out, that it is difficult "to manage the boundary between Hospital and Community systems of care. Management of a system is concerned internally with regulating its activities and externally with regulating its relations to other systems in such a way as to get its task performed." (p.13)

from the waiting room to be examined, and selects which patients see the Consultant, Registrar or Housemen.<sup>1</sup> She uses various criteria for her selection i) first time women who have not yet seen the consultant, ii) women with a history of previous obstetric complications, iii) women who have not yet seen the consultant in this pregnancy. The aim is that all pregnant women see the consultant at least once in their ante-natal career.<sup>2</sup> The Sisters act as gatekeepers to the consultants by restricting women's access to them.<sup>3</sup> The Sister in charge of the private area of the clinic, will often help out in performing tasks, such as booking patients, if the clinic is short staffed. Both of the Sisters are State Registered Nurses and qualified in midwifery, they wear dark blue belts to signify this.

Below them in the midwifery hierarchy are six staff midwives, they also are qualified in midwifery, but three of them are State Registered Nurses and the other three are State Certified Nurses. They have less seniority than the Sisters, but wear the same coloured belt as this denotes the midwifery qualification. They work on a rota basis, covering three different sets of tasks at each clinic session. Two of them book new patients into hospital and take down personal details (marital status, age, name, address, occupation of self and partner are all recorded in addition to previous medical history). The women are then given leaflets about pregnancy, birth

---

<sup>1</sup>The consultant selects from the GP referral letter which of the first-time attenders at clinic he wishes to see.

<sup>2</sup>Some women with obstetric complications will see the consultant at every visit - these women are regarded as more interesting to the specialist. What is not widely advertised at the clinic is that every woman is entitled to see the consultant if she asks.

<sup>3</sup>If a woman asks to see the consultant the Sister usually explains that this would involve a long wait and suggests that the woman has her record noted to see the consultant on her next visit. (Conversation with Sister-in-charge, 18th May, 1977).

and their maternity entitlements. Two of the other staff midwives are involved in testing urine, taking blood pressure readings, preparing materials that the doctor may want to use (for example, for cervical smear tests) and occasionally chaperoning the doctor. The other two staff midwives collect the women's hospital records from the reception desk on arrival and call the women to be booked-in, weighed, have their urine tested and see the doctor. A staff nurse assists the midwives in their duties and refers any problems to them as she has no midwifery qualification. Her belt is pale blue in colour.

At some clinic sessions there are seven pupil midwives and obstetric nurses who are required to attend the clinic for eight weeks as part of their general training. Their duties include accompanying the doctors in the examination of patients, learning how to feel for the position of the baby, helping the staff midwives to book patients in. They perform these duties on a rota basis so they have covered each of the areas by the end of the eight week period. Both the pupil midwives and obstetric nurses wear lilac belts.

In the clinic there are four other workers who do not have any formal qualifications. There are two nursing auxiliaries who wear gold belts and whose duty it is to weigh the patients. The other non-qualified staff are the receptionists, they arrange appointments and check that all the women have turned up for their appointment. They do not wear any uniform at all.

The doctors are distinguished from the nursing staff by their sex and also by their clothes for they wear the usual white coat.

The consultant is at the top of the medical hierarchy and is seen to have the greatest amount of expertise, he therefore sees the most "interesting" cases. The consultants perform the same tasks as the other doctors (a full physical examination) with the exception of one consultant who would routinely give his patients a cervical smear. The doctors were less visible than the female staff as they occupied the private domain of the clinic, they were less accessible for those women who wanted to ask them questions. The only time the woman saw the doctor was when she was on the examination couch.

ii) How the women perceive the division of labour in the hospital.

The women perceived the hospital ante-natal clinic as a place where they went to be "checked". They recognised that different members of the staff performed particular duties, but what some of the women did not realise was that some of the staff had varying degrees of expertise. Although the nursing staff wore different coloured belts to denote their position within the hierarchy, many women referred to them all as "nurse". All of the British women (except one) were able to recognise "their" consultant, but only seven (27%) Asian women could. Fifteen (58%) Asian women did not know "their" consultant's name, while four (15%) knew his name but did not know what he looked like. They often referred to all the male staff as "doctor" irrespective of whether he was a Consultant, Senior Registrar or Houseman. The first time pregnant British women who were unfamiliar with the hospital hierarchy were also unable to distinguish between the various hospital grades.

"Every time there is a different doctor. Whichever doctor has the time, he sees you.....I've had three children like this - it doesn't matter if it's the big doctor (consultant) or the small doctor".

(Case No. 15A, Parity 4 WC)

"They're all doctors".

(Case No. 13A, Parity 1 WC)

"Dr. Z he's my consultant. I don't know if I've seen him yet. They don't tell you their names, they just come in you know, and I think 'Is this Dr. Z?'"

(Case No. 7B, Primipara WC)

The women who could distinguish the different levels of expert in the hospital staff were more likely to have particular expectations of each of the different experts in accordance with the tasks they performed. For example, four (15%) British women who were all middle class thought they would be "better looked after" if they saw the consultant at every clinic visit:

"Basically I suppose I think that childcare is very important and I don't think it's the same as the common cold or sprained ankle".

(Case No. 26B, Parity 1 MC)

"If I'd seen Dr. Z (consultant) I'd have probably felt differently. But most of the time I just came out worried...I think you only see the consultant once, unless there's something especially wrong with you".

(Case No. 9B, Primipara MC)

Other women realised that they were only likely to see the consultant if there was "something wrong" with them:

"I'm under Y (consultant), but I've only seen him once in the whole of the pregnancy and that was because he was needed to come and turn the baby around. I hadn't set eyes on him till then".

(Case No. 24B, Parity 2 MC)

"If my blood pressure is high, or if there is something wrong in my urine, I see Mr. Z (consultant)".

(Case No. 10A, Parity 3; married to Registrar)

One woman who had a stillbirth in her previous pregnancy was particularly anxious to see the consultant again in this pregnancy, if this was not possible at the ante-natal clinic, then she was going to go privately:

"The main thing is, when I started going back after this pregnancy (stillbirth), when I started going again for me ante-natal, um..I was seeing Mr. Y (consultant) the head one you know, all the time for the first few visits. But now, it's slipped back and I'm seeing all the different ones again...It makes you wonder if they know all your...you know...more so when you've had something go wrong, you know, you wonder if they know all your details.....And I asked me GP 'Would it be worth me going private, would we get better attention, would things perhaps work out better you know?' And he said 'No, not really'."

This woman knew other people who had been to see the consultant privately when they had been dissatisfied with the NHS treatment:

"I just assumed I could see Mr. Y privately. He's got a clinic up...somewhere, it's in a house. So you know, you just go and see him there...I know it's about £17 a visit...I know people who've been, my mother went for something or other. They went because they weren't satisfied with the treatment they were getting, whatever the illness."

(Case No. 23B, Parity 2, previous stillbirth, MC)

Two other British first time pregnant women said they would consider paying for their health care. One woman was prepared to go privately "if there was something really wrong with me" (Case No. 9B, Primipara MC), and the other woman wanted a private room when she went into hospital for the delivery (Case No. 8B, Primipara MC) These three women all felt they would receive better treatment (in terms of access to consultants and privacy) if they paid.

Not all of the women were so eager to see the consultant in their pregnancy. Two women had changed their consultant in this pregnancy because they were dissatisfied with the consultant they had in their previous pregnancy. They did not question the consultant's expertise, it was his personal attitude towards them they were upset with. They expected the consultant not only to perform a job (i.e. detecting pathology) they also expected him to be polite and show an interest in them as an individual. They wanted patient-oriented care rather than task-oriented examinations:

"When I was in hospital last time Mr. X came to visit me and he was er...very rough, clumsy with his hands (when performing an internal). Also his bedside manner left much to be desired. He came up with a whole load of students and just looked at me quickly and he talked about me to them and never said a word to me...This time (this pregnancy) I told my GP I wanted to change consultants. I'd talked to my friends about the consultants and they seemed to think that Mr. Z was the best, so I asked my GP if I could change to him".

(Case No. 22B, Parity 1 MC)

"When your doctor sends you to the hospital you're given a form and I just put Mr. Z at the top because I knew there was no point seeing Mr. Y because we'd had so many arguments over it (sterilisation) last time".

(Case No. 11B, Parity 4 WC)

This last woman recognised that the consultant was the only person who could give permission for her to have a sterilisation, so she changed to a consultant she thought would be more sympathetic. Other women said that they thought their consultant was "a bit rude", "a very busy man", "he makes sarcastic remarks", and "you can't understand a word he says", indicating that they expected the expert to adopt a more person-oriented approach. They certainly did not expect the consultant to be rude and it was not appreciated:



"And he (consultant) asked me if I was all right and I says that I was going through it a bit, and he turns round and says 'Well you shouldn't have got pregnant then should you?' And I thought 'Well that's a bit of a hard thing to say'...I'm not really looking forward to coming face to face with him again".

(Case No. 10B, Parity 3 WC)

Moreover, women who expected to see the consultant were annoyed on the occasions when he arrived late at the clinic or left early.<sup>1</sup> In these instances it could be assumed that detecting pathology in pregnant women was not the only commitment the consultant had:

"What I find very offensive as well is that appointments are made in bulk at the same time and the consultants are not always there. On one occasion I went in for a two thirty appointment and heard one nurse say to another 'Oh Mr. X won't be in till three o'clock'...On another occasion I actually saw him leaving at twenty past three and there was still an afternoon full of patients waiting to see him...I have a feeling that it happens all the time".

(Case No. 26B, Parity 1 MC)

The majority of women [twenty two (85%) British women and twenty five (96%) Asian women] did not want to see the consultant at their clinic visit unless there "was something wrong". They assumed all the doctors at the hospital were competent:

Q. "Would you like to see the consultant?"

A. "Not particularly, as long as they're competent and I presume they are".

(Case No. 21B, Parity 2 MC)

"I don't mind as long as they do the job right".

(Case No. 7B, Primipara WC)

"Well there again it doesn't really bother me you know. 'Cos as I say they've all been very good. I say they know what they're doing down there more than I do".

(Case No. 6B, Primipara MC)

---

<sup>1</sup>The design of the clinic is such that the consultants (and other staff have to walk through the public waiting area to get to the back of the clinic.

"All three doctors were good"  
(Case No. 6A, Primipara - educated)

One half of the Asian women (50%) said "it doesn't make any difference to me" when asked if they would prefer to see the consultant. The other Asian women responded that it was up to the hospital who they saw and they would do as they were told.

Several of the women remarked that the clinic doctors generally were more thorough than their own general practitioner:

"But there again his (GPs) examination isn't as thorough as what their's (clinic) is, you know... Down the ante-natal they would um..really examine you more like you know - he just sort of feels to see if the baby's in the right place, I think, and that's it. He doesn't um...he's not as exacting as what the ante-natal are you know".

(Case No. 2B, Primipara WC)

"If I was pregnant again I'd just leave the doctor (GP) you know 'cos he's no good and just go to the ante-natal at the hospital".

(Case No. 11A, Parity 1 - English speaking)

However not all the women thought that the clinic visit was more thorough and there were many complaints about seeing different doctors at each visit (see p. 411), particularly as the doctors gave contradictory advice which led some women to doubt their expertise:

"I've seen a different doctor each time...I think it's better to have the same one, rather than every time see different. He knows the problems, otherwise they don't read about it, like yesterday".

(Case No. 11A, Parity 1, English speaking)

"I have seen a different doctor on every occasion... Since I don't know my dates every single doctor I've seen at that hospital has started out by saying 'When is it due?' Last time that was said to me, I said 'I was hoping you could tell me that'. After all they are supposed to know these things".

(Case No. 26B, Parity 2 MC)

This lack of expertise was often seen in the clinic and at the time of birth among the junior hospital doctors, it was particularly

noticed if the woman felt she was being practised on:

"There seems a difference as far as experience goes, some of them, I don't know, little things, they don't seem quite so good...I suppose they're trained now though? I don't really like seeing a different doctor every time".

(Case No. 9B, Primipara MC)

"I had this young student doctor practising on me with his needlecraft. And he had to have two qualified doctors standing there the whole time watching him. And I thought it was awful because they'd say 'No, no, you don't put it there, you put it...'"

(Case No. 11B, Parity 4 WC)

The boundaries between the different medical personnel were most blurred in the clinic when an experienced midwife was assisting a junior hospital doctor. In these instances, the doctor's lack of proficiency was seen in the context of him learning, or acquiring expertise.

"One doctor one week couldn't even hear the baby's heart beat - he had to be told by the midwife where to listen for it".

(Case No. 19B, Parity 1 MC)

"They (the doctors) seem to have looked to the midwives for advice the last couple of times".

(Case No. 9B, Primipara MC)

In these learning situations the midwife is the expert and is seen to have superior knowledge to the young doctor.<sup>1</sup> In other instances, the senior nursing staff were seen to have authority over junior doctors:

"With my last one there was a doctor who was prepared to discharge me after forty-eight hours. He was Indian and new to the job, but the Nursing Officer had a larger say than the doctor and she said 'Five days' and that was it. There was nothing wrong with me or him (baby)".

(Case No. 11B, Parity 4 WC)

The boundary between the division of labour of the female midwife and the male doctor was most commonly blurred when the doctor was young or "new to the job". More generally the British

<sup>1</sup>Walker (1976) also makes this point when she says that the midwives "guidance was usually accepted by the junior doctors themselves, who were regarded by their seniors as doctors still in training, who could learn from the more experienced midwives". (p.137)

middle class pregnant women perceived the hospital midwives as aides to the doctors, who performed the more menial tasks:

"I've only sort of looked upon them (midwives) as people who were there to do your blood pressure and weight really, nothing more".

(Case No. 23B, Parity 2 MC)

"She does all I suppose, the menial tasks"

(Case No. 20B, Parity 1 MC)

Their role as chaperone was also commented on:

"But there again, they tend to be more involved with the consultants and they take your blood pressure, then off they go.. If you're not seeing the consultant they go off. Obviously they have to stand with the consultants".

(Case No. 22B, Parity 1 MC)

Most of the English-speaking women found the midwives more approachable than the doctors and easy to engage in general conversation:

"They (midwives) talk to you they do, you don't have to say anything to them 'cos they say, they talk to you first...Well I suppose the doctors don't have much time to sit and talk like, if they've got other patients waiting like".

(Case No. 15B, Parity 1 WC)

"I feel more easy to talk to them (midwives) than I do with the doctor".

(Case No. 3A, Primipara, Englishing-speaking)

The midwives were expected to be "friendly and helpful" and this was seen as a part of their role which was as important as the tasks they performed. In the few instances when the midwives were not friendly this was commented on:

"I don't feel that they (nursing staff) are anything like as friendly and helpful with the Asian woman. There have been incidents that I have found very disturbing sitting and watching".

(Case No. 26B, Parity 1 MC)

"First the nurses used to be nice, now - I'll tell you the truth - now they aren't nice any more".

(Case No. 18A, Parity 3, non-English-speaking)

In addition to providing a friendly service, it was the midwives who were expected to give information. They were seen as having more time at their disposal than the doctors and the woman had more contact with them than the doctors:

"When the nurse is examining you before the doctor they tell you a lot more than what the doctors do. Last time I went I had two nurses and one was saying that the baby's head was engaged, but he (doctor) didn't say anything. He didn't even say if it was the right way or anything like that".

(Case No. 12B, Parity 2 WC)

"They talk to you when you have an examination and that, they give you a bit of advice as well".

(Case No. 7B, Primipara WC)

Several of the British women said they thought it was important to get to know the midwives because it was often them who delivered the baby. Six (23%) British women said they thought the midwives were as capable as the doctors in carrying out the routine ante-natal checks at the ante-natal clinic, and even more women expressed faith in the capabilities of their domiciliary midwife (see p.490-493):

"The care here (ante-natal clinic) most times is adequate without the consultant coming in...Well I presumed I wouldn't see him anyway. I mean it's the midwives who deliver you anyway, so they're the ones you've got to get to know".

(Case No. 5B, Primipara WC)

In contrast, the women had less confidence in the pupil midwives who were seen to be lacking in experience and expertise:

"They're very nice...I suppose really, I suppose it's a horrible thing to say, but you just don't feel you can have the same confidence in them (pupil midwives) really. It isn't very fair, they've got to start off somewhere. 'Cos if I need to ask anything I'd much rather ask you know, one of the midwives, or who ever you're seeing, the doctor you're seeing".

(Case No. 25B, Parity 1 MC)

The pupil midwives are seen to lack status within the clinic and this gave one woman confidence to ask them not to "practice" on her. The pupil midwives spent most of their time (when they were waiting for the doctor) feeling for the position of the baby; commonly referred to as "prodding" by the women:

"I did refuse, not this time, the time before - you know how the nurses (pupils) want to have a feel of your tummy and they try and decide how far you are - well for twenty minutes they were prodding and they were poking at my stomach trying to find out if it was breech. And in the end I told them to go away. I said, 'I've got someone kicking from the inside and you prodding from the outside'. I said 'Just go away and leave my stomach alone'"

(Case No. 11B, Parity 4 WC)

"I've had some prodding in my time from some of the young uns...There was a Chinese one with curved nails who used to make a pattern on me".

(Case No. 18B, Parity 1 MC)

Although the pupil midwives were feared because of the prodding they engaged in, they were also seen as providing information which was not normally available. The women were able to ask them questions while the pupils performed their manipulations or waited with them for the doctor:

"When I was waiting to see Mr. X (consultant) on my second hospital visit...a pupil midwife (I think she was almost qualified) sat with me. And I was asking her about my pregnancy with Karen and she was very nice because she kept looking back and saying 'Oh yes, so and so happened, didn't it?'...and she did tell me one or two things. She told me I had quite a lot of stitches, which I hadn't realised, she said 'Ooh, you had a nasty tear didn't you?' Which I hadn't realised you see, but obviously it's down on the record".

(Case No. 19B, Parity 1 MC)

Access to the women's hospital records gave the pupil midwives some knowledge about past obstetric histories, which they could impart to the pregnant woman. This knowledge compensated for the pupil midwives lack of expertise.

The division of labour in the ante-natal clinic is primarily concerned with performing certain tasks to detect pathology in pregnancy. Rather than these tasks being carried out in a perfunctory manner, the attenders at the clinic expected a certain amount of care, that is, personal attention, and also they would like to be given advice about the progress of their pregnancy. Broadly speaking, it was the male doctors who were the most task-oriented in their approach to ante-natal care; the female midwives on the other hand, attempted to combine a more personal approach when carrying out their clinical duties. Inevitably, the personal characteristics of the individual members of the staff do affect the kind of services offered.<sup>1</sup> For example, out of the three consultants, one was much more popular than the other two; this meant that his clinic session was always more crowded (see p.193). One of the Sisters-in-charge of the clinic was commonly referred to as "the battle-axe" and women would try and avoid her as much as possible because she could be intimidating.

"She seemed to be such a prominent one. One has to kind of get past her all the time".

(Case No. 25B, Parity 1 MC)

The other Sister was much more sympathetic and managed to combine performing her tasks with sensitive treatment of the woman as a person:

"The Sister...was asking me all sorts of questions (when she was booked in) you know, and she was very nice, I liked her...Because I told her I wasn't married at the time you know...And er..she says that 'You didn't have to tell me', but I'll tell you what she did and I thought it were lovely. She got a sticker and stuck it over the other name and put his (boyfriend's) name down and put 'Common law husband'

<sup>1</sup>Eaton and Webb (1979) argue that the individual personalities of members of the medical profession are one important factor in defining the allocation of tasks:

"Task allocation often depends not so much upon the intentions of those within the system to take more upon themselves or delegate to others, but equally upon expediency, available resources and facilities, staff levels, and individual personalities". (p.85)

in pencil, so that it can be rubbed out. And I thought that was lovely".

(Case No. 16B, Parity 1 WC)

Although the nursing staff tend to be more person-oriented in their approach, the dominant ideology of the clinic is the search for the abnormal.<sup>1</sup> In the cases where abnormality is suspected the women are referred for further investigations (e.g. ultra sound scan, X-ray) or in some instances to other hospital departments:

"I think they're (clinic staff) very helpful. They told me - 'cos when I was young I got my chest burned and then two years ago I went to Scotland to have an operation on one of the lungs - they told me to take care of it and they made an appointment for me to see Dr. P (chest consultant)".

(Case No. 3A, Primipara WC)

The pre-occupation of the clinic staff with the abnormal tends to ignore the woman's concern over the normal progress of her pregnancy. The clinic is not a place where advice and information is readily disseminated and this is a major criticism of the clinic by the women. The general feeling was that the clinic staff were too busy carrying out their tasks (e.g. weighing, taking blood pressure) to have time to offer advice about such things as weight gain or preparation for breast-feeding:

"They (clinic staff) don't give advice, I suppose that's why they give you the leaflets and the books. I suppose they haven't got the time to tell you themselves".

(Case No. 17B, Parity 1 WC)

Even if the clinic was less busy, it is unlikely that the clinic staff would play a role in providing information about normal aspects of pregnancy or in preparing the women for motherhood.<sup>2</sup>

---

<sup>1</sup>Kloosterman (1973) states that doctors are always on the alert for pathology in pregnancy (p.49).

<sup>2</sup>Two of the British women studied referred to their experiences of ante-natal clinics elsewhere, one was given information on diet by a nutritionist at the clinic, the other was instructed on breast-feeding.



These tasks are seen to be the domain of the domiciliary workers who have been trained to deal with these matters. I shall now turn to the division of labour amongst the domiciliary health workers and to an evaluation of how the women experience these services.

b) The division of labour amongst the domiciliary health workers

The domiciliary maternal health services are much more fragmented than the centralised consultant clinic. The domiciliary services are dispersed throughout the city (which is about six miles in diameter) and in this area there are over one hundred general practitioners who are qualified to provide maternity care. The GPs are independent contractors and have more autonomy in organising their maternity services than the hospital doctors have in determining the nature of the hospital clinic. The individually based organisation of primary health care means that there is often considerable variation between the services offered by different general practitioners.<sup>1</sup> (see pages 187-189 ).

i) Who does what? The general practitioner's role in pregnancy is more diffuse than that of the hospital doctor, for the GP is concerned with all aspects of the woman's health, not solely her pregnancy.<sup>2</sup>

The GP is more likely to be in contact with other community

---

<sup>1</sup>Horobin and McIntosh (1977) refer to the literature on variation in general practice. They discuss differential consultation rates; the variations in medical prescription, home visiting patterns and referrals to outpatient departments. Further they claim that research in Aberdeen has shown "up to ten fold differences between practices in their hospital referral rates". (p.88)

<sup>2</sup>The Royal College of General Practitioners (1972) defined the GP as "a doctor who provides personal, primary, and continuing medical care to individuals and families".

services,<sup>1</sup> and to subscribe to, or reinforce, folk beliefs.<sup>2</sup> The GP will probably have met the woman before her pregnancy and may be familiar with her medical and social background. In the instances where the doctor is well known to the woman, she is more likely to ask questions about her pregnancy and these may be placed in the context of her previous health care.

The tasks the GP is expected to perform consist of i) the initial "medical" diagnosis of pregnancy; ii) making the arrangements for the woman's first clinic appointment; iii) provide information about maternity entitlements; iv) prescribe iron tablets; v) perform routine checks throughout the pregnancy, for example, urine test, weight, blood pressure, position of the foetus; vi) give general advice and information about diet in pregnancy, when to give up work and to allay any anxieties the woman may have. The GP is also responsible for the health care of the woman and the management of illness episodes throughout. In cases where the pregnancy is not progressing normally the GP will refer the woman to the consultant clinic for specialist attention.

The variation between general practices permits some GPs to delegate the more menial tasks to their midwifery staff. In Coventry there are thirty group practices which have a midwife participating in the ante-natal session. The main tasks the midwives perform are checking the blood pressure, weight, urine sample and providing general information and advice. The domiciliary midwives are also supposed to visit every pregnant woman in her home before

<sup>1</sup>Horobin and McIntosh (1977) state that "hospital doctors are relatively encapsulated in a 'medical' world - the hospital - GPs are subject to a greater variety of inputs from the non-medical world of their clients, and the other agencies with which they share boundaries - social work, 'welfare', public health, etc." (p.90).

<sup>2</sup>Helman (1978) discusses the way in which GPs reinforce folk beliefs in the treatment of colds and fevers.

the birth of the baby. Staff shortages often made this task impossible. Another task which did not involve all pregnant women was the Parentcraft classes which were conducted by both midwives and health visitors.

The sexual division of labour amongst the domiciliary staff is very similar to that in the clinic. All the midwives were female and the majority of GPs male. (Only 4% of the women studied had a woman doctor and approximately 12% of the GPs in Coventry were female in an analysis of the Medical List). The health visitors and practice receptionists were also all female. Despite the sex similarity between the hospital and community midwives, there are fundamental differences in their frame of reference. The hospital midwives have a clinical orientation, they work either in the consultant clinic or the consultant delivery wards of the hospital. They have very little autonomy and usually assist the doctors.<sup>1</sup> The domiciliary midwives have a much broader perspective, they are involved in conducting the Parentcraft classes and instructing in relaxation exercises; in delivering babies in the GP Unit and the occasional home birth; and it is their responsibility to visit the mother and baby for the first ten days after birth. The domiciliary midwife has much more autonomy than the hospital midwife and will often work unaided. Her expertise is in normal delivery and she is likely to reject unnecessary medical intervention. As one woman stated:

---

<sup>1</sup>Walker (1976) looks at differing perceptions of the role of the midwife. She claims that doctors saw midwives "as nurses who assist obstetricians" whilst midwives "saw themselves as practitioners in their own right, able to take responsibility in normal, but an assistant to the doctor with the abnormal, aspects of maternity care". (p.136)  
Comaroff (1976b) argues that the hospital midwife "acts as an intermediary between doctor and patient" and that they "explicitly defer to the doctor's seniority". (p.25)

"The midwife (domiciliary) said 'Did you have stiches with your other babies?' And I said 'Yes'. 'Well' she said, I'm not going to let you have stiches. They're scissor happy downstairs (consultant wards), they can't wait to get their scissors out'."

(Case No. 19B, Parity 1 MC)

This example portrays the differences the domiciliary midwife recognised between her own practice and that of the hospital midwives. I shall now turn to the differences between the hospital and community services as perceived by the pregnant women.

ii) How the women perceive the division of labour in the community services. At the first interview all the women were asked their preference for the location of their ante-natal care (see page 196). By the time of the second interview a considerable number of women had changed from wanting all of their ante-natal care from their GP to wanting hospital-based care (Table XXI ). There are two possible explanations for this change in attitude: 1) in the early stages of pregnancy most women are less pre-occupied with "things going wrong", as the birth becomes imminent they are more aware of their susceptibility to certain illnesses (for example, toxæmia) and would prefer specialist attention; 2) during the course of their pregnancy some women become dissatisfied with the treatment they receive from their general practitioner and compare his services with those they receive at the consultant clinic.

For those women who at the end of their pregnancy would still prefer to have all their ante-natal care from their GP, it can be surmised they prefer GP care because they perceive this to be

qualitatively different from that received at the consultant clinic. The British women in particular had a notion of a "family" doctor who provided a personalised service, while the Asian women were much more critical of their GPs than they were of the hospital services.

### Family doctor

The concept of a "family" doctor was something the Asian women were not familiar with and this can be related to their previous experiences of the health services in India and their comparatively shorter length of residence in the city (see page 184 ). The idea of a "family" doctor was expressed by over one-third (35%) of the British women and all of whom had lived in the city from birth:

"I preferred my GP because it was more personal....  
It's a doctor I've had all my life".  
(Case No. 8B, Primipara MC)

"He's a family doctor, we've had him from birth sort  
of thing".  
(Case No. 22B, Parity 1 MC)

"He's more of a family doctor really. When I was a  
child I very rarely went to the doctor's really. But  
he was very good and took an interest in the family  
circle like and more or less knows us by name, not by  
your surname like".  
(Case No. 17B, Parity 1 WC)

The personal service some women received from their GP was often compared with the impersonal hospital clinic:

"He's (GP) perhaps a little more um, he takes a look  
at the personal side a little bit more. I think he  
thinks a little bit more about you, whereas down the  
hospital you're more or less a person and a number  
you know, there's more of us like".  
(Case No. 2B, Primipara WC)

One woman whose last pregnancy had resulted in a stillbirth was concerned at the lack of attention she was receiving from the consultant clinic and went to see her GP to check that the clinic were doing all they should to ensure the successful outcome of this pregnancy:

"Well actually after last week when they upset me at the hospital, I came home and went up to my own doctor that night, I made an appointment. Because I wanted to know if anything was dreadfully wrong and what they were doing about it".

(Case No. 23B, Parity 2 MC)

The women who viewed their GP as a family doctor were more likely to consult him (sic) with any queries relating to their pregnancy than the unknown hospital doctors. Moreover, some GPs encouraged their patients to raise problems with them:

"My doctor always says to me 'If you feel unhappy about anything and you've only seen me two days ago' he says 'You can still come back you know, don't worry', he says, 'I'll see you anytime'. He says 'You don't have to wait the month if there's something you're not happy about'."

(Case No. 8B, Primipara MC)

Two British working-class women mentioned instances when their GP had discussed aspects of their health care which fell outside the narrow medical definition of what constitutes care in pregnancy:

"Oh he (GP) does everything and asks you questions and he's helped me on my personal problems as well...Well I was on nerve tablets you know, and he asked me what was troubling me and I told him you know, and he did everything he could".

(Case No. 16B, Parity 1 WC, changed GPs during pregnancy when she moved from marital home to live with her mother)

"Like I've got a vein on my leg which started when I was in an accident six years ago and he (GP) turned round and said 'Has anyone ever told you what to do if you knock it and it starts to bleed?' And he showed me as well you know."

Just get a handkerchief or a cloth or something and press hard on the vein with the leg up till an ambulance came. You know he was really good like - none of the others have got on to a thing like that".

(Case No. 10B, Parity 3 WC)

In this last case the doctor was sharing his expertise with the woman so that she could cope in the event of a future emergency.

All of these women (except the one who had moved home during her pregnancy) had been on their GP's list for a long period of time and felt they received a personalised service from their GP.

#### General practitioner

Women who were less well acquainted with their GP, or were on the list of a group practice and saw a different doctor at each visit, expressed more criticism of the general practitioner services. Women who had experience of GPs in other parts of the city (or country) tended to make comparisons with the services offered elsewhere and to be more critical. The main criticisms these women had of their doctor was that he was not a specialist in obstetrics and the services offered were of a very general nature:

"I'm very uneasy about GPs in pregnancies, I prefer not to go to GPs. I've had experiences in the past of GPs who haven't struck me as being particularly well qualified on such a specialist subject".

(Case No. 26B, Parity 1 MC)

"Neither of them (GPs) were, now what's the word? - gynaecologists, neither of them were that, which is unfortunate because I would really have preferred to have a doctor who could take full care of me".

(Case No. 23B, Parity 2 MC)

"He (GP) just reads me notes, takes me blood pressure - I mean, he doesn't even say 'Oh you're blood pressure is all right' which they do down the hospital...He doesn't, he doesn't say anything really, he just asks me how I am in general like, he doesn't say anything about whether the baby's all right or the right way or nothing". (Emphasis added)  
(Case No.17B, Parity 2 WC)

Another view expressed was that although the GP had information on past illness episodes, he did not have the full details of the woman's obstetric history which were contained in the hospital records:

"I prefer to just go round there (to GP) you know, like it's quicker and all that. But I suppose they know more at the hospital - like they've got all the files down there to see. The doctor's only got the Co-operation card".  
(Case No. 17B, Parity 1 WC)

"I think if you go down the ante-natal clinic regular ...I think they know your case better 'cos they have your notes and everything."  
(Case No. 2B, Primipara WC)

The GPs equipment was seen to be less sophisticated than that at the hospital clinic. For example, several women complained that they were weighed on a "pair of bathroom scales" at the GP surgery. Other women towards the end of their pregnancy said that they felt "safer" going to the hospital ante-natal clinic because if anything went wrong they were on the spot for treatment:

"At the end (of pregnancy) I would rather go there (hospital clinic) 'cos at least if they do find anything, you're there on the spot. And if you've got to go in that's it".  
(Case No. 10B, Parity 3 WC)

"The hospital's better. I feel safer, after all it is a hospital".  
(Case No. 22A, Parity 2 WC)

The visit to the consultant clinic tended to make the women aware of the potentially pathological nature of pregnancy (as



defined by the medical profession) and to make them more critical of the GP services. If the GP did not perform all the examinations carried out at the clinic then the women experienced this as a lack of concern, or care, for them by their GP. They did not question the necessity of the clinic procedures:

"You're own doctor don't seem to bother.....he don't care less".

(Case No. 3B, Primipara WC)

"Dr. M (GP) - he doesn't...well I don't like to say anything about the doctor, but he doesn't seem to bother much...I used to go to him, but sometimes they weren't bothered about putting it down on the card you know".

(Case No. 15B, Parity 1 WC)

The Asian women were certainly more critical of their GPs than they were of the hospital services; they had expectations of the tasks GPs should perform which were based on their experience of the ante-natal clinic. Asian and British women alike expected the GP to take their blood pressure:

"He (GP) doesn't take blood pressure - he did take it the first two or three times, but not any more".

(Case No. 3A, Primipara, English-speaking)

"I went there (GP) one day and he's supposed to take my blood pressure and he guessed it. He guessed it and he put it in - he didn't take it - I didn't like that, and it's down on my card now. I can show you, and I didn't like that".

(Case No. 16B, Parity 1 WC)

Another woman learnt that it was normal to take a blood pressure reading at every ante-natal visit when she was shown a film at the Parentcraft class:

"On the film you see, they say blood pressure every time, well he (GP) didn't give me one that time. And he put one down for me though, but he didn't take it. He did it the same as all the rest, because I've been the same all the time you see, except for the first two beginning ones. So he just put the same as the rest down and he didn't bother to take it".

(Case No. 7B, Primipara WC)

In addition to taking blood pressure readings, the women expected to be weighed and to have a physical examination. In several instances these procedures were not carried out:

"He (GP) doesn't check you or anything".  
(Case No. 17A, Parity 1 English-speaking)

"It's just that I haven't got all that much faith in him to tell you the truth...Well you go up there sometimes, well I don't think he's ever examined me when I've been up there".  
(Case No. 10B, Parity 3 WC)

One woman was so annoyed her GP did not "check" her properly that she stopped going to him and only attended the ante-natal clinic.

"Well any problem you tell this doctor, he doesn't really bother about. Nothing at all...He never checked me up for this pregnancy at all. Last time I used to go to see the other doctor because he called me. But this time he didn't even call me to come back and see me. Why should I go and see him all the time? The last time the other doctor used to take blood pressure and weight, but this time, he never...And he doesn't know anything about me pregnancy this time, because he never checked me at all. How does he know what's going on? or how many weeks I'm pregnant?"

(Case No. 11A, Parity 1 English-speaking)

The routine checks in pregnancy were considered important by the women studied; they saw them as an essential part of the GP's duties, but only one part. They had further expectations of the GP role which included the GP as a source of information and advice. However, at the time of their first interview only four (15%) Asian women and fourteen (54%) British women felt that they had been given advice about their pregnancy by the GP. By the time of the second interview (eight months pregnant) nearly all the women felt they had been given some information by the GP and the main topics discussed included resting and taking iron tablets. There was considerable variation in the amount and kind of information received:

"He didn't give me any advice. He just prescribed iron tablets".

(Case No. 4A, Primipara, English-speaking)

"He said 'Well you're pregnant' and that's it. He didn't give me any advice although he knew I'd lost some".

(Case No. 1B, Primipara - but three previous miscarriages, WC)

Experienced women, that is, those who had been pregnant before, remarked that their GP did not give any advice because he "just assumes that I know", which was sometimes not the case:

"I didn't know whether or not it was because it was a third pregnancy and they think you should know it all. But as I say they don't put your mind at ease or anything here".

(Case No. 21B, Parity 2 MC - first pregnancy in Coventry and completely unfamiliar with the organisation of the maternity services)

These comments can be contrasted with those made by the women who regarded their GP as a "family doctor", for these women found their doctor more forthcoming with information. Women who had experience of more than one GP found tremendous variation in the services offered and the way in which the doctor practised the art of medicine, which can be related to the independent contractor basis from which GPs work.

#### Variations in practice

The differences between GPs in terms of advice offered has already been discussed. It is possible to argue that individual GPs adopt particular strategies for communicating or withholding information from their patients.<sup>1</sup> One woman remarked that she

<sup>1</sup>Comaroff (1976a) looks at the different strategies employed by GPs in communicating information about non-fatal illness. MacIntyre (1976a) argues that there is a difference in the length of consultant-pregnant woman interaction depending on the strategy employed by each individual consultant.

had difficulty in asking her doctor questions, or in initiating a conversation, she felt that the doctor determined the nature of the communication:

"It's not very patient-oriented, the conversation. It's doctor telling patient. But as I say, he tends to dominate".

(Case No. 19B, Parity 1 MC)

In addition to the different communication strategies employed by GPs to control the amount of information they impart, there is also reason to suspect that doctors interact in varying ways with patients according to their sex, race and class. The literature on doctor-patient interaction suggests that the social class background of the patient is an important determinant in the length of the consultation. Working class patients having on average shorter consultations.<sup>1</sup> The language doctors use in their encounters with patients is seen to vary depending on the doctor's evaluation of the patient's social class.<sup>2</sup> This study shows the difficulty the working class women experienced in understanding what the doctor said, which meant that communication was severely restricted:

"I would prefer to see Dr. P really you know, 'cos I can understand him better. Dr. M does be so in a rush all the time...I don't mind seeing him, but I can't understand what he's saying to me".

(Case No. 13B, Parity 2 WC)

"The GP I've got he'll tell you things, but he won't explain - he'll say it in the words they'll know. You don't understand nothing when you go out. I wonder if anybody else knows what it means?...He (previous GP) was different - he told you. If he was going on you could stop him and say 'Well, what does

---

<sup>1</sup>See Cartwright and O'Brien (1976).

<sup>2</sup>Oakley and Graham (1977) note the different terminology used by doctors when speaking to middle class and working class women about their body parts (see p.28).

that word mean?' And he'd explain it to you,  
which I always found easier...So I felt more  
secure than I do with the doctors I've got now".  
(Case No. 14B, Parity 1 WC)

The Asian women also experienced difficulties in communicating  
with their GPs:

"He writes prescriptions before you've finished  
speaking".  
(Case No.4A, Primipara English-speaking)

The sex of the doctor is probably also an important factor in  
communication with pregnant women. However, as so few of the  
women studied had a woman GP it is impossible to develop this  
argument further. All that can be noted is the women's comments  
about how much easier it was for them to talk to the female  
midwifery staff (both hospital and domiciliary).

Other variations in the practice of medicine the  
women experienced were i) differences in referral practice to  
the consultant clinic. (The figures on Table XIV suggest  
that the Asian women are referred to the clinic slightly later in  
pregnancy than the British women). One British woman found out  
from her pregnant friends that her GP did not refer to the clinic  
as soon as other doctors:

"Both of my friends - I've got one that pregnant at  
the moment and one that's had a baby - and by three  
months they'd both been to the hospital. Well I  
didn't go at all - my doctor wouldn't send me. My  
friend that is expecting her baby in August and the  
doctor knew she was pregnant, she said 'I'll send you  
straight to the hospital 'cos of your age, over twenty  
five'. She's twenty eight the same as meself. But  
my doctor, I just don't know, he didn't seem to think  
it was worth bothering with the hospital until I'd  
left work.....Apparently he doesn't believe in sending  
'em until twenty eight weeks. It seems as if they've  
all got different ideas".

(Case No. 9B, Primipara MC)

ii) differences in maintaining patients' records:

"He (GP) never does any notes. Other doctors I've been to, they get your file out and jot down what they've prescribed. And he never does any notes. Well we think 'How does he remember? Does he write them up when you've gone, or what?'"

(Case No. 24B, Parity 2 MC)

iii) differences in visiting women in the GP Unit:

"When I was in (hospital) under GP, my doctor was the only doctor who ever came regularly to see me on the ward. And some of them were in and they were being discharged and they hadn't seen their doctor".

(Case No. 11B, Parity 4 WC)

iv) the variations between GPs in prescribing medicines in pregnancy (these have already been referred to, pages 363-372).

The differences between general practitioners and the women's experience of various practices led the women to make evaluations about what they considered to constitute a "good" GP. This was usually a doctor who would make home visits, was polite and prescribed "good" medicines:

"In fact my husband's just changed to my GP like you know. That's how good we think he is like you know. And there's no trouble - any time he's got to be called out you know, they come...the same day, as soon as they can".

(Case No. 2B, Primipara WC)

"We like him (GP) - he'll always come out, he's never refused. We've never called him unnecessarily, but he's always been very good".

(Case No. 24B, Parity 2 MC)

Not all GPs fulfilled the criteria of a "good" doctor; and the more experienced women were prepared to change their doctor if he did not meet up to expectations:

"He (GP) would get irritable at times. I got annoyed with him once when I asked him for medicine for my son and he said to me 'You trouble me too much', so I left him".

(Case No. 20A, Parity 3, non-English-speaking)

"I was bleeding for 15 days and the doctor wouldn't come out, so we changed to an Indian doctor. Now I can talk more how I feel".

(Case No. 18A, Parity 3, non-English-speaking)

"I could never understand what he (GP) was talking about - he's a Pole...When I got married I used the excuse to change, I wanted to be the same as my husband. And Dr. L (new GP) is a nice doctor and so is Dr. P (the other GP in practice) - you can talk to them better."

(Case No. 23B, Parity 2 MC)

One woman went to great lengths to ensure that she was placed on the list of a "good" GP:

"I used to be with Dr. B (British GP) then we moved, so I changed to Dr. S (Asian GP) but I wasn't happy with his medicine because it failed to cure my nazala (nasal trouble) then again I changed to a doctor on the Harnall Lane...I had changed doctors and given a different address because of my illness, and I kept that doctor for 6 months. Later on I made Dr. B once again because I wanted to come back to Dr. B, I had to make the other doctor, because he wouldn't accept Dr. S's patients. That is why I had to give another address and change doctor. It took one and a half hours to walk there. My bachola (Matchmaker) used to live that side, so I gave his address and kept that address for six months before we moved here".

(Case No. 14A, Parity 4, non-English-speaking)

The less experienced women tend not to have such confidence when it comes to changing doctor, though they might want to:

"I wanted to change my doctor....he was a bit rude and I was a bit upset....And I felt like changing, but my husband said 'Leave it for while, because changing you have to get the reports and everything. This GP knows everything, so it's no use changing now'. After I've had the baby if I think he's no good then I'll change him".

(Case No. 3A, Primipara. English-speaking)

Despite the amount of experience a pregnant woman or patient has, it is the doctor, the expert, in the last instance who controls the resources. For example, it is the doctor who determines whether or not medicine is prescribed:

"I used to ask Dr. S for some good medicines because I suffered from phlegm at the time, and couldn't even eat. He gave me one tablet and when I used to complain to him, he used to say 'I'm the doctor not you. You shouldn't talk too much! I used to keep quiet then - what can one say?"

(Case No. 14A, Parity 4, non-English-speaking)

It is also the doctor who decides at what time of day ante-natal patients will be seen. If they present at the surgery at an inappropriate time, he can refuse to see them:

"When I went for a check up off Dr. M he told me to come back again in the morning 'cos it's only for people at work who can go in the night....And when I went over at night, that's when they start, arguing with you saying that you're supposed to come in the morning with the kids".

(Case No. 12B, Parity 2 WC)

"To start with I wasn't feeling very good and I feel like vomiting, I don't know why it came. But I went down there (GP surgery) and he didn't tell me that pregnant women should go only Tuesday. And I didn't know about that and I went in the evening and he said 'You should come only Tuesdays' and I said 'I didn't know about that you should have told me. I don't mind going back. I'll come back on Tuesday'. I was really mad. I had to wait a long time and when I went inside he just said 'You don't have to come any other day, only on Tuesdays'."

(Case No. 10A, Parity 3, English-speaking)

The doctor's receptionist also plays a role in regulating access to the doctor. Two British women mentioned the receptionist as an important figure in determining whether or not a home visit was made:

"When I had a miscarriage, the doctor didn't come - he was too busy. I must admit it wasn't his fault it was the receptionist 'Oh no he's too busy, he's got sick people to come and see'...I rang three times. I'd got a stomach ache and everything, and she just said 'Just rest, take it easy, he'll be along'."

(Case No. 24B, Parity 2 MC)

In most instances the GP was more accessible than the hospital clinic being nearer to the woman's home, but despite the



the proximity there are social constraints which prevent the woman having unlimited access to primary health care workers. The data also seems to suggest that the GPs have a different perspective towards pregnancy from the hospital staff. The women's comments about the way they were treated by their GP indicate less emphasis upon the pathological aspects of pregnancy. In fact, one woman said that her doctor had told her not to visit him unless she felt ill, advice which undermines the hospital philosophy of constant monitoring:

"After five or six months I started feeling well, my blood pressure and blood seemed better. The doctor at the Coventry and Warwickshire hospital said I was well and that he'd give me an appointment after two months. And the doctor (GP) told me that I was well and needn't come until I felt unwell because there are lots of patients and you have to wait a long time".

(Case No. 5A, Primipara aged thirty six -  
a medically defined high risk category)

#### Domiciliary Midwives

At the time of this study there were thirty three domiciliary midwives working in Coventry. These midwives are not attached to GPs in the same way as health visitors, but thirty of the group practices did have a midwife participating in the ante-natal sessions.<sup>1</sup> The midwives work on a rota basis, alternating between assisting GPs, running Parentcraft classes, visiting pregnant women and newly delivered Mums, performing the occasional home delivery

---

<sup>1</sup>The other twenty three group practices do not have a midwife in attendance, neither do most of the solo practices. The GPs who use the GP Unit are more likely to have a midwife in attendance at their surgery.

and working in the Maternity hospital, delivering babies in the GP Unit. The hospital work is organised in shifts so the Unit is staffed twenty four hours a day. The range of tasks performed by the domiciliary midwives often results in a lack of continuity between the midwifery staff. The same midwife would not necessarily be present at the GP surgery, conduct the Parentcraft classes and make home visits within the same geographical area. Women who befriend the midwife at the surgery or Parentcraft classes view the lack of continuity as problematic:

"I've been going to the relaxation classes up there (clinic) and there's been a coloured midwife taking the course, Mrs. W. and I've found her very easy to get on with. I'm hoping that she'll be coming visiting when I come out of hospital, but I didn't get the same midwife last time."

(Case No. 20B, Parity 1, MC)

Sometimes lack of co-ordination between GP and midwife meant that the midwife was engaged in unnecessary errands, as the following account shows:

Respondent to midwife as she enters living room :  
"I didn't expect to see you. I've got an appointment tomorrow at Dr. F's".  
Midwife: "Oh isn't he! He wastes our time no end doesn't he? (Looking to pupil midwife accompanying her)  
I've got a lot of visits this morning as well....I'll murder him when I see him next week!"

(Case No. 18B, Parity 1, MC)

A shortage of midwives coupled with their heavy work load often meant that the midwife was unable to visit the women at home before birth. By the time of the second interview when the women were eight months pregnant only two women had received domiciliary visits and both these women had been hospitalised ante-natally:

"She came once, I was surprised because they haven't done that before (fourth pregnancy). She came here

not long after I'd been to hospital...She this student with her as well, you know. She was here about five minutes you know, that's all...She seemed all right anyway. We just had a short chat and that was it."  
(Case No. 10B, Parity 3, WC)

The women who had not received their statutory home visit did not appear too concerned, they saw the visit as a general introduction which it was possible to "manage" without:

"I'm sure he (GP) said to me something about a midwife - this was earlier on in my pregnancy you know. I'm sure he said 'We'll be sending a midwife round a couple of weeks before, just to introduce you to her, or something.' I'll just wait till they knock at the door, if they come sort of thing."  
(Case No. 8B, primipara, MC)

"I still don't know who my midwife is...she hasn't been...Well, we'll manage."  
(Case No. 21B, Parity 2, MC)

Thirty-five (66%) women mentioned seeing their domiciliary midwife in this pregnancy (sixteen - 62% Asian women and nineteen - 73% British women had). The midwife had been in contact with the women either at the GP surgery, at a home visit, or at the Parentcraft class. Through this contact and encounters in previous pregnancies, the women made evaluations of what they perceived to be the role of the domiciliary midwife in pregnancy.

The British women recognised the importance of the midwife in checking the normal progression of pregnancy and three women referred to the competence of midwives as practitioners in their own right. The Asian women did not refer to the midwife as a person who played a significant role in pregnancy, this can possibly be related to the low status of the midwife in India and Pakistan (see Gardezi, et al., 1969 and Gideon, 1962). Although the midwife delivers the majority of babies in rural areas she is of low caste origin, while the doctors

at the hospitals in urban areas are of high status and high caste. The Asian women who accorded the midwife some expertise saw their role as providers of information particularly in the context of the Parentcraft classes. These classes are conducted in English and only English speaking women attend:

"There are two midwives, one she discussed some things with us, she was very nice, they both were very friendly ...They told us about diet and about resting and things like that."

(Case No. 3A, primipara, English speaking)

The British women found the midwives more forthcoming with information and they tended to have a more informal relationship with them than the other health care workers:

"He (GP) hasn't given me any advice. It's the midwife really who's been my best friend really in that sort of way."

(Case No. 18B, Parity 1, MC)

"Actually you know, she's very nice. I asked her in fact a few things - like on my card you know, they put things, I asked her what these things meant you know - like baby's head's in position and this kind of thing."

(Case No. 25B, Parity 1, MC)

Experienced women tended to know their local midwife from previous births and home visits:

"I know them all, there's Mrs. G. over the back, then there's Marion, there's Mrs. W. I know all the midwives round here, we're all on a friendly basis. We all say 'Hello'. One of them is a friend of the family anyway."

(Case No. 11B, Parity 4, WC)

The domiciliary midwives appeared to be more popular with the experienced working class women. A possible explanation for this alliance is that the midwives proffer information which is easily understood by the women. This knowledge is acceptable as it is traditional rather than scientific in origin. Midwives were cited as advising women to suck polo mints as a cure for heartburn; saying

that some women can't carry boys and some women can't carry girls (i.e. they miscarry); and one woman was told by her midwife that because she had a "bad" pregnancy she was likely to "have a good time in labour". Certainly these comments are not representative of all midwives and the differences between the midwives will be discussed in more detail in the context of the Parentcraft classes (page 499). However, there did seem to be distinctly different approaches between the hospital midwives and the domiciliary midwives. This different frame of reference was alluded to by those women who had experience of the GP and consultant wards:

"The district midwives have got more feeling. I mean, they meet the mothers outside so they know what problems they face whereas the hospital midwives don't. The only environment they (hospital midwives) know is in that ward, and the atmosphere is totally different....I find that the district midwives are far better. They seem to realise that you are a human being whereas the hospital midwives, the only environment they seem to know is a ward full of beds with people coming in and out, shuttling. Whereas the district midwives, they see you all the time".

(Case No. 11B, Parity 4, WC)

"Last time I was in M6 (GP Unit) which had the district midwives in and they were a lot more friendly than the normal hospital midwives. The hospital ones tend to be a little bit vicious...It's more relaxed I think when you've got the district midwives."

(Case No. 21B, Parity 2, MC)

Other accounts of the GP Unit indicate that it is more relaxed and the women are not so regimented. However, only women who are likely to have a normal delivery are admitted to the GP Unit, and this again depends on them being registered with a GP who uses the Unit. The midwives on the Unit are likely to know the doctors through their domiciliary work, and from the accounts given it would appear that the midwives had more autonomy in the hospital setting than

in the doctor's surgery. GPs are only called to assist in the Unit if the woman requires stitching. If any obstetric complication should occur the woman will be transferred to the consultant ward.

The tasks the midwife performs at the GP surgery depend very much on the amount of autonomy she is permitted by the GP. In some surgeries the midwife conducts the most menial tasks and the doctor does the "examination":

"She weighs you, takes your blood pressure and the doctor examines you."

(Case No. 7B, primipara, WC)

"The midwife checks urine and stomach and whether the feet are swollen. Then the doctor checks you."

(Case No. 23A, Parity 3, non-English speaking)

In these practices the midwife is viewed as an aide to the doctor and the division of labour is such that the midwife performs the routine work. In other practices the midwife is seen to be more prominent and it is the doctor who is "in the background" and consulted if there is "something wrong".

"They (midwives) check the urine...and they do the examining, they feel the baby. The doctor's in the background, they do all the work."

(Case No. 20B, Parity 1, MC)

"You see the midwife unless there's something wrong, then the doctor will call in if she's worried at all.

But mostly you see her."

(Case No. 11B, Parity 4 WC)

These accounts suggest differences in the division of labour from one general practice to another. However, it cannot be assumed that the organisation of work is the same at each ante-natal session as the following account shows:

"Yesterday two midwives were there, they did the blood pressure and examined me, and then the doctor followed up. The previous time there wasn't a midwife there at all and he did it all."

(Case No. 23B, Parity 2, MC)

The competence of the midwives in performing their tasks was commented on by the experienced women. They also remarked on the relatively small role the midwife plays at delivery, an area which was once seen as her field of expertise:<sup>1</sup>

"If I was to go down for my appointment (at GP surgery) and start my labour there, she (midwife) still wouldn't deliver me...they'd (the ambulance) be there that quick. I'd feel just as confident with her as I would with the hospital, unless anything - but even complications, she's had years and years of experience.....It seems such a waste."

(Case No. 18B, Parity 1, MC)

"They (midwives) see you right up to the end, but they never see the result of what they've been monitoring you for like. They see me every week or two....She sees all these pregnant women a lot of the time, yet she doesn't seem to the end product. I wonder if she'd like to be in at the end?"

(Case No. 25B, Parity 1, MC)

These women recognise the ambiguity between their own perception of the midwife as an expert in her own right, and her subordinate position within the medical hierarchy. A further ambiguity arises in the experience/expertise dictotomy in the instances when the midwives are seen to combine experience with expertise:

"The one (district midwife) that's usually based at my doctor's, she's very nice. She's got twins, twins and one other."

(Case No. 21B, Parity 2, MC)

This combination is seen to be advantageous and some women remarked quite strongly when the midwives did not possess personal experience themselves.

"The ones (midwives) that have had babies, you can tell them as soon as you talk to them, the ones that have got children. It's the one's that haven't had children that say 'It's not as bad as all that, don't make all that fuss'. How the hell do they know? They haven't been through it."

(Case No. 11B, Parity 4, WC)

---

<sup>1</sup>1902 Midwives Act refers to midwives as practitioners in their "own right".

Donnison (1977) and Ehrenreich and English (1974) look at the erosion of midwives powers and the midwives subsumption to the male dominated medical profession.

"The one midwife died. She was a Miss, and it always strikes me as ever so funny because they've never had a baby. It's incredible really, how can they give you advice when they don't know? I mean she was quite good, but she'd never done it herself. And until you've done it you can't possibly know."  
(Case No. 24B, Parity 2, MC)

These examples illustrate the different expectations the women have of the experts depending on their sex. The female midwife is expected to combine experience with expertise, while the male doctors possess expertise in obstetrics, but have no experience of what it is like to be pregnant and give birth.<sup>1</sup> By this criteria almost all doctors "can't possibly know" because they have not been through the experience.<sup>2</sup> However, it was only the British experienced women who felt confident with the midwives, and these women were predominantly from working class backgrounds. Middle class women and those with a bad obstetric history were much more likely to want the greatest amount of expertise available, i.e. consultant care. (Figure 4).

---

<sup>1</sup>83.7% of doctors of the grade registrar and above in obstetrics and gynaecology are male. (DHSS 1976 Health and Personal Social Service Statistics, 1975)

<sup>2</sup>Mayer and Timms (1970) discuss a similar lack of empathy between professional and client. They say "The clients assumed that only persons who had a similar experience could possibly comprehend what it was like. This assumption incidentally explains one of our findings - namely, that clients typically preferred workers of the same age, marital status, and sex as themselves. Being similar they would understand what they, the clients, had been through." (p.73)



FIGURE 4      PREFERENCE FOR PERSON PERFORMING ANTE-NATAL CARE

Expert	Frame of reference	Which women prefer
Consultant	Detecting pathology + expertise	Asian and British middle class + those British with bad obstetric history
Hospital staff	Detecting pathology	Asian and British primiparae + those dissatisfied with GP
GP	Checking normality	Coventry locals
Midwife	Checking normal	Experienced British working class

n.b. 39% of Asian women did not mind where they received their ante-natal care

This crude categorisation suggests that women with a previous "bad" experience will be more dependent upon the experts, as will those women who themselves belong to the professional elite (e.g. teachers, and women married to doctors or accountants). Women who are familiar with the British medical hierarchy have a preference for certain medical personnel which largely reflects their own class position. In the cases when it does not, it is the woman's previous exposure to pathology which is the determining factor.

A further distinction between how the experts conceptualise pregnancy is brought out at Parentcraft classes and in the booklets distributed at the ante-natal clinic. These will now be examined briefly in turn.

PARENTCRAFT CLASSES

1. Background to classes

The classes were of two hours duration and divided into two parts of equal length. The first half consisted of formal preparation for motherhood and taught by a midwife and health visitor (depending on the topic for discussion) and the second part consisted of relaxation exercises to prepare the woman for labour. Both these components of the Parentcraft classes have a separate and distinct history.

The idea of formal instruction in motherhood gained acceptance at the turn of the century when British mothers were seen to be deficient in successfully bringing up healthy children. Infant mortality was high and a popular explanation for this was maternal inadequacy; to overcome this incompetence women were to be instructed in the craft of motherhood (see page 26). As Davin (1978) says:

"Doctors, district nurses, health visitors, were all asserting their superior knowledge and authority, establishing moral sanctions on the grounds of health and the national interest, and denigrating traditional methods of child care - in particular by anyone except the mother: neighbours, grandmothers, and older children looking after babies were automatically assumed to be dirty, incompetent and irresponsible." (p.13)

Instruction in mothercraft continued to be provided by local authorities until about ten years ago when the classes attempted to include fathers-to-be in the formal preparation and the classes commonly became known as Parentcraft classes. Although the classes are now aimed at parents, fifteen out of sixteen classes were held in the day-time when most men are at work. Moreover, in a course of eight classes only one is specifically geared to men and their involvement in the birth - this is the father's evening which took the form of a film showing the birth followed by a general discussion.

Relaxation in labour does not have such a long history as formal instruction in motherhood. Relaxation as a technique was widely popularised by Grantly Dick-Read whose book Childbirth Without Fear (1932) advocates that concentrated relaxation in labour can reduce the amount of pain experienced. More recent studies<sup>1</sup> support the claims of Dick-Read and Lamaze and recommend widespread introduction of the psycho-prophylactic technique to all pregnant women in an attempt to develop more positive attitudes towards childbirth.<sup>2</sup> In Britain the National Childbirth Trust has adapted the techniques of Dick-Read and Lamaze in conjunction with those of Erna Wright<sup>3</sup> and Sheila Kitzinger<sup>4</sup> to provide what it calls "psychophysical" ante-natal preparation. These classes are fee-paying and therefore not readily accessible to all women. Out of all the women studied only four (8%) had attended National Childbirth Trust classes in this or a previous pregnancy. All these women were middle class women (see Table XV, p.190).

One woman attended both National Childbirth Trust classes and the local Parentcraft classes. She argued that there was not much difference between the two classes in terms of the relaxation exercises taught:

"I think this idea of the National Childbirth Trust all for natural childbirth is perhaps over-rated, people get the wrong idea. They don't really do a lot different from the ordinary ante-natal classes at the clinic really. It's a little more thorough, they go into more topics,

---

<sup>1</sup>Bergström-Walan(1963) claims "Expectant mothers who were educated for childbirth were calmer and experienced less pain during the dilation and expulsion stages of labour than those who did not take the course." (p.144).

Doering and Entwistle (1975) state that "the more preparation a woman had, the more aware she was at delivery, and that awareness was strongly associated with positive reactions to the birth and the baby." (p.825).

<sup>2</sup>Although the psycho-prophylactic technique has gained in popularity, a study by Zax et al.,(1975) carried out in Rochester, New York, found insufficient evidence to support "the expectation that childbirth training through the Lamaze method reduces anxiety in expectant mothers, as measured by the LPAT anxiety scale."

<sup>3</sup>See Erna Wright (1968), The New Childbirth.

<sup>4</sup>See Sheila Kitzinger (1970), The Experience of Childbirth.

but the relaxation is the same."  
(Case No. 20B, Parity 1, MC)

Whether or not relaxation does help women in labour is outside of the scope of this thesis, however, what is important to note at this juncture is the way relaxation has been presented to women as something which can be done to control a bodily process. This notion is related to that of formal instruction in parenthood, parenting is no longer seen as a natural process, it is now viewed as a science and people have to be taught how to parent. Likewise with medical intervention in childbirth and the scientific management of life events, doctors are attempting to control the outcome of the pregnancy and the woman is instructed in techniques to control the process of giving birth. Observations of the Parentcraft classes reflect this view and also throw up tensions between different health care professionals teaching the course and illustrate inconsistencies in the information given by the same health care professional.

## 2. Content of Parentcraft classes

In an attempt to standardise what was taught at each clinic, the midwives and health visitors teaching the course were given detailed instructions about topics to be covered at each session. The list of instructions was compiled by health care administrators (some of whom had been practising midwives and health visitors in the past). The health care workers who were responsible for teaching the classes felt that the content of each class had been imposed on them and sometimes they found this unworkable. For example, before the new course it was customary for midwives to take one session on breastfeeding and the health visitor taught about bottle feeding separately. In the new programme breast and bottle feeding were dealt with at the same session and the midwife and health

visitor were both present to teach their respective topics.

In the session on feeding the baby which was observed, the midwife went over the time allocated for her talk on breast-feeding and this caused the health visitor to comment:

"Normally we do breast-feeding and bottle feeding separately, but with this new regime....."  
(Health visitor, Class No. six)

On another occasion the discussion at the end of the session veered towards abnormalities in babies and their causes. As the original session was on diet the health visitor commented:

"Oh dear we seem to have steered away from our topic, which is what we are not supposed to do." (Emphasis in original)  
(Health visitor, Class No. two)

Throughout the period of observation of the Parentcraft classes comments such as these were made and expressed the annoyance of the health visitors and the midwives, who felt the programme of classes was imposed on them. Another source of dissatisfaction with these health care workers stemmed from a disagreement over who should teach which part of the course. According to the programme, the midwife was to conduct the session on the puerperium and to include the topic "post-natal depression". One health visitor considered this topic should be taught by health visitors as (in her opinion) they have more dealings with the depressed mother. At the session attended when post-natal depression was discussed both a midwife and health visitor were present. The midwife in her talk stated that depression occurred on the third day after birth, at which point the health visitor interjected and claimed that post-natal depression did not occur until at least the eighth or ninth day after delivery.

Another point of disagreement between the health care workers came to light in the session on feeding the baby. The midwife considered breast milk on its own to be sufficient for the baby, while the health visitor argued that breast should be supplemented with the bottle as "you can't see how much milk the baby is getting on the breast." These disagreements may reflect differences in the training of the health care workers, and it is also possible they stem from differences in their area of expertise. For example, the midwife may be familiar with depressed women in hospital on the third day after delivery, while the health visitor who sees the new mother after the tenth day post-partum, may encounter incidents of depression at this time.

Apart from the intra-professional tension which was expressed at certain junctures throughout the Parentcraft programme, there were also inconsistencies in the information given by any one health worker. These discrepancies can possibly be related to a dislocation between what midwives and health visitors taught in the hospital setting under male supervision, and what they themselves experience in their day to day work in the community. These inconsistencies are most commonly expressed in terms of pregnancy and childbirth as normal and natural on the one hand, and as something which can be scientifically managed (sic) and is quantifiable, on the other hand.

3. The beliefs of midwives and health visitors as expressed through Parentcraft classes

a) Pregnancy and childbirth as normal and/or natural: In the first Parentcraft class the midwife said the hospital staff liked to see

women as early in pregnancy as possible so that certain tests could be done. Unlike the doctors (who stress the importance of these tests for detecting pathology) the midwife claimed the tests were done to gauge normality. Thus blood pressure readings were done because:

"It's nice to know what your blood pressure is, not essential, but nice, as it changes throughout pregnancy".

and urine was tested because:

"We can tell if you've been vomiting. Also we test for sugar and can tell if someone is going to be diabetic later in life."

(Midwife, Class No. one)

In a later session women were told that breast-feeding was "natural" and "the perfect food for baby" (Midwife, Class No. five)

In the class on labour (number six) the pregnant women were told:

"Having a baby is not an illness. It is a natural function and people are having babies every day."

(Emphasis added)

(Midwife, Class No. six)

The mothers-to-be were also told that it is "normal" to feel emotional in pregnancy and "particularly after birth" (Health visitor, Class No. two).

Infused with the notion of pregnancy and childbirth as normal and natural were statements such as:

"Red-haired people bleed more"

(Midwife, Class No. four)

"Mardy mums have mardy babies"

(Midwife, Class No. one)

These statements appear to be based more on traditional knowledge rather than scientific ratification. Compare this last statement with the traditional Asian saying which instructed pregnant women to think "good" thoughts (page 301). Despite these comments, the same midwives and health visitors also stressed that pregnancy and

childbirth could be medically controlled (through drugs and medical intervention); is quantifiable; and should be located in hygienic, sterile conditions.

b) Pregnancy and childbirth as requiring scientific management:

The same midwife who in the first class stressed the normality of pregnancy also discussed labour in terms of average lengths which could be measured, and advocated performing episiotomies as it "saves having a nasty tear". She spoke of weight increase in pregnancy and divided up the pregnant woman's body into different areas each having a specific weight increase. For example, she allocated seven pounds to the baby, one sixth of this amount (i.e. just over one pound) to the placenta, one pound to each breast and a 25% increase in water content and the blood stream. She thus saw pregnancy as a condition which was scientifically quantifiable. Another example of this was in the class on diet when women were instructed to "eat a good, well balanced diet" (Health visitor, Class No. two). The women were told what foods should be eaten and in what quantities. In Class number five, the midwife spoke of the uterus in terms of its dimensions:

"The uterus increases from 2 oz. to 2 pound in weight and from two inches to ten inches in length."  
(Midwife, Class No. five)

Another theme which ran throughout the Parentcraft classes was that of childbirth as being "clean" and well ordered. Women were told that prepping (i.e. the shaving of pubic hairs) was done:

"to ensure a nice clean delivery"  
(Midwife, Class No. four)

Implying of course that it is the woman herself who is dirty.

Women were later told that it is preferable for the baby to be given a sterilized dummy rather than suck its fingers or an old rag (as these



may not be clean). (Health visitor, Class No. five).

The maternity hospital was presented to the women as a well-ordered and efficient establishment:

"We try and make it as much as possible like home, but it's more like a hotel really. It's run by the clock and at such and such a time certain things happen."  
(Midwife, Class No. three)

"The babies are labelled straight away, so you cannot possibly lose your baby." (Original emphasis)  
(Midwife, Class No. three)

Women were told that inductions:

"are not done for nine to five staff convenience, but to help the baby out once he's been in there forty to forty-two weeks, he should be out"  
(original emphasis)  
(Midwife, Class No. four)

- Note, that all babies are male!

The midwife who claimed breast-feeding was natural also argued it was not "instinctive". Women have to be taught how to breast-feed by health care professionals (Midwife, Class No. five). These statements all argue for the dependence of the pregnant or newly delivered woman on the health care professionals. This dependence is probably most strongly advocated at the time of birth when the women should submit themselves to the experts:

"All you have been told you must do. The doctor or midwife can see what is happening, so listen to what they say. You can feel what is happening but they can see." (Emphasis in original)  
(Midwife, Class No. four)

If women did not follow the advice of the experts this could be determined at the time of their check-up. For example, women were advised to do their post-natal exercises as:

"We know when you come for your check-up whether or not you've been doing your exercises". (Emphasis added)  
(Midwife, Class No. six)

Also, the women were advised to seek professional advice and not to rely on information given by experienced women:

"Be guided by the domiciliary staff who visits you, not Mum who had her baby twenty years before."  
(Midwife, Class No. six)

The inconsistencies in the information given by these health care professionals may reflect a lack of total commitment to the scientific management of pregnancy. These domiciliary workers may themselves consider pregnancy and childbirth to be natural events, but their training and their own role is that of instructing women how to give birth and become "good" mothers. They are therefore put in the position of advocating dependence on health care professionals, although their own experience may lead them to question the scientific management of pregnancy and childbirth.

Attendance at Parentcraft classes is voluntary and it is likely that the women who attend regularly are those who agree with, or find acceptable, the views expressed by the health care professionals. Attendance at the classes throughout the city varied considerably and two classes (one in the Asian area) were discontinued because of insufficient support (see page 190).

#### BOOKLETS ISSUED AT ANTE-NATAL CLINIC

Two booklets<sup>1</sup> were supposed to be issued to all women at their first ante-natal clinic visit. The extent to which these books were used by the women studied is discussed later in the section on how women gain information about pregnancy and childbirth. What will be focussed on in this section is the nature of the advice given in

---

<sup>1</sup>You and Your Baby, Part One and Part Two. Part One deals with from pregnancy to birth, and Part Two is concerned with from birth to one year after. They are both published by the British Medical Association.

the first of the booklets (which is concerned with pregnancy and birth) as this reflects the advice of the experts who wrote it.

The first booklet is divided into ten sections written by six different doctors - only one section, that on feeding, is written by a woman doctor. In addition, there are diagrams showing the growth of the foetus and ante-natal exercises; six questions and answers and numerous advertisements directed at the pregnant woman and the forthcoming baby. An analysis of the differences between photographs and drawings contained in this booklet (and other similar ones) has been made by Graham (1976a). It is not intended here to dwell on the pictorial representations in the booklet, but rather to concentrate on the beliefs of the experts who contributed to the booklet. On reading through the booklet, four main themes emerge which seem relevant to this discussion. They are 1) the expert's perception of women; 2) the expert's perception of pregnancy; 3) the role of scientific intervention in pregnancy and 4) the dominance of medical knowledge.

1) The expert's perception of women. According to the authors of the booklet, pregnant women exist only in relation to their husband and the forthcoming baby; they are home-centred and enjoy preparing the house for the baby; they are responsible for the baby's state of health. The pregnant woman is encouraged to be well-groomed in order to "give pleasure" to her husband:

"Make up well and nicely. Pay attention to your nails and your hands and your hair. If you look good you will give pleasure to others. If you give pleasure to your husband and to others you will feel a lot better."

(McClure Browne, p.38)

The woman is also told that "home is the best place for the pregnant woman" (Philipp, p.25) and the health of the baby "is largely determined by what you eat and drink during the months of pregnancy" (McClure Browne, p.35). Later, when the baby is born it is the woman's job to provide it with food and security which are "important for the baby's future happiness" (Tyrrell, p.59):

"In other words, when he (sic) has been fed, he knows that the world is a Good Place, and his mother is the person who makes it so". (Tyrrell, p.59)<sup>1</sup>

Home is a haven for the pregnant woman, and later on for the baby. The mother-to-be is shown as a home-maker who enjoys this role - we are told that:

"every woman enjoys shopping for the pram, and so will her husband". (Brown, p.39)

Also the woman is seen as having a "wonderful time getting the first layette ready". (Brown, p.40)

The ideal is therefore one of a smooth transition to motherhood. If the mother-to-be is sensible and responsible she will have a trouble free pregnancy and delivery. She is told not to:

"come into contact with German measles before the twelfth week of pregnancy" (Philipp, p.26)

or to "catch colds", smoke or move house (Philipp, p.26). It is assumed that the woman is individually responsible for all of these actions and they can be avoided by endeavour on her part. She is also advised:

"to rest if possible for about two hours every afternoon with your feet up" (McClure Browne, p.67)

The pregnant woman portrayed by the experts is always married, with a supportive husband who will not complain if he comes home and his supper is not ready because she has had her afternoon rest. He is also the sort of man who:

---

<sup>1</sup>It is important to note that the baby is referred to as he throughout the booklet and by all the authors except one (p.26).

"with the right kind of temperament will sustain his wife's morale during the first part of her labour, and in some cases right through the delivery."  
(Philipp, p.17)

The woman appears as middle class, and she may be considering taking a holiday abroad during her pregnancy, hence the advice on flying in pregnancy (p.25). It is also assumed that the woman will have enough money to buy a new pram and all the articles detailed in the section on the layette. There is no mention of unsupported mothers and their entitlements. Neither is there any consideration of women who belong to ethnic minority groups. The section on diet refers to middle class British notions of "a well balanced diet" (p.36) and the woman is advised to eat seafish "perhaps twice a week" (p.36) as well as liver and pork. The book is therefore directed at a very specific readership - married British middle class women. It is also aimed particularly at first-time pregnant women - they are seen as needing education for pregnancy, childbirth and motherhood. There is no mention of the particular difficulties facing pregnant women with toddlers in terms of being able to rest, separation at the time of birth and possible feelings of displacement in the older sibling (earlier discussion, p.318-319)

2) The expert's perception of pregnancy. The experts consider women can to a certain extent control their health in pregnancy by following the advice of doctors. If they avoid illness and eat a well balanced diet then they should have an uneventful pregnancy. However, for those women who suffer from discomforts in pregnancy, these are "normalised" in such a way that the woman is told "there is nothing to worry about". (p.43-46 in booklet and previous discussion, pages 363-364).

Pregnancy is, according to this set of experts "a natural process" (p.7) when the woman looks at her most feminine:

"there is nothing more feminine than a woman who is carrying a baby" (McClure Browne, p.37-38)

Against this holistic view of the feminine pregnant woman is another contradictory notion of the pregnant woman as portrayed by the experts. This is the compartmentalisation of the pregnant woman's body into areas of attention for medical intervention. Thus the romantic notion of the pregnant woman as the personification of femininity is sharply contrasted with the notion of a body which can be divided up into particular problem areas.<sup>1</sup> Feet are seen to change shape during pregnancy becoming longer and broader with the arches flattened (p.38); the woman's waist "if we may still call it that, will increase to about forty inches, and the woman may need support in the form of a corset" (p.38); breasts increase in size and are seen to require a special support bra.

The fragmentation of the female body into areas each requiring support undermines the earlier picture of the feminine pregnant woman at one with nature. This contradiction is important to recognise because it reflects the tension between the notion of pregnancy as normal or natural, and the more recent concept of pregnancy as potentially pathological and the impact of Flexnerism, that is the concept of the body being composed of different parts which fit

---

<sup>1</sup>Janice Winship (1978) develops a similar theme in relation to women and advertising. She argues that in the 1950's "whole" women were portrayed in domestic activities to sell household products. In the 1960's, however, advertisers began to break down women into smaller sections, e.g. hand, hips, feet, all of which could be "sold" in terms of nail polish, lipstick, shoes and tights.

together in a mechanical model. It is these latter ideas which have aided "scientific" intervention in pregnancy and undermined women's knowledge of their own bodies.

3) Scientific intervention in pregnancy. The booklet places emphasis on scientific knowledge which can be subjected to verification. Women's knowledge and experience is therefore regarded in a suspicious light, although Flack (p.9) says:

"no doctor would ever dispute the highly unscientific accuracy of most feminine intuition."

While Flack claims doctors will not dispute women's accuracy (and here he is speaking of the expected date of delivery), elsewhere in the booklet it is assumed the doctor will tell the woman she is pregnant, implying that it is only a doctor who can verify the fact of a woman's pregnancy.

The scientific model is carried further when Flack (p.10) refers to morning sickness as "a little technical trouble in the mornings." (emphasis added). He also explains that weighing "doesn't look very scientific" (p.13) but is a useful indicator for the doctor. Similarly, there is an ideal weight for the woman to put on in pregnancy, and an agreed amount of food for the woman to eat, (see earlier discussion, pages 345-350).

Whether women breast or bottle feed their babies is posed in terms of naturalness vs science. The expert claims:

"most women think it is nature's design for the baby to be suckled at the breast" (Tyrrell, p.55)

When bottle feeding though "the quantity of made-up milk offered can be increased, whatever the weight or age, according to the baby's appetite" (Tyrrell, p.58). The naturalness of breast-feeding is contrasted with the quantifiability of bottle feeding.

Hospital deliveries are encouraged by the experts because of the accessibility of high technology medicine. The expectant mother is advised that:

"she will be in a fully-equipped maternity department surrounded by other mothers, all engaged in this same rewarding business". (Philipp, p.18)

These notions of being able (through science and technology) to control pain in labour, length of labour, the amount of food the baby consumes, are continually reinforced through the statement "doctor knows best". The routinisation of the hospital day further attempts to regulate the newly delivered woman's daily actions:

"In a maternity ward the mother has to adjust to a certain routine. She has to be wakened at a definite time, to be washed at a definite time, have her meals when all the other patients have them...." (Emphasis added) (Philipp, p.18)

Routinisation is also applied to the baby's day and there is a whole page (p.64) devoted to what should be done to the baby and at what hour of the day. It is possible to argue that routinisation and hospitalisation are attempts on the part of members of the medical profession to control uncertainty (see earlier discussion of relationship between hygienic hospital and fear of pollution, p.309-310). The booklets further reflect areas of uncertainty, particularly in relation to miscarriage, discomforts and time of birth.

The woman who threatens to miscarry is told to rest in bed and:

"with luck you will be perfectly alright" (Fleck, p.13)  
(Emphasis added)

The doctor is unable to give the woman any guarantee that he can prevent the miscarriage. In the case of faintness and dizziness in pregnancy, Professor Rhodes says these symptoms are:

"probably due to increased blood flow to the pelvic organs, so that, for very brief moments, the blood supply to the brain is insufficient for its needs". (Emphasis added) (p.44)



Again, the expert is not certain of the cause of the symptoms, but at least he admits to this.

Women who are concerned because they have not gone into labour on their "expected date" (given to them by the doctor) are told:

"just as no two people are exactly the same height, so no two pregnancies last for exactly the same time. All the apples on a tree do not ripen at the same moment exactly. So there is no cause for alarm if you have not gone into labour by anything up to ten days after your estimated date" (McClure Browne, p.68)

In these examples, the experts admit they do not know the reasons for some complaints. They also recognise the individual nature of the woman's pregnancy which has tended to be ignored more recently with a greater number of inductions being performed. Although the experts admit to areas of uncertainty, they also argue that they know best, and have superior knowledge to the woman.

4) The dominance of medical knowledge. Women who are concerned about anything in their pregnancy are instructed to "ask the people who really know" (p.23, Philipp, emphasis added). By this, it is meant that the woman consult "the doctor or midwife" who are professionals not:

"the friendly amateur, who may be has just had a baby herself, or even if she is your mother who bore you some twenty years ago, is not usually the person who knows most about pregnancy." (Philipp, p.23)

In instances when vomiting persists for more than two days the woman is encouraged to consult her family doctor who will "help" her (Flack, p.10). This advice can be contrasted with what the women in this study experienced when they consulted their GP with discomforts of pregnancy. In most cases the woman was not given any advice and only 27% of the women who suffered with sickness were prescribed anything, (see pages 366).

The doctor is also put forward as the person to consult about intercourse in pregnancy and immediately after delivery. The woman is advised not to deprive herself and her husband "of the normal pleasures for a young married couple" (Philipp, p.24) in pregnancy. After birth she is told to wait until her post-natal examination before recommencing sexual relations with her husband. The assumption here is that the doctor is the legitimate person to advise on sexual relations and furthermore it is taken for granted that the woman is able to regulate her husband's sexual behaviour (see page 252-253).

The dominant themes contained in the clinic booklet all stress the woman's dependence on the expert. Her own knowledge and experience is undermined by declaring it "highly unscientific". However, those women studied who subscribed to a scientific frame of reference were dissatisfied with the booklet because it was out-of-date and did not include the latest scientific innovations in pregnancy and childbirth (see later page 559).

#### SUMMARY

Experts subscribe to different concepts of pregnancy which relate to their own training, position within the medical hierarchy and experience. Although the different states of cognitive knowledge can be separated out at a theoretical level (Figure 4), in practice the distinctions are less precise. The experts may incorporate their own lay beliefs into the advice they give, while at the same time arguing for the dominance of medical knowledge.

The class and culture specific nature of expert advice means that it is most tangible to white middle class women and least appropriate to Asian women from rural areas. The failure of the experts to understand the experiences of all pregnant women and the importance of the social milieu in shaping these experiences, leads to the reproduction of inappropriate advice.

EXPERIENCE vs EXPERTISE

CHAPTER TEN

EXPERIENCE

Introduction

To understand what constitutes pregnant women's experience it is necessary to recognise the diversity of acquired knowledge and how this is shaped through the social network.

The distinction between experience and expertise was referred to earlier (pages 447-452) together with a brief discussion of the different aspects of the division of labour in pregnancy (page 453). The preceding chapter looked in detail at the division of labour among the experts the women encountered. To supplement this analysis, we now turn to the division of labour among the social network; in particular, the extent and nature of support and advice given by a) male partners, and b) female relatives. In addition we look at the knowledge acquired independently - 1) at Parentcraft classes; ii) in literature and iii) from television programmes.

This analysis furthers an understanding of where different groups of women gain their knowledge and which sources of advice are most appropriate to them. By selecting two areas where pregnant women have to make decisions it is possible to judge

the extent to which their social network, independently acquired knowledge and medical opinion, influences their decision. The areas looked at are i) when to go to hospital in labour and ii) intended method of feeding the baby.

#### THE DIVISION OF LABOUR AMONG THE SOCIAL NETWORK

The discussion on the division of labour has up until this point focussed on occupational differentiation. The importance of sex, class and race as factors determining who holds what positions in the medical hierarchy were alluded to. The sexual division of labour within the occupational sphere can also be seen to reflect the sexual differentiation of tasks in the household.<sup>1</sup> Social differentiation in the household was recognised by Durkheim (1964) as an important facet of the division of labour. However, he saw the divisions within the family as "natural" based on the difference in constitution between men and women and the dominant authority of the father. (p.264)

"It appears quite natural that the different members of the family should have duties, that is to say, different functions according to their degree of relationship; that father and uncle, brother and cousin, neither have the same rights or the same duties." (p.265)

It is to be disputed whether the sexual division of labour arises from "natural" differences between men and women, as

---

<sup>1</sup>Barron and Norris (1976) draw attention to this point when they say that for a comprehensive analysis of sex-related occupational differentiation in the labour market

"it is necessary to consider both the sexual norms which define the place of men and women in the household and outside it, and the forces which operate in the labour market itself." (Emphasis in original) (p.47)

Rubin (1975) and Oakley (1974) say, notions of maleness and femaleness (gender identity) are a result of repression (see earlier discussion, pages 35, 36) through the suppression of natural similarities. Also, while Durkheim (1964) recognises that the father holds paternal power because of his age and "the blood relations he has with his children" (p.265), he notes that this is not universally the case and quotes matriachal societies as an exception. In western industrial societies today there is a marked sexual division of labour and male and female tasks are valued differently. The way in which these tasks are allocated is based not on natural aptitudes but on a lengthy period of socialisation into specific sex roles.

From birth onwards children are taught there is a male way of behaving and a female way, children who transgress these norms are called "cissies" and "tomboys". The clothes children wear, the way they are spoken to, and the activities they are encouraged in are largely sex-specific. Children's literature reinforces what is appropriate behaviour for boys and girls.<sup>1</sup> The activities girls are engaged in are primarily based in the home, helping mother, this is to encourage the girl to accept her future role of wife and mother.<sup>2</sup>

---

<sup>1</sup>The Ladybird series of Peter and Jane, Janet and John, though now very dated are still used extensively in primary schools.

<sup>2</sup>Best (1977) has written about the sex role socialisation which takes place to make "Girls into Wives". Sharp (1976) looks at the social construction of sex differences and how girls are prepared for "femininity" - "their education reinforces sex divisions through school organisation, and the curriculum teaches them 'skills' suitable for 'women's work' in which they encounter some measure of discrimination throughout all parts of the occupational structure." (p.9)

The way in which household tasks are divided up is also determined by the social class of the family and the social network of the family (Bott, 1971; Rosser and Harris, 1965). However, this study is not concerned only with the division of tasks in the household, but also the way in which different members of the social network provide information and support for the pregnant woman. This will be discussed in further detail later, but it is important to note at this juncture that certain concessions are made to pregnant women over the division of labour within the household, which would not normally be made in the non-pregnant condition. These concessions are similar to the alterations in diet referred to earlier (pages 282-291) and reflect the temporary elevation in the woman's status:

"My husband, he does everything for me...It's the last month so he doesn't let me do anything".

(Case No. 3A, Primipara, Hindu, living in nuclear family)

"Particularly now he helps a lot. He does most of the heavy housework."

(Case No. 19B, Parity 1 MC)

i) Division of labour in household tasks

There have been numerous studies which look at the sexual division of labour in the household (Pahl and Pahl 1972; Rapoport and Rapoport 1971; and Young and Willmott 1973). These studies suggest a greater involvement of men in household chores and a move towards egalitarian relationships as expressed

in the "symmetrical family" (see Young and Willmott 1973).<sup>1</sup> More recent studies of fatherhood, have argued that men are playing an increasing role in the division of labour in child care (McKee, 1979a; Cleary and Shepperdson, 1979). Both these studies look at the extent to which first-time fathers assist their wives in feeding, bathing, changing or playing with the baby, and conclude that men are actively involved in most of these tasks. It is interesting to note that the tasks selected for study are all person-(or baby) centred, neither of the studies take into account the additional household chores that accompany the arrival of a baby. There seems to be an assumption that women are automatically responsible for these tasks; and an example is cited when the father takes the baby out for a walk so that the woman can have time (not for a rest but) to clean the house.<sup>2</sup> It could therefore be argued that men's involvement in childcare consists of an appropriation of the pleasanter person-oriented tasks and that their assistance in routine household chores is negligible.

The limitations of these kinds of study are obvious, they focus on specific tasks and how these are distributed between

---

<sup>1</sup>Bell and Newby (1976) argue that Willmott and Young (1973) concentrate on superficial changes and do not "confront the form of the social relationship between husband and wife." Furthermore, Bell and Newby do not envisage "major changes in the domestic division of labour" (p.166) which Willmott and Young predict in their move "towards symmetry". Oakley (1974b) also argues that "superficial changes in the relationships between female and male over recent years have not altered women's traditional oppression to domesticity (p.236).... The increased 'egalitarianism' of modern marriage (in so far as egalitarianism exists) has not directly affected the institutional segregation of marital roles" (p.237).

<sup>2</sup>"We try and work it that Sunday mornings I'll take him out for a walk so Linda gets a bit of time to do the house." (McKee 1979a, p.27).



the husband and wife (unmarried couples being excluded from study). This approach also assumes that the couple are living in a nuclear family, where there are two adults (one male and one female) to distribute the tasks amongst. This is an assumption that should not be made if we recognise that about 10% of children are brought up in single-parent households and others may be born into families where there are more than two adults present. For example, four (15%) British women and eleven (42%) Asian women, were not living in a nuclear family.<sup>1</sup> (see pages 200-201). A comprehensive study of the division of labour in household tasks takes these factors into account. It is proposed therefore to look at the role of male partners<sup>2</sup> and other female relatives<sup>3</sup> in assisting the woman during pregnancy and at childbirth.

a) Male partners. An analysis of the data about men's role in household tasks shows a low level of involvement. Nine (35%) Asian women said their husband helped them with household tasks other than childcare, compared with twelve (47%) British women. One British woman claimed her boyfriend played an active role in performing household tasks. Men's involvement in childcare was greater with seventeen (65%) Asian fathers and eighteen (70%) British male partners actively participating.

<sup>1</sup>Two British women were separated from their husbands (one lived alone and the other lived with her mother). One unmarried British lived with her parents and one married British woman lived with her husband at her parent's home. The Asian women lived in extended families.

<sup>2</sup>None of the women lived as a couple with another woman.

<sup>3</sup>No male relatives (or female friends) helped with domestic chores though they did provide other assistance.

(The assistance men gave when women attended the ante-natal clinic is detailed on pages (pages 406-409).

The low level of domestic activity by Asian men can be related to the organisation of the family. All the Asian women who received help from their husbands lived in nuclear families (or were the only women in the household). In an extended family there were other women available to help and the impetus for men to learn these tasks was not so great.<sup>1</sup>

For all the women except one<sup>2</sup> assistance with domestic chores was only provided when they were pregnant. The regularity of this assistance also varied considerably. Some women said they only received help when they felt tired or ill:

"If I says to him I just don't feel like doing a thing, he'd say 'Well sit down and I'll do it'. You know it doesn't bother him, he's quite good like that. If I didn't feel like cooking dinner he'd get up and do it. He wouldn't do the washing, he wouldn't know how to use the washing machine sort of thing".

(Case No. 8B, Primipara MC living with husband)

"He (husband) does the work when I can't do it. Otherwise ordinarily he doesn't do the houswork, but when I'm not well he won't make me do it, he will do it then." (Emphasis added)

(Case No.23A, Parity 3, living in nuclear family)

---

<sup>1</sup>It is probable that the couples living in a nuclear family by choice had wanted a more egalitarian relationship.

<sup>2</sup>One British woman who was living with a man who had been married before and had three children was given assistance in the home before she became pregnant. This man already had experience of looking after a home and children on his own.

Others stated that the assistance they received varied from "at times" and "when I need it" at the irregular end of the scale to:

"He does a lot of things for me at week-ends and when he's got days off. He comes home and does washing up and everything - just cook meals, that's all I have to do".

(Case No. 3A Primipara living in nuclear family)

"He's very good, he does housework and clears up. In school time he will get up and get the girls ready for school and bring me a drink in bed."

(Case No. 3B Primipara, living with widower fiance)

Three men had very definite views that their wives should **not** perform certain household tasks towards the end of pregnancy. If these women disobeyed their husband and did some housework, the husband was likely "to go mad":

"Oh he's great. He really is - he's really good, he's terrific. I mean he goes really mad, I mean, if he does come in and he thinks I've done a load - then he goes mad...If I start Hoovering when he's here, he goes mad and he'll take the Hoover and you know..."

(Case No. 25B, Parity 1, MC)

"He doesn't let me do anything. If I do and he comes home he'll go mad at me. He rings up me Mum, he rings her straight up and tells her...and my Mum tells me off."

(Case No. 3A, Primipara, living in nuclear family)

For these women, the amount of help they received was related to their husband's conception of what they should not do. Moreover, these prohibitions seem to be based on the traditional premise that lifting, bending and stretching contribute to complications in pregnancy (such as the cord becoming wrapped around the baby's neck). The men were reflecting folk advice which older women

subscribe to (see pages 295-297) and the one man was seen to collude with his mother-in-law in restraining his wife's household activities.

As mentioned previously, there was no impetus for Asian men living in extended households to assist their wives with household chores. These households tend to be more traditional with a well-defined sexual division of labour. With the British sample, it is much more difficult to isolate one variable which indicates the extent to which male partners do or do not participate in household duties. Only one British woman was married and living in an extended family and her husband did not help at all in the home. He did not "really want children yet anyway" and was particularly dis-interested in the woman's pregnant condition.

Marriage per se did not appear to affect the amount of household assistance men provided, but the sample size is too small to draw any conclusions. Of the three unmarried women living with men, two did not receive any household help at all and the other woman had regular domestic assistance from her partner. It is also difficult to relate the type of occupation of the male and the amount of time he has available, to his activity in the domestic sphere (but this could again be due to the small sample size). For instance, a self employed engineer did not help his wife in the house because he was too busy, a security guard working shifts was not expected to work

in the house, and an unemployed unskilled worker did not help with the domestic chores although he had plenty of time available:

"He's pretty busy, you see being in his own business"  
(Case No. 23B, Parity 2 MC)

"He never helps, he just sits around doing nothing. He gets bored...the only reason he gets bored is that he's got no job to go to and it makes me sick looking at him like, you know what I mean".  
(Case No. 13B Parity 2 WC)

The rationale behind the sexual division of labour in the British couples is difficult to determine. It is to be expected that a closer study of a larger scale sample would throw-up some consistent patterns not apparent here. An interesting feature of both the Asian and British samples is the greater participation of men in child care than domestic tasks. This can be related to the person-oriented nature of child-care; the men restricting their activities to child-minding, rather than the domestic labour associated with child-rearing. Female relatives were more often called on to perform these duties.

b) Female relatives participation in the domestic division of labour - Active participation in domestic chores by the pregnant woman's female relatives was most marked for those women living in extended families.<sup>1</sup> In all of these cases the woman was not seen as solely responsible for the household chores, she either helped her mother (or mother-in-law) in these tasks or was

---

<sup>1</sup>Eleven (42%) Asian women and three (11.5%) British women lived in extended families, i.e. they lived with either their parent(s) or parent(s)-in-law.

helped by the older woman. The way in which the tasks were divided up depended on the age of the older woman, the status within the household of the pregnant woman, and whether or not any of the adult women were in paid employment. The division of labour of household tasks is likely to change when the woman is pregnant; older women place considerable emphasis on the pregnant woman not lifting, bending, and stretching (see pages 295-297) and they are more likely to ensure the pregnant woman does not do these things if they are living in the same household:

"When I was expecting Anthony I used to live at me mother's...And when I was six or seven months she told me to stay with her so she could keep an eye on me. I got married before I had the baby, but I stayed with her. She used to make me sit down, I couldn't do nothing in the house. She used to watch me like, so I wouldn't pick up heavy things."  
(Case No. 13B, Parity 2, WC)

For the Asian mother or mother-in-law certain duties are expected of her when a daughter or daughter-in-law living in the same household is pregnant. If the older woman does not fully observe these prescribed duties then she may be blamed if something "goes wrong" in the pregnancy. One woman mentioned instances of a baby being still born and no-one knowing what had caused this because "mother was doing everything right..."

"It happened to some-one here (in Britain) her child died in the womb. I don't know why. It also happened to my sister-in-law the same way. Her nine months were complete when she felt sick and went into hospital...the doctor didn't say anything about the reason for it...she had been very careful about not working too much and mother was doing everything right. We don't know what happened."  
(Case No. 12A Parity 2 Muslim)

The role of the mother (mother-in-law) in this context is to ensure that the pregnant woman does not do heavy household work and eats the correct foods. Thirteen (50%) Asian women and six (23%) British women had regular household help from their female relatives. For the women who did not live in extended families, household assistance most often took the form of specific tasks performed on a weekly basis (e.g. washing, cooking).

"She's (mother) very good, she comes up one day a week...She comes up and spends the day. She'll say 'Now you go and have a lie down upstairs' - she's always like that, helpful. And she'll tidy up whilst I'm resting.

(Case No. 24B Parity 2 MC, previous miscarriage)

"They've (mother and sister) being doing me washing since I've come out of the hospital".

(Case No. 2B Primipara WC, hospitalised ante-natally for high blood pressure)

Female relatives also play a considerable role in childcare. This is particularly noticeable when the pregnant woman has a clinic or GP appointment (see pages 406-409). Ten (37%) British women, received help with childcare from friends and neighbours and this was often organised on a reciprocal basis. At the time of birth, female relatives are particularly helpful with domestic chores and child care. Traditionally, the Asian woman would go to her parent's home for the birth of her first child and stay with her in-laws for the birth of her subsequent children. The absence of kin in Britain has led to changes in the involvement of married female relatives at the time of birth. Twenty one (81%) Asian women said they would have

female relatives (usually the mother or mother-in-law) staying with them after the birth. Caring for the newly delivered woman is something married Asian women do without question and it is expected of them.

"Mother is mother after all, she will come".  
(Case No. 20A, Parity 3, living in nuclear family)

These women take charge of the domestic tasks and childcare and try to ensure that the newly delivered mother has the traditional forty days rest (see pages 317-318 )

"In our custom we rest for the first one and a half months, then start working a little".  
(Case No. 5A Primipara, living in extended family)

"She (mother-in-law) keeps me in bed....almost forty days I stayed up in the bed".  
(Case No. 11A, Parity 1, living in extended family)

It is not always possible for the mother or mother-in-law to attend to the newly delivered woman, and other kin living in Britain are likely to help out:

"The first time when I went to hospital, there was only my husband at home, but when I got back my mother was there for some days and then for some weeks my jathani (sister-in-law) came...This time, not my sister-in-law, but my husband's aunty will come - she will come before I go to hospital because somebody has to be here to look after the baby".  
(Case No. 17B, Parity 1, living in nuclear family)

Asian women with no female kin in Britain and those with elderly or infirm female relatives are unlikely to observe the traditional forty days rest and they are also likely to be more dependent upon their husband for help (see page 318):



"When I had my first baby we had my husband's friend's wife staying with us. She helped me out for three or four weeks. The second time my husband took holidays. The third time my sister got married and she stayed with me and both the daughters were born while she was with me. So there has never been a situation when I didn't get rest....This time either the same sister will come or my husband will take leave".

(Case No. 14B, Parity 4, living in nuclear family)

The women who receive help at the time of birth are expected to reciprocate these duties when other family members become pregnant.<sup>1</sup> If the mother or mother-in-law is available she is expected to supervise the pregnant and newly-delivered woman. In their absence, sisters or sisters-in-law take over this role. It is the older women who tend to be most traditional and they are likely to perpetuate the custom of giving newly delivered women dabra<sup>2</sup> to eat. Seventeen (65%) Asian women said they expected to be given dabra on return from hospital after birth.

The British women expected to receive less help at the time of birth from their female relatives than their Asian born counterparts. Thirteen (50%) British women had made arrangements with female kin to help them at the time of birth, eight (31%) women said their husband was taking time off work, and five (19%) British women intended managing on their own.

---

<sup>1</sup> Saifullah-Kahn (1976) examines the features of the Pakistani extended family and speaks of "the close inter-dependent relationships of rights and duties to family and kin".

<sup>2</sup> Dabra is the traditional food given to newly delivered women - for fuller discussion see pages 333-336.

The British women were far more individualistic in their approach to childbirth and seem to lack the deeply entrenched notions of reciprocity and the collective ideology that the Asian women from extended families possess. The working class British women were more likely to have kin in Coventry and tended to have closer family links.

"I haven't got a mother, so my grandmother is going to come and look after the children whilst I'm in hospital. She comes over on average twice a week now. It gives her pleasure and kids adore her...and she does most of our babysitting anyway".

(Case No. 11B, Parity 4 WC)

The notion of reciprocity is not so apparent in these relationships and one British woman paid her sister money for the food her children would need while she was in hospital:

"She's (sister) looking after them when I go into hospital...she asked me 'Did I want her to look after them?' So I just pay her one pound a week till I go to hospital so she'll have enough for the food. I prefer to have her looking after them 'cos she knows them. And it's something to do for her".

(Case No. 13B, Parity 2, WC)

The geographically mobile British women who were not Coventrians by birth, placed less emphasis on help from female kin and more upon their male partner or paid outside agencies:

"I've been basically on my own, but we've managed. But once again, I think for instance, in Germany, you could always get some-one to help for a short period of time".

(Case No. 21B, Parity 2 MC, second baby born in Germany when the woman received paid household assistance)

ii) Lay advice and support during pregnancy and childbirth

Assumptions are often made about the amount of advice and support male partners (usually husbands) give. These assumptions are perhaps most marked in discussions of "joint decision making processes" in the nuclear family setting.<sup>1</sup> There is a tendency to assume that couples living in nuclear families jointly discuss and decide on certain issues in a rational fashion. The previous discussion of family size indicates that the decision to have children is not necessarily mutually agreed upon by both partners, and some children happen along without any discussion (see pages 227-232).

Other literature<sup>2</sup> suggests that the "love" marriage which is dominant in the western world permits couples to enter into relationships which are based on mutual compatibility and a sensitivity towards each others' needs. This literature ignores the unequal basis of the male-female relationship and the tensions inherent in this, and it also fails to recognise the distinct differences between the male public world of production and the female private domestic domain. These differences are important if we are to recognise the extent to which different family members and friends can give advice and support to the

---

<sup>1</sup>See for example Komarovsky (1963) and Wolfe (1962).

<sup>2</sup>Winch (1967) argues that "where the extended family appears to be relatively non-functional and where the functions of the nuclear family also tend toward the low end, love can exist as a criterion for mate selection and its absence as a criterion for marital dissolution". (p.212)

parturient woman. For example, pregnancy and childbirth were, until recently, regarded exclusively as women's concerns. The medicalisation of pregnancy and childbirth legitimates the intervention of male doctors in these areas, and gradually other men have begun to realise that pregnancy and childbirth can be approached in a scientific manner which is tangible to them. Their involvement is often in terms of the "scientific management" of pregnancy and childbirth and how it can best be controlled. Lay male involvement will be discussed further by looking separately at the role of male partners during pregnancy and at the time of birth.

a) Advice and support provided by male partners.

During pregnancy. An analysis of the advice and support male partners give to women when they are pregnant falls clearly into two areas: i) a supportive role where the male reads books, watches television, and discusses the pregnancy and impending birth and ii) a policing role where the male tries to prevent the pregnant woman from engaging in certain activities. Reference was made previously to the male partner "going mad" when the woman engaged in certain household chores. Male partners were also active in trying to prevent women from smoking during pregnancy and determining when they went to the doctor.

i) Supportive males - The kind of support some male partners give during pregnancy can be related to the scientific management of pregnancy and childbirth. Couples learn how to be parents, they

are educated (through the media) about the physiological processes of pregnancy and childbirth. Despite this, there is a low level of involvement of males in formal preparation for parenthood and this is most marked amongst Asian men for whom it is still "women's business". Five (19%) Asian husbands read the books issued to their wives at the clinic, this was not for their own information, but because their wife could not read English. Two (8%) Asian men watched television programmes with their wife, both these couples were expecting their first child and living in a nuclear family. None of the Asian men attended the Parentcraft classes (while three Asian women had done so).

The British men have a slightly higher degree of involvement in formal preparation for parenthood. Four (15%) husbands read books about pregnancy out of their own interest and ten (38%) male partners watched the television programmes. Two men about to become fathers for the first time, went to the fathers' night at the Parentcraft classes and one man went to all three National Childbirth Trust fathers' nights. The first-time fathers were the most involved in the pregnancy and one woman carefully detailed the extent of her husband's support:

"He's been interested all the way through...He's been a good help to me really. I think I'd er freaked out a few times really if it hadn't been for him - especially towards the end like you know ...We've sort of gone through it together, you

know...I mean he's read the books the same as I have...I think he knows more than me sometimes - he's put my mind at rest over a few things... He's not the panicky sort - I am, but he's not - he calms me down. If I was to start in the night, and I started to panic, he'd be the calm one - he'd time the contractions, I wouldn't! There's not much he doesn't know about it you know."

(Case No. 2B, Primipara WC)

This example shows the extent of support one woman received from her male partner during her pregnancy, the couple had "gone through it together", it was a shared experience. However, this was by no means typical of the responses received, and represents the extreme of a continuum ranging from total involvement to complete detachment. At the other end of the scale, is the husband who left his wife without support as soon as she went into labour:

"I went into slow labour about ten thirty in the evening and I just sat down here (living room) all night. I told me husband, you see he's funny like, he didn't know what to do and he went down me mother's in the meantime. And we hadn't got no money like to 'phone up for the ambulance. But when it came to half nine the next morning I told one of the neighbours that I'd gone into labour. They 'phoned up and the ambulance came out. And just as I got into the hospital I had it, you know about half an hour later. And I had to leave Adrian (other child) here (at home) until his (husband's) mother came up and got him".

(Case No. 13B, Parity 2, WC ; recounting her husband's behaviour in her last pregnancy)

Most Asian men fall at the "unsupportive" end of the continuum, to them pregnancy and childbirth are women's business and something not discussed between the sexes. As one woman said when asked if she had spoken to her husband about her pregnancy:

"I haven't spoken to him about anything"  
(Case No. 13A Parity 1, living in nuclear family)

Among the Asians who originated from urban areas there are signs of men becoming more involved in pregnancy. Both the men who watched the television programmes were educated men of urban origin.

ii) The policing role of male partners - The involvement of men in pregnancy gives them access to information which was previously considered exclusively women's knowledge. With this information, men can either become more involved in the pregnancy (out of a genuine interest in the welfare of the pregnant woman), or they may reinforce traditional restrictions on the pregnant woman for the good of their baby.<sup>1</sup> The traditional restrictions such as, lifting, bending and stretching have already been discussed, and it is interesting to note that some British men who were aware of current research into pregnancy used this as evidence for restricting the pregnant woman's activities. One such example, is the medical debate about the effects of smoking during pregnancy. Two first-time pregnant British<sup>2</sup> women claimed their husbands had tried to prevent them from smoking in pregnancy:

---

<sup>1</sup>Earlier (page 262) we saw how four Asian men argued against their wives breastfeeding.

<sup>2</sup>None of the Asian women smoked.

"I think my husband must have gone through every magazine there was, finding every article there was about smoking in pregnancy. He'd plonk it in front of me every night, but it didn't work."

(Case No. 6B, Primipara MC)

"I was smoking that many before (pregnant), but cut down to ten a day. My husband nagged me and you know he says 'Cut down' and I tried".

(Case No. 8B, Primipara MC)

Neither of these women had given up smoking in pregnancy, despite their husband's protestations. They both had reduced the number of cigarettes smoked and they were more likely not to smoke in their husband's presence.

Another instance when the male partner influences the pregnant woman's behaviour, is in her negotiations with members of the medical profession. For example, the father of a previous still born child would brief his wife on what questions to ask when she went to the ante-natal clinic:

"In fact my husband said to me last week when I went down to the ante-natal, he said um 'Well ask them what's going on, are they having you in (to hospital), or aren't they? Ask them this time, if they don't say anything, instead of leaving it nearer the time (birth)'."

(Case No. 23B, Parity 2 MC, previous stillbirth)

Another husband was so annoyed at the way his wife had been spoken to by the GP, he went to see the doctor himself. In this way the husband was mediating between his wife and the doctor:



"But now my GP's allright because my husband gave him, you know, he was mad at him, so now I think he's frightened of my husband coming back,..so he's more polite".

(Case No. 3A, Primipara living in nuclear family)

The role of men in mediating between the private world of women and the public world of the doctors, indicates an assumption held by some men, that is, women cannot possibly negotiate successfully their encounters in the public world. In another piece of research (McKee 1979b), a similar observation is made, for here it is argued that fathers of young babies are far more likely to seek medical care (or insist that the mother does so) than the mother would of her own initiative. The mothers were more likely to consult female relatives and friends before turning to professional advice.

The recent involvement of men in pregnancy and childbirth has been encouraged by some health care professionals as evidenced by the introduction of a "Fathers' Night" to the Parentcraft classes. Observations made at one such evening class reflect some of the attitudes held by men towards their involvement in this women's subject. At the class studied, eight British couples and one British woman on her own attended. They were shown a film of three women giving birth and after this had finished the men were invited to ask questions of the health visitor and midwife in attendance. The men were eager to ask questions and tended to do so in a

joking fashion.<sup>1</sup> The first question asked came from a man who wanted to know when his wife should go into hospital after labour started. The midwife replied that as first labours are usually long there is no immediate rush to get the woman into hospital, and she may as well stay at home where she is comfortable. Hearing this reply another man interjected with "so she can finish painting the house then?" to which the rest of the men laughed. At this juncture another man commented it was now "opening time" indicating that men have more important things to do than discuss childbirth. On a more serious note a man asked:

"Will the hospital staff give my wife help to persevere with breastfeeding?" (Emphasis added)

The midwife responded that she did not like the use of the word persevere in connection with breastfeeding, and of course the woman would be given assistance. A brief discussion then followed in which it became apparent that the men present were in favour of their partners breastfeeding.

After the discussion had ended and people were leaving the hall, one man remarked "And I didn't feel a thing!" implying that childbirth is completely painless. Another man rejoined with "All you have to do now is pray for one that doesn't wake in the night"

---

<sup>1</sup>It is possible to speculate that the men felt uneasy discussing childbirth in the presence of other men and with their partners present and that the joking behaviour was adopted as a means of coping with the situation. See Radcliffe-Browne (1940).

suggesting he hopes for a child which causes the minimum disruption. During the discussion only one man raised a question which was supportive of his wife. All the other comments suggest that men's involvement in pregnancy and childbirth is primarily in their own interests. They want their partners to breastfeed and they think women should be made to persevere in this; they want to know when women should go into hospital in labour so that they can control and determine this, rather than leaving the woman to decide. From the hostile looks exchanged between some partners during the discussion it would appear that some women resent the policing role adopted by their men. Some women also resent the fact that men do not "feel a thing" at the time of birth and this point is referred to in the following section on men's involvement at the actual birth.

#### At birth

The amount of support men partners give at the time of birth varies considerably and can be related to men's perceptions of what birth is about. The more traditional men, particularly those from households with a strict sexual division of labour, tend to view childbirth as women's business, a time of pain and suffering and something which is polluting. Most of the Asian men fall into this category. Only five (19%) Asian women and twelve (46%) British women thought their partner would be with them for the birth. As one woman said:

"Who ever wants to be there!! (laughs) (Emphasis in original)  
(Case No. 19A Parity 5, Muslim)

This statement also reflects the woman's own attitude towards having company at birth. The British women were more explicit in their statements about why they thought men would not attend the birth:

"They (men) think there's going to be a lot of blood and mess".  
(Case No. 23B Parity 2 MC)

"He's (husband) worried about the gruesome bits they see".  
(Case No. 6B Primipara MC)

"He hasn't got the stomach for it".  
(Case No. 10B Parity 3, WC)

These comments express traditional attitudes towards childbirth as polluting or dirty, and the holders of these attitudes refused to attend the birth. (An earlier discussion on pages 309-310 focussed on the polluting aspects of childbirth). The men who held these traditional beliefs were the same men who did not participate in domestic chores, and these couples were the most traditional in their outlook.

Another group of men who did not wish to be present at the birth, but had a more supportive relationship with their partner, were found to be unable to watch the partner suffering. Their perception of childbirth was one of great pain and this was often based on the woman's previous experience:

"He's scared...He was upset because I was having terrible pains for twenty-four hours (in previous birth)"

(Case No. 17A, Parity 1, living in nuclear family)

"I won't ask him to (be present), he suffered much at the first birth, if he sees that some-one is suffering. I think it might have upset him seeing some-one you lovesuffer so much".

(Case No. 10A, Parity 3, husband-doctor)

This last woman said she would not ask her husband to attend because of her previous experience. Several other women were not going to ask their partner to accompany them because they themselves thought it was an unpleasant experience:

"I was in so much pain last time I couldn't speak to anybody. I wouldn't have liked to have thought that he'd saw that really, it would have made him miserable as well. I may as well keep me misery to myself."

(Case No. 18B, Parity 1, MC)

Couples who regard childbirth more positively and those who expected to share all their experiences (whether pleasant or unpleasant) were likely to want to be together at the birth, unless there was some medical complication. These couples were more likely to be expecting their first child. Three out of the four Asian women who expected their husband to attend the birth were primiparous, and seven out of the twelve British women were:

"I asked him whether he would come and he said he would come. I told him that since I'd never experienced it before I might get upset or disturbed, so it would be nice if he was there".

(Case No. 5A Primipara Hindu)

"Yes I'd like him (husband) there...he could be needed for some reason, or he can be asked when I can't understand anything, or simply for confidence and encouragement".

(Case No. 12A Parity 2, living in nuclear family)

"I think it's very beautiful to see your own child being born into the world. And it's a moment that you can't miss really, it's wonderful really. I would like him (husband) again at the birth. He helped me as well tremendously...and he wouldn't want to miss it for the world, he thinks it's great anyway. It's only one moment and I think it's very precious really".

(Case No. 17B, Parity 1, WC)

One woman went so far as to say she would like her husband present at an operative delivery:

"I would like him to be there seeing the birth, even a Caesarian. I don't know why they don't let them watch actually, as long as they're sterile and what have you...I don't think they should let them see them slitting you open, because that would put a lot of men off. Once they've cut you open and they've put all the stuff round you to cover it up, I think they should let them watch it. I don't think there's anything wrong with it".

(Case No. 8B Primipara MC)

Another first time pregnant woman threatened to refuse to have the baby unless her husband was there:

"I've told him (husband) I'm not having it unless he's there...He says he wants to come...I think it's a good experience, I think they enjoy the baby better".

(Case No. 7B Primipara WC)

Unlike the couples from traditional backgrounds who regard childbirth as women's business to be observed only by other women (and men doctors), the couples in sharing relationships expected the men to be present at the birth. One group of particularly independent British women considered the father of the child should be present at the birth. They said men "should see it" so that "they

know what women go through".<sup>1</sup>

"I think it's good for him to see what you go through anyway, 'cos a lot of husband's just take it for granted you know".

(Case No. 20B Parity 1 MC)

"Let's face it - if you just go in, have a baby, and then come out and they see it all bundled up in sheets - they don't see anything that happens you know...Because men have been molly-coddled for so many years. The woman goes through all the pregnancy and the pain, and they don't see any of it you know. There's no wonder men say "Having a baby's nothing".

(Case No. 9B Primipara MC)

The absence, or presence, of the male partner at the birth largely depends on whether the couple have a traditional relationship (where male and female spheres are separate and distinct), or a sharing relationship (where the woman negotiates for her partner's involvement). However, in the last analysis, it is other factors such as hospital policy and the occupation of the man, which determine whether or not the man attends the birth.

The hospital policy is that husbands can accompany women in labour and normal delivery. An unmarried British woman would have liked her boyfriend to be present at the delivery, but the hospital told her it was strictly "husbands only". Moreover, some women found a difference between the hospital policy and reality. For instance, three Asian men had been prevented from attending a previous birth:

---

<sup>1</sup>Cleary and Shepperdson (1979) also make this point; they quote one woman as saying she wanted her husband at the birth "then he'd see what mothers have to go through". (p.6)

"He would like to stay, but the nurse told him to stay out. So he didn't go in."

(Case No. 23A Parity 3 Sikh, living in nuclear family)

British men had also experienced difficulty in attending the delivery, but they were less easily intimidated:

"I know the last time I had a woman in the bed opposite and her husband was there. He came in, you know, and the nurse sent him out. The nurse sent him out and he came back in again. Oh, she didn't like it at all - she sent him out again and he came back in again. He said: 'I'm not missing this one, I missed the last one!' 'Cos they sent him out as well. He wanted to be there".

(Case No. 15B, Parity 1, WC)

Other women were worried their husband would miss the birth because his occupation was such that, either he could not have time off work without giving notice, or, it was manual work which made a wash and change of clothes necessary before attending the hospital:

"It depends on the circumstances - if he's not at work, if he's free then perhaps he'll come. But he can't have time off".

(Case No. 3A Primipara, living in nuclear family)

"He hopes to be there (at the birth) yeah. He probably will, but it all depends on really on um... er..how quick I start and that you know. If he can get there, he'll be there. But I mean he works in cast iron a lot of the time and he's going to have to be clean before he gets there and all that you know. If it works out to be that way he definitely wants to be there".

(Case No. 16B Parity 1 WC, first pregnancy in this marriage)

Only one woman mentioned paternity leave, her husband worked for British Leyland and was entitled to three days leave. None



of the other women thought their partner was entitled to paid leave and some men had been saving their annual leave so they could either attend the birth, or be at home to look after other children. Men in jobs which were less flexible said their attendance at the birth depended on the birth taking place on a certain day. The occupation of the men, whether professional or unskilled, affects their annual leave entitlement and the flexibility of their working day. The social class of the partner is thus another factor which determines his presence, or absence, at the birth.

b) Advice and support provided by female relatives and friends in pregnancy and childbirth

Support and advice for the pregnant woman is not confined to female family members in the same way that assistance with domestic chores is. Any woman who has been pregnant herself feels qualified to give advice and support based on her own experience. Friends of the pregnant woman, and women she meets in the street or at social gatherings are likely to pass comment on her pregnancy and impending birth. Often the comments concern the sex of the child in utero, determined by the way the woman is carrying (see pages 301-303). Close relatives are likely to give the mother-to-be advice on diet (Chapter Six and Seven) and avoidances (page 297). The most common source of this advice was the woman's mother or mother-in-law, seventeen (65%) Asian women and eighteen (70%) British women said they had been given advice

of this nature by their mother or mother-in-law.<sup>1</sup> Fewer women, [two (8%) Asian women and eleven (42%) British women] mentioned receiving advice from their mother about what to expect in labour and at the birth. The women who received this kind of support tended to think their relationship with their mother (or mother-in-law) was unusually good:

"My Mum is very good - according to Indian mothers you can talk dead freely. When we are sitting alone I can talk to her about anything and she will give me advice. I'm proud of her!....You get more frightened listening to other people (about the birth) but if you've got some-one close and they can give you good advice, then you are alright."

(Case No. 3A Primipara, urban origin)

"The first time (pregnancy) I went back and had the baby in the town where my mother was living...My mother, I remember said 'The first sure sign (of labour) is when you get a show, that's the first thing. When you get that, that's when you think about going in'...Certainly it was from my mother that all the back-up and support came after the baby was born - particularly on the physical changes that happened to me".

(Case No. 26B Parity 1 MC)

"She (mother-in-law) is, she's really good. I'm lucky. There aren't many mother-in-laws like that... She told me what to expect like you know (when first pregnant). She was good in that way".

(Case No. 10B, Parity 3, WC)

Although women had spoken to their mother (or mother-in-law) about pregnancy and the birth itself, sometimes they felt they could not rely on the older woman's advice as it related to their experiences in another country or decade:

---

<sup>1</sup>The older women were also seen to restrict the pregnant woman's actions (pages 295-297) and her diet (pages 332-338).

"It's a bit different what she (mother) tells me, she's used to different things (in Uganda)".

(Case No. 3A Primipara, Ugandan Asian)

"I get on very well with my mother, we sort of talk about things and that. But she's forgotten, thirty years ago things were sort of different".

(Case No. 24B Parity 2 MC)

Implicit in what some women said about their mother or mother-in-law's advice, was the idea that childbirth had changed from a painful natural event to being a potentially pathological condition involving high technology medicine:

"I think my Mum, she's in her sixties, and I think that then it was just a natural thing and they didn't have all this advice anyway".

(Case No. 9B Primipara MC)

"If they (mother and mother-in-law) get on talking, it's more about what it was like when they had their children, you know. Well it's a lot easier now, or sounds a lot easier, obviously you know we've advanced a lot more and they know an awful lot more".

(Case No. 6B Primipara MC)

"Me mother was a nurse you see, and I used to sit for hours talking to her...but you can't rely on her advice, everything's different now, the drugs are different...it's changed that much since she was a nurse".

(Case No. 18B Parity 1, MC)

These women accepted that pregnancy and childbirth are treated differently now from when their mothers (or mothers-in-law) gave birth, yet at the same time they respected the older woman's knowledge. Some of the British middle class women though, considered the older woman's information so out of date they would not listen to her advice:

"My mother-in-law and I have very different opinions about babies. I tend to go more by the modern approach and read books about different things, whereas she's going by old fashioned things...I'm not that close to her really".

(Case No. 24B Parity 2 MC)

"She (mother) knows I'm a bit of a know-all, so there's no point telling me. She'll just say look after yourself....but I don't think she would presume to give me advice".

(Case No. 21B, Parity 1 MC)

Comments such as these reflect tensions between family members of different generations. The British middle class independent women most commonly expressed differences of opinion with older female relatives. The younger women felt they knew all there was to know about pregnancy and childbirth and the older woman was "interfering":

"They're both very similar (mother and mother-in-law) ....they don't like to interfere. They've not said a word".

(Case No. 20B, Parity 1 MC)

"I've got a fairly forceful character underneath it all and sometimes I like to think I know it all...She (mother-in-law) gives me more advice, more advice than my mother. And she has tended to say things....which go against the grain".

(Case No. 19B, Parity 1 MC)

The majority of Asian women on the other hand, recognised certain constraints which prevented them from discussing pregnancy and childbirth with older women, particularly their mothers-in-law. Certain topics such as menstruation, sex education, pregnancy, and childbirth are not openly discussed between women of different generations in the same household (see earlier discussion pages 238-249). The Asian women thus feel shy about discussing pregnancy with these women:

"I stayed with my mother-in-law one year in India (when first pregnant). I used to be very shy then. Also it's the kind of relationship that makes it like that".

(Case No. 22A, Parity 2, Sikh now living in nuclear family)

"She's (mother-in-law) so shy, so I don't ask her anything".

(Case No. 11A, Parity 1, living in extended family)

"I feel shy talking to her (mother-in-law)".

(Case No. 1A, Primipara living in extended family)

Educated women originating from urban areas tend to have much freer relations with their mother, although their relationship with their mother-in-law may be constrained by the newcomer status of the daughter-in-law.<sup>1</sup>

The tremendous changes in the management (sic) of pregnancy and childbirth in Britain over the last thirty years, coupled with the constraints evident in some mother-daughter (or daughter-in-law) relationships, are contributing factors to the popularity of female contemporaries as sources of advice and support. The Asian women were most likely to draw on the experience of their sister or sister-in-law (if they lived nearby) (seven women - 27%), and the British women were more dependent on their friends (nine women - 35%).

"Our jait (husband's elder brother) and jathani (his wife) live next door in number sixty-one. When my daughter was born I went to their place. She is my būa (father's sister-in-law) also she told me what to expect."

(Case No. 16A, Parity 1 living in nuclear family)

---

<sup>1</sup> Saifullah Khan (1976) examines the tenuousness of the daughter-in-law's status. (p.239)

"My jathani (sister-in-law) and būa (father's sister-in-law) tell me whatever I ask them, when to go (to the hospital in labour), what to do. They told me what would happen, but I still feel scared".

(Case No. 2A Primipara, living in extended family)

The British women who were Coventrians and had sisters living in Coventry were likely to discuss the progress of their pregnancy with them:

"My sister's got three kids and we talk about it (pregnancy) a lot - all our complaints you know!.."

(Case No. 21B, Parity 2, MC)

"I've talked to my sister a lot, and asked her all about it".

(Case No. 2B Primipara WC)

The British women with no female relatives of their own living nearby, tend to rely more on the experience of previously pregnant friends:

"My friend's just had a baby and if I think there's something wrong I'll be on the 'phone or I'll be round there. She's been very helpful. She says she wishes she'd had somebody that had gone through the same thing to ask about".

(Case No. 9B Primipara MC)

"Both **neighbours** and my friend lives just up the road - they've all had babies....With my friend we do talk and pass remarks about, well, when I was carrying my daughter we'd pass remarks about what happened to each of us, so we could get a good idea".

(Case No. 14B, Parity 1 WC)

The more independent British middle class women (those who rejected the advice of their mother or mother-in-law) were most dependent on advice from professional sources, and some of these women had friends or relatives who were professional people:

"As to information I've obtained it mainly through my sister-in-law, because she's a health visitor. And I was very fortunate, any queries and I would go to her".

(Case No. 20B, Parity 1 MC)

"I've two friends, one is a district nurse who's across the road here, and the other is um, a girl who is a midwife. And they've both said if you need any help at any time to ring them up".

(Case No. 26B, Parity 1 MC)

These independent middle class women with access to professional sources of advice can be contrasted with the four (15%) Asian women who did not have relatives in this country. These women are not in a position to call on professional advice and the support they receive is limited, as the following two examples show:

"I don't have any relatives, but I ask any siyana (old wise women) living in our street.

Q. Is there anybody nearby?

R. Yes in number seventeen.

Q. What does she tell you?

R. Just that you should have things that give you strength (energy) after the delivery - things like sundh (ginger). She also says what will happen (at the birth)."

(Case No. 22A, Parity 2 living in nuclear family)

"I don't have any relatives in this country.

Q. Who helped when your children were born?

R. God helped me, who else?"

(Case No. 19A, Parity 5, Muslim living in nuclear family)

This last woman interpreted the question about domestic assistance at the time of birth as one about support. Her answer reflects her belief in a much wider support-system, that of the Muslim religion (see page 210 for discussion of religion).

Other sources of information the women cited were Parentcraft classes, literature and television programmes. These will now be looked at in turn.

FURTHER SOURCES OF SUPPORT AND ADVICE

1. Parentcraft classes

The content of these classes and the perspective of teachers was discussed earlier (pages 498-504). What follows is an account of which women attended the classes and their perceptions of them.

a) Attendance at classes - By the time of the final interview four (15%) Asian women and fifteen (58%) British women had attended Parentcraft classes in this, or a previous pregnancy (see Table XV, p.190). Despite the variance in attendance rate, there is one similarity which pertains to both groups of women. This similarity is that primiparous women of both samples are more likely to attend than multiparous women. One third of Asian primiparae and two thirds of British primiparae attended Parentcraft classes. All three Asian primiparous women were educated and could speak English, while the multiparous Asian woman who went to classes in her previous pregnancy had a limited knowledge of English.

The British multiparous women's attendance at classes was closely associated with the woman's length of education.<sup>1</sup> All the British women who were educated beyond age sixteen attended

---

<sup>1</sup>Rathbone (1973) also makes this observation when she claims that length of education is the most significant factor affecting attendance at Parentcraft classes (p.8).



Parentcraft (or NCT) classes in this, or a previous pregnancy. For the primiparous women, this correlation does not hold, and five out of the six primiparous British women who attended Parentcraft classes left school at age sixteen or younger. The higher rate of attendance by primiparous British women with minimum **secondary** education can in part be attributed to a recent attempt by health care workers to attract all first-time British mothers to their classes.

At the time of study, the particular language problems of Asian women were not considered and eleven (42%) Asian women did not attend the classes because of language problems.<sup>1</sup> Other reasons women gave for not attending the classes are detailed below.

i. Reasons women gave for not attending Parentcraft classes -

Women who did not attend the classes gave several reasons for this: i) they were not told about the classes; ii) did not want to go, or advised not to; iii) no spare time, or difficulty with other children; iv) transport problems; and v) they felt they were unnecessary as they had attended classes in a previous pregnancy, or they felt confident without attending.

Five (19%) Asian and three (11%) British women had not been informed of the classes:

"The doctor never told me I should be attending such classes"

(Case No. 7A Primipara non-English speaking)

---

<sup>1</sup> Without taking account of cultural differences it is possible that these classes would be inappropriate even if an interpreter was present.

"No one ever mentioned relaxation classes to me  
...No-one at the clinic told me, nor my GP".  
(Case No. 20B, Parity 1 MC)

Two Asian (8%) and two British (8%) women did not want to go  
to classes or they were advised not to:

"The nurse told me about these classes where you are  
shown how to change the nappies and how to feed the  
baby, but I don't want to go".  
(Case No. 20A, Parity 3, little English)

"The other week I asked him (GP) about breathing  
lessons, you know. And he says that I didn't need  
to go 'It's only the girls that are, that  
we think are going to panic when they're having the  
baby', he says. But he says 'You're a calm person,  
you don't really need to go'."  
(Case No. 8B Primipera MC)

These two examples illustrate what some women were told about  
the classes by health care professionals. The Asian woman  
decided not to go as she was told they were specifically to do  
with care of the baby - an area she felt competent in as  
she already had three children. The latter example indicates  
that the woman's doctor felt the classes were geared to women  
who were in some way inadequate.

Seven (27%) Asian and eight (31%) British women said they did  
not have time to attend classes, or there were problems with  
child care:

"About going (to classes) there is always the problem  
with leaving the children behind. I want to go, but  
I can't because I have to look after the children".  
(Case No. 14A, Parity 4 living in nuclear family)

"The trouble is, with me going to the midwife and hospital, if I've got to go down (to clinic) another day, my week's going to be filled in...you're supposed to be resting, but they have you running around everywhere".

(Case No. 18B, Parity 1 MC)

"I would have liked to have gone, but with moving and having the children off school on holiday - there's no time I can go, morning or afternoon, I just can't go".

(Case No. 21B, Parity 2 MC)

One (4%) Asian and eight (31%) British women felt the classes were unnecessary because they had attended them in a previous pregnancy. A further four (15%) British women said they knew about pregnancy and childbirth from their own experience:

"I went to those (classes) when I was carrying Rachel, but I didn't bother again....I think they're very good for your first baby, but I never thought it was worthwhile going back".

(Case No. 17B, Parity 1 WC)

ii) Source of information about classes - The main source of information about the classes was the midwife at the booking-in session (first ante-natal clinic visit). Friends and posters were the other two sources of information cited:

"The midwife at hospital told me about them when I'd seen her the first time. That's when she put me down to go and what time to be there".

(Case No. 3B Primipara WC)

"There was a notice in the Cov and Warwick hospital clinic about these classes and also when I was booked-in I was told that these classes were recommended for first time pregnant women".

(Case No. 4B Primipara WC)

- iii) Reasons given for attendance at classes - The women gave two principal reasons why they attended the classes:
- i) to be better informed, so they would know what to expect, and
  - ii) as a social event.

It was only primiparous women who attended classes so they would "know what to expect":

"They're (classes) a couple of hours...and um I'm at the end of the course and they've got to the stage where the baby has just been born....and how you feel in hospital and what happens to you while you're in there. And it was very interesting and it puts you in the light, you know what to expect."  
(Case No. 6B Primipara MC)

"They (midwives and health visitors) tell us it's nothing to worry about (childbirth). They took us around Walsgrave to show us around. I think that was quite helpful. I feel confident more".  
(Case No. 3A Primipara, educated English speaking)

The social aspect of the classes was also mentioned by women in their first pregnancy and those who had recently given up paid employment outside the home:

"It is useful (to go to classes) to get out of the house, a little walk and a little fresh air and exercise. And meeting other people helps to pick up English".  
(Case No. 5A Primipara, educated, little English)

"I've made a lot of friends through going to these classes".  
(Case No. 1B, Primipara WC)

"I went simply to get myself out of the house you know...I really went to kill time".  
(Case No. 25B, Parity 1 MC - speaking of first pregnancy)

b) Women's perceptions of classes - What the women thought of the classes and the amount of knowledge they gained from them, was very closely related to their existing knowledge and experience of pregnancy and childbirth. Thus first-time pregnant women with little experience of motherhood, found the classes most useful (and this applies particularly to the educated English speaking Asian women who attended):

"No Indians go to that class, but I go every Tuesday....they make you do exercises, tell you what to eat and what not to eat, what happens, not to worry - they also show films".

(Case No. 3A Primipara, educated - English speaking)

"I think it is quite helpful going to the relaxation because there are some things which you wouldn't know before.....They told us about diet and about resting and things like that...And for every week we have to discuss different things".

(Case No. 5A, Primipara, educated - little English)

Primiparous British women with friends who had recently become mothers found the classes less useful and relied heavily on friend's experience:

"The other things, like making foods and changing nappies, you learn anyway. But I think they are useful for some people...I don't think I've learnt anything I didn't already know, um, possibly because as I say my best friend's just had a baby and I see her all the time and I see everything she does".

(Case No. 9B, Primipara MC)

Generally, the British women's reaction to the classes was mixed and depended on her previous experience and social class. Their reactions vary from at one extreme,

teaching the woman "everything about mothercraft" to,  
at the other extreme, being "an awful waste of time":

"I learnt everything about mothercraft, all the different aspects of babies. And they were very helpful".

(Case No. 17B, Parity 1 WC, recalling the classes attended in first pregnancy)

"I thought they were an awful waste of time....I found them an awful load - very ill prepared talks and um, I didn't find them that much use at all actually. A couple of odd things were quite useful, like a demonstration of bathing the baby, which does seem quite elementary, but really is quite tricky if you do it for the first time - a small wet baby".

(Case No. 25B, Parity 1 MC - teacher recalling classes attended in first pregnancy)

## 2) Literature

i) Clinic books - The content of the first booklet has already been discussed (see pages 504-512) and it is proposed here to look at the extent to which the women used these booklets, and their reasons for doing (or not doing) so.

a) Women who used the clinic booklet - Fourteen (54%)

Asian and twenty-two (84%) British women used the booklet issued at the clinic (see Table LIX).

Twelve (46%) Asian women said they could not read and therefore did not use the booklets:

"I can't read English books, only Punjabi. I've not seen any books in Punjabi".

(Case No. 2A, Primipara Sikh)

TABLE LIX

RESPONDENTS' USE OF CLINIC BOOKLET  
DURING PREGNANCY

Final sample	Asian		British		Total	
	No.	%	No.	%	No.	%
Could not read	12	46			12	23
Books read to woman	6	23			6	11.5
Booklet useful	8	31	8	31	16	31
Booklet inadequate <sup>1</sup>			14	53	14	26.5
Could not understand booklet			2	8	2	4
Booklets not issued			2	8	2	4
<u>Total</u>	<u>26</u>	<u>100</u>	<u>26</u>	<u>100</u>	<u>52</u>	<u>100</u>

<sup>1</sup>Twelve (46%) British women used literature other than clinic books. One (4%) Asian woman read additional literature.

Another six (23%) Asian women could not read, but some-one read the booklet to them. Five (19%) women had the books read to them by their husband and one (4%) woman had assistance from her sister:

"Yes he (husband) does read them loudly to me sometimes.  
(laughs)"

(Case No. 7A, Primipara Sikh)

Two multiparous British women were not given the booklets at their first clinic appointment, and assumed they were only given to first-time pregnant women. Another two British women said they had tried to read the booklets but found them difficult to understand. Both these women were working class:

"I don't really take much notice of them, I just look at 'em...I probably just get to about the third page. I don't really understand 'em. I can't understand the long words..."

(Case No. 13B, Parity 2, WC)

Primiparous women tended to use the clinic booklets more than the women with previous experience. The books provided a useful guideline for the inexperienced mother-to-be:

"The first time you don't know anything - you can come to know by reading them. But I've had no experience..."

(Case No. 5A, Primipara, educated Brahmin)

"Yes, I think they've (clinic books) been helpful because I think as I say you know, being your first you don't really know what to expect. And it's helped me as I've gone along in each stage you know. I've more or less, anything that's gone on, I've known there and then by reading the book that it's alright, that's everything's going fine like you know. I've been quite pleased with them".

(Case No. 2B, Primipara WC)

The multiparous women often recognised a discrepancy between the information provided in the clinic literature and their own experience. They were much less dependent on the clinic booklets in their second and subsequent pregnancies. One Asian woman in her sixth pregnancy was asked if she found the booklets and said:

"I don't know, when you've had a child once, you know by yourself. Only the first time is a problem".

(Case No. 14A, Parity 4, Sikh)

A British woman responded in a similar fashion:

"The clinic books are very good for first time pregnancy. But the second time around you do it your own way - it's the same as with typing, you spend two years being taught how to do it, but once you get a job, you do it your way". (Emphasis in original)

(Case No. 20B, Parity 1, MC)



This woman viewed the literature as an instruction book, but once she had gained experience she felt these instructions were no longer necessary.

Eight (31%) women who had been pregnant before, were annoyed because the same booklets were given in each pregnancy. The women with substantial time differences between their pregnancies were amazed the booklets had not been changed to include the more recent innovations in childbirth:

"The books were the same as my other pregnancy. No different."

(Case No. 17A, Parity 1, Sikh)

"The book is the identical book which I was given when I was first pregnant five years ago - absolutely identical. A different format, a different cover and different advertisements, but it's the same book. It tells you exactly the same things".

(Case No. 26B, Parity 1, MC)

"They are the same books with a different cover. I said 'Good grief! Surely something must have changed'. It was the same knitting patterns and the same letters".

(Case No. 10B, Parity 3, WC)

Other experienced women considered the information contained in the booklets to be "nothing like the real thing" :

"I sat down and read them and had a good laugh because it was nothing like the real thing".

(Case No. 11B, Parity 4, WC)

"I read some things in those books and I think it's just too ridiculous for words!"

(Case No. 21B, Parity 2, MC)

b) Information gained from the booklet - The sixteen women who found the booklets useful, mentioned different aspects of the booklets which were helpful to them. The most frequently mentioned topics which women had learnt about from the booklets were - diet in pregnancy, discomforts in pregnancy, exercises to prepare for the birth, what to take into hospital, what to buy for the baby, and how to look after the baby once it was born. Two Asian women, educated in Britain and not living in an extended household, found the information in the booklet on diet was useful:

"I learnt about the food, from which things you can get the vitamins and what you should eat during pregnancy, what your body requires".

(Case No. 3A, Primipara, educated)

The British women used the clinic booklets mainly for information about what to take into hospital with them:

"It's (book) been more useful in that I couldn't remember what I should take into hospital".

(Case No. 19B, Parity 1, MC)

However, some British women were very critical of the information contained in the booklet, particularly the section referring to the baby's layette

"What they tell you there (books) some of the things are stupid you know. I mean um..about the clothes - this business of you should get two vests, and two this and that - that to me is silly. Why tell a woman what to get, obviously she knows what she's got to get. Well I mean what good's two cardigans to you, you're going to be washing every day - washing one while they've got one on. Well that's stupid you know".

(Case No. 8B, Primipara MC, looked after younger sister when she was a baby)

"I think it (book) tends to be very misleading, very misleading in terms of advising women what to get for babies. They don't seem to take into account the fact that if you have a baby in July you do tend to need different things".

(Case No. 26B, Parity 1 MC)

Another British woman who was disappointed with the content of the clinic booklets used them mainly as a source of information about new baby products and obtaining free samples:

"Oh yes I gave that one (clinic book) to Sandra (daughter) I found that there wasn't enough information in it for me really...I used the clinic books mainly for 7p off vouchers and I also sent for - in the back of the book it's got a reader's service and I ticked a few of those just to see if I could get some free samples. I didn't get much".

(Case No. 22B, Parity 1 MC)

The women who found the booklets most useful were - primiparous women, Asian women able to read English (or who had a relative who was prepared to read it to them) and some British working class women who did not have access to other literature. Only ~~the~~ educated Asian woman married to a doctor had seen other literature on pregnancy.

c) Other sources of literature used - Twelve (46%) British women and one (4%) Asian woman used literature in addition to that provided by the clinic. Nine of the British women who consulted other books were middle class and three of them were working class. The main reason for consulting additional books was because the women thought the clinic books were too superficial.

A total of eighteen different books and leaflets were used by the women<sup>1</sup> and one woman mentioned using four different books:

"Clinic books - they don't give much information, so I've read quite a selection of er...um...some I've got from the NCT (National Childbirth Trust) and various leaflets...I can't remember where I got them from now - I've borrowed them from people and bought them".  
(Case No. 24B, Parity 2 MC)

"Well I looked through those (clinic books) - I didn't find them, well they don't go into great detail - everything was in just small paragraphs or just a short chapter. I didn't find them all that interesting. I went out and bought some".  
(Case No. 19B, Parity 1 MC)

Not all of the women who used alternative sources of information went to such lengths, they were more likely to seek other literature if they had a specific concern, or interest, for example, breastfeeding or complications in a previous delivery:

"Well I got a book on breastfeeding.....which is very interesting actually, very good".  
(Case No. 25B, Parity 1 MC)

"Since I've had Sandra (daughter) I've had several books from the library...I used them because of complications in pregnancy and also all through her first year".  
(Case No. 22B, Parity 1 MC)

The British working class women who read literature other than the clinic booklets, often read leaflets they were given and/or magazines:

"Well I've had some (leaflets) from Boots and some my friend gave me".  
(Case No. 16B, Parity 1 WC)

---

<sup>1</sup>These included Llewellyn-Jones (1978); Rayner (1973) Wright (1968); Flanagan (1963) and articles in Readers Digest; Family Circle; Parents; Loving and Living; Boots Baby Book; Bounty Book and NCT leaflets.

"'Family Circle', you know, I've had 'Family Circle' and um...'Parents' - I've had a couple of those while I was in hospital as well. And I looked through them you know".

(Case No. 2B, Primipara WC)

The women's use of the clinic booklets was closely related to their length of education and their previous pregnancy experience. The first-time pregnant woman who has been educated over the age of sixteen in the case of British women, or educated to be able to read English in the case of Asian women, is most likely to use the clinic books. Asian and British women with a low level of formal education and British middle class women who have been pregnant before, are the least likely to gain information from the clinic books.

### 3. Television programmes on pregnancy and childbirth

At the time of study there were two series on the television about pregnancy and childbirth. The women were asked at their first interview if they had seen any of these programmes (or any previous programmes on pregnancy). In the final sample, eighteen (69%) Asian women and twenty-three (88%) British women had seen at least one television programme on pregnancy. Seven (27%) Asian women who had not seen a television programme did not possess a television and the other woman said she was too busy to watch television. Two (8%) British women were working at the time of their first interview and gave this as their reason for not watching the programmes, the other woman said she

did not have time to watch television because her young child was too demanding. Whether the women thought the programmes were of any help to them, or caused them concern is detailed in Table LX.

The high rate of viewing in this study (the York study reports 68% of their sample watching television programmes on childbearing and parenthood - Graham and McKee 1979) can in part be attributed to one of the programmes being filmed in Coventry. The British women in particular said they had watched these programmes initially to see if any-one they knew was "on". However once the attraction of trying to spot a known face was over, some women did not view on a regular basis. Three (11%) British women expressed annoyance at the ATV programmes which were filmed in Coventry because they were "nothing like the real thing". One of the consultants featured in a programme and several women remarked that he never spoke to them like he did in the programme. Moreover, the filming of ante-natal patients was not done in the ante-natal clinic but in a spacious and plush empty clinic. Given that the clinic the women attended was over-crowded and sparsely furnished, the women watching the programme were annoyed the "real" conditions were not portrayed. The scenes from the maternity ward were also "mocked", an empty ward being used.

At the time of the second interview, ten (38%) Asian women and eighteen (69%) British women said they had watched the programmes on a regular basis. The BBC 2 programme was repeated on a Sunday, so there were three occasions when the programmes

could be viewed. Despite the availability of programmes at the time of the study, twelve women (23%) (Asian and British) gave valid reasons for not watching the programmes.

a) Reasons for not watching the television programmes -

Three main reasons were presented by the women for not watching the programmes: i) the presence of some-one else in the house; ii) not enough time, or the programmes on at "the wrong time of day"; iii) the programmes caused the women to worry.

- i) One Asian women and three British women mentioned not watching the programmes on pregnancy and childbirth because there were other people in the house who did not want to watch the programmes. An Asian woman said she could not watch these programmes when her husband was around and two British women made similar comments:

"But when there's anybody about like my husband or his uncle - his uncle does come up now and again - I never bother (watching the programmes). He doesn't like looking at them".

(Case No. 13B, Parity 2 WC)

"I thought it a bit degrading for anybody to watch, 'cos it isn't all very nice at all. I think they should have put the programmes on in the day time really, so if the mother's at home it's up to her...I can't watch them with him (husband) around".

(Case No. 17B, Parity 2 WC)

Working women who did not have the opportunity to watch the programmes in the week, found the programme on Sunday at lunch time was at an inconvenient hour if they had visitors:

"I've missed them because I'd either got people here, or they were on the nights I teach....Sunday lunch time was ideal for me in lots of respects, but once or twice I had um... like my grandmother came and I didn't want to watch it when she was here particularly. Not from any sort of prudish attitude, but I just felt that she wouldn't have been interested. So we didn't have it on. And once my neighbour's child who is eight was here, and I didn't know whether I ought to have it on because I thought if there's anything in it, she might go rushing home to mother and I might cause her all sorts of embarrassments for her mother".

(Case No. 19B, Parity 1 MC)

Underlying what these women said is the notion that the programmes might have "something" in them, or they are not "very nice", thus reflecting the woman's own attitude towards childbirth as well as that of her family members. Implicit in the statements of some women was the belief that childbirth was "women's business" and should not be shown to others:

"It's good for us (women) to see it, but it's perhaps a bit off-putting for any-one else".

(Case No. 18B, Parity 1 MC)

ii) Three women (one Asian and two British) said they were too busy to watch the programmes. These were all women with other young children:

"I haven't had chance really (to watch programmes), I don't really watch much television now with Rebecca (daughter)".

(Case No. 15B, Parity 1 WC)



"They're (programmes) all at such funny times, there's one on at 7 o'clock in the evening when I'm putting the children to bed, or Sunday lunch times!"

(Case No. 21B, Parity 2 MC)

iii) The most often cited reason the women gave for not watching programmes on pregnancy was that the programmes sometimes worried them. Thirteen women (six Asian and seven British) said they had been worried by one of the programmes they watched and had not looked at them since:

"I saw one but it made me sick. I didn't like it."

(Case No. 10A, Parity 2 - urban educated)

"I watched a few at first, I haven't seen any for a while...we got as far as where they started talking about abnormalities and that and we didn't watch any more...I just didn't want to take that into consideration at that time".

(Case No. 5B, Primipara WC)

All the British women who had been worried by the programmes to the extent that they did not continue to watch, were working class women. The British middle class women also mentioned being worried by some of the programmes, but their interest in the latest techniques used in childbirth was greater than their concern over the subject matter of the programme, and they continued to view:

"I remember when I was having my daughter I saw a programme on Caesarians and I thought 'My God, if ever that was to happen to me, I'd die! The thought actually turned my stomach. It frightened me, but then again it's something that does happen, you've got to accept the fact whether you want to or not. You've no choice".

(Case No. 19B, Parity 1 MC)

This woman felt she had no choice over which medical techniques were used and would rather therefore be informed about these techniques so she would at least know what to expect. Women who were uninformed about pregnancy and childbirth and wanted to know more, gained most from the television programmes.

b) Women who found the programmes useful - All the first-time pregnant Asian women with access to a television (i.e. seven out of nine) watched the programmes and found them useful. These women found the television programmes provided them with information they did not know before, for example, how the baby is born and where the baby comes from:

"One gets quite well informed...You come to know how the delivery happens, how it starts, how it happens". (Emphasis added)

(Case No. 6A, Primipara - non English speaking)

"You come to know about things - where the baby comes from". (Emphasis added)

(Case No. 9A, Primipara - non English speaking)

"You come to know how the baby is born". (Emphasis added)

(Case No. 2A, Primipara - non English speaking)

Whether or not the Asian women spoke English did not seem to deter them from watching the television programmes on childbirth - the visual message was clear enough for them to gain information. As one Asian woman in her second pregnancy said:

"Yes they (programmes) are good because there is no-one else to tell women about these things".

(Case No. 13A, Parity 1, little English)

This woman did not mean there was a shortage of people to speak to, but that the subject matter was not something openly discussed (see pages 235-250).

Primiparous British women also expressed similar sentiments, although some of these women had spoken to friends and older female relatives about childbirth and had an idea of what to expect. Most women admitted this knowledge was limited and said it was not until they saw a delivery on television that they knew "what actually happens", thereby questioning the information previously received:

"There's been a lot more on just recently about childbirth, which I think is a good thing...It's good to see what actually happens you know, and I mean they've sort of had different births and they've showed you a messy birth and a clean birth, you know. 'Cos you know some people have a clean birth and they think 'Oh everybody's birth's like that' - then they tell you and you may find your's is completely different". (Emphasis added)  
(Case No. 8B, Primipara MC)

"But I thought they (programmes) were very good. I thought they brought it home a bit more to you, you know, a bit more helpful than some of the horror stories you hear."

(Case No. 2B, Primipara WC)

Multiparous women who knew what to expect, were less likely to be interested in programmes of the actual birth:

"The programmes might have helped in my first pregnancy, but there weren't any programmes then.. Once you've had one you know what to do".

(Case No. 14B, Parity 1 WC)

They were, however, interested in finding out about the latest equipment being used in the hospital:

"I saw quite a few of those (programmes)...they were very explanatory. Not only that, they showed you most of the deliveries. They showed you a Caesarian with epidural, which I thought was absolutely marvellous. I didn't even know you could have a Caesarian with epidural. I thought that was marvellous because there again you're getting that mother-baby relationship straight away".

(Case No. 11B, Parity 4, WC)

For many of the women the television programmes had the effect of raising their expectations to a level the local hospital could not always meet (as the following discussion shows).

c) Television as a medium for raising women's expectations about hospital practice - Both Asian and British women used the television as a means of finding out more about current obstetric practice. The first-time pregnant woman with no previous experience often expected to have a choice at the time of delivery over the use of high technology medicine, for example, epidural analgesia:

"They've shown me how if it's too painful they give you an injection so you won't know how the baby is born. I think I might like that".

(Case No. 4A, Primipara - English speaking)

Multiparous women also said they would like to use the latest innovations for pain relief in childbirth:

"There was something on quite a while ago, er... when I turned on to one of the stations, where they did show you where they were just putting the needle into the woman's back. And I thought 'Oh I wouldn't fancy that you know'. But when I thought about this epidural I thought it would be nice to have it, without any pain"

(Case No. 10B, Parity 3 WC)

Or for detecting abnormalities in the foetus in early pregnancy:

"I didn't know about this amniocentesis until I saw that on the television...It didn't go into any great explanation did it, about how the woman who had had that test had had her first child aborted, because the head or something, or some part of it was malforming? And um...I hadn't actually realised that they could tell that or do that and I thought that's - well if you were very bothered - it's good, because I think this is the worry behind most women, isn't it?"

(Case No. 19B, Parity 1 MC)

Only one woman mentioned that she did not think the techniques she had seen on television were available to all women:

"And there was one programme, and I think this doctor was American or German. But it was about his ideas of birth - where it should be in a dark room, dimmed room...I don't suppose any of you get that! It's not generally done".

(Case No. 6B, Primipara MC)

The programmes increased women's awareness of high technology medicine and for a few women, the programmes answered specific problems the women had (about a previous miscarriage, still-birth or breech presentation). Four (15%) British women were disappointed when they missed a particular programme they wanted to see:

"Apparently there was one about some-one who had a still-born, and I missed that. I would have liked to have seen that, to see what happened there".

(Case No. 23B, Parity 2, MC - previous still birth)

"I saw quite a few, the one I missed, I wanted to see the breech one and I missed that one".

(Case No. 22B, Parity 1 MC, previous breech presentation)

One British woman found the programmes made her more critical of the British health services as she had not realised how they compared with other western countries:

"On television they say that we are so far behind the other countries as far as preventing anything that's wrong. Well anything - babies born mentally handicapped, they say there's far more here (Britain) than a lot of other countries".

(Case No. 9B, Primipara MC)

The raising of women's expectations through the medium of television tends to make the women more critical of the services offered. One British woman compared the presentation of information on the television with the local Parentcraft classes. She said:

"They've worked out how to tell you in television. Like the midwife at classes, she cr...she'll be in the middle of saying something and forget what she's saying. She does tell you things that help, but watching television they explain it better".

(Case No. 3B, Primipara, WC)

The television programmes were a greater source of information for all women who had access to a set than either the literature issued at the ante-natal clinic, or Parentcraft classes. Although television was the most popular medium for

gaining information, there were criticisms about some of the programmes. However, the women studied were certainly more critical of one series of programmes on pregnancy and childbirth than the other.

d) Differences between the programmes watched - Only the British women made distinctions between the two series of programmes being shown at the time of the study. The series on ATV (which was filmed partly in Coventry and at Charing Cross hospital) was specifically aimed at an audience:

"With a minimum of formal education and not usually involved with adult education schemes, nor using libraries or books generally".

(p.1 ATV publicity sheet for programme "All About Babies")

However, both women who had been educated beyond the age of sixteen and those who had left school before age sixteen, found the programmes superficial and "gimmicky":

"Yes I saw odd ones here and there, but I found them so stupid for words. They were pathetic, absolutely stupid. I mean, the level of intelligence they must think we've got is zero!"

(Case No. 11B, Parity 4 WC, left school age fifteen)

"I never watch that. I wouldn't continue to watch it. I did watch the first one or two and then - well, I think it's an insult to your mentality".

(Case No. 20B, Parity 1 MC, terminal education age twenty)

Despite being unimpressed with the programmes, two women continued to watch because the local hospital was used:

"I didn't think they were very good at all. I only watched about two, I thought they were terrible! It was very garbly...I didn't understand what they were trying to put over...Some people I know watched them because Walsgrave was on".

(Case No. 22B, Parity 1 MC, terminal education age twenty)

It was the series on BBC 2 "Having a Baby" which was most popular with the British women (and this was the only series the Asian women mentioned by name):

"I watch 'Having a Baby' on Sundays and Thursdays. I've seen one about epidurals where they showed what they did. And there was one where they showed the Health Visitor after birth and everything".

(Case No. 4B, Primipara WC, terminal education age sixteen)

"It's very good the BBC 2 one - they showed you the Caesarian operation last week...and they did some very interesting programmes at the beginning on abnormalities...I found them very interesting and reassuring".

(Case No. 20B, Parity 1 MC, terminal education age twenty-one)

All the women with access to a television (i.e. 85% of women), found the programmes an acceptable independent source of information. The visual message was clear for women who could not understand English.

It is difficult to isolate one source of information as more appropriate than the others, although information which requires a certain reading ability or transportation to classes, is more applicable to educated, mobile women. Often the women were reluctant to isolate one source of information as all important, as they saw their knowledge deriving from several sources.



DIVERSITY OF INFORMATION

British women mentioned gaining information from many diverse sources, assimilating this knowledge and then making their "own mind up":

"I think you tend to build up your knowledge, you get it from all sides. You hear everybody's point of view, you get all the information from the booklets, you pick up bits and pieces from people, then you say to yourself 'Right, now I've heard all that, I've read all that, now I'm going to make my own mind up".

(Case No. 19B, Parity 1 MC)

Experience also constituted an essential part of their knowledge:

"Well I don't know really, I think it's sort of come together through everybody...In hospital ...you'd get mothers sort of one end and ante-natal up the other, and we all used to meet together for dinner. And you sort of listened and picked up bits and pieces....Since I've been pregnant everybody's helped. As I say, family wise they've all helped in that way you know, by trying to put my mind at rest".

(Case No. 2B, Primipara WC)

The Asian women were more limited in the number of sources of advice available to them. This can be related to language problems, lack of friends with professional expertise and a greater dependency on traditional familial advice.

As was indicated in the previous Chapter, women who combined knowledge with experience had confidence to challenge medical decisions. One British woman hospitalised ante-natally for high blood pressure in her previous pregnancy, was determined to argue against this action in her current pregnancy:

"The nurses said they couldn't understand what I was doing in there (hospital) as it (blood pressure) was normal, which made me mad 'cos I felt so fit and well last time...That's what made me so determined to argue with this doctor this time when he wanted to send me in. I said 'They took me in before and when they took me blood pressure they said there was nothing wrong with me".

(Case No. 18B, Parity 1 MC)

Other areas in which the women incorporated their experience into decision making were a) when to go into hospital in labour and b) how to feed the forthcoming baby.

a) When to go to the hospital in labour - It was the multiparous women who said they would delay going into hospital. They based their decision on previous experience of labour in hospital which may have involved long waits, being left on their own and not being comfortable. They felt they would be more relaxed and comfortable if they stayed at home as long as possible:

"I've learnt now I don't go in until right near the end, I was on my own (with him) the whole time...But I'm not going till I know I'm too far gone for them to stop me".

(Case No. 11B, Parity 4 WC)

"This time I will hang on because it's very difficult in the hospital anyway to try and be comfortable. You've only got the bed or a hard chair to sit on".

(Case No. 22B, Parity 1 MC)

Some primiparous women knew in theory what labour involved, but they had also heard differing accounts from friends and

relatives which tended to confuse them. It was not until they had experienced the labour pains that they felt confident enough to delay going into hospital:

"Last time (first pregnancy) I was prepared to wait until they were coming quite strongly, every ten minutes or so. But I had one or two false alarms, you know, I thought 'I'm off'...and I watched the clock and yes they came every twenty minutes for perhaps an hour or an hour and a half. Then just nothing.. But you hear so many - some women say they get it all in their back and some women it's all across their front and I had just assumed from the regularity of this pain that it was a contraction...But I'm fairly confident this time...I would like to just get there (hospital) in order to produce it".

(Case No. 19B, Parity 1 MC)

"I'll hang around home...Fourteen years is a long time, but I'm not so stupid as I was when I had Jackie like you know. I mean, I think you get that excited as well with the first one and that, you have the show and you think 'I'll go into hospital, you know'. Well, I know that you can have a show and you can actually go on for a while, before the actual pains start you know".

(Case No. 16B, Parity 1 WC - first child aged fourteen)

The women who were the most confident of staying at home until the last minute were those who had a combination of theoretical knowledge, advice from friends or relatives and their own practical experience. Primiparous women and those whose previous labour was induced were more apprehensive:

"The only thing I'm worried about is (laughs) I don't know whether I'll be able to feel the contractions. I keep telling everyone that and they keep saying 'Yes you will when they come! But I get loads of different pains".

(Case No. 7B, Primipara WC)

"I've been told that it is very painful - that sometimes there is a pain on the side and you shouldn't be upset about it, but go to the hospital".

(Case No. 9A, Primipara, No English)

"I'll panic. I'm hoping that it'll be a slow enough process in the beginning to give me time to get him (son) down to me Mum....I did hear another girl talking, when I had him, and she said it's like stomach ache all the time. But I don't know I never had a gap - they induced me and I was in continuous pain".

(Case No. 18B, Parity 1 MC)

Similarly, when the women discussed which method of feeding to adopt, the decision they made was based on previous experience, advice of family and friends and material and social constraints.

b) Breast or bottle? - At their first consultant clinic appointment women were asked how they intended feeding the baby. Eight (31%) Asian women and sixteen (61.5%) British women in the final sample said they planned to breast feed. In reality, five (20%) Asian women and twelve (48%) British women breast fed their baby while in hospital (see page 220, Table XXXIV). The lower rate of breast feeding among

Asian women in Britain is an interesting phenomenon as it indicates a shift from a tradition of breast feeding in country of origin, to a predominance of bottle feeding in Britain. This shift can be related to changes in household organisation (cf pages 261-262 ), exposure to another culture, and different sources of information.

An analysis of the reasons women gave for wanting (or not wanting) to breast feed, provides an indication of the importance of different sources of information and the impact of personal experience in influencing the decision. Earlier (cf pages 260-262) we saw that two women (one Asian and one British) were repulsed at the thought of breast feeding. A further seven (27%) Asian and four (15%) British women were embarrassed at exposing their breasts and four (15%) Asian women said their husband did not approve of them breastfeeding. On pages 336-337 we saw how mothers/mothers-in-law may advise against breast feeding if traditional dietary prescriptions are not adhered to.

Other factors which affected the women's decision not to breast feed are detailed in Table LXI. Three (11%) Asian women said they learnt about bottle feeding in hospital, either because they had an operative delivery or because the nurse suggested bottle feeding:

"I've never given my own milk. When I had my first child, I had to have an operation and the nurse gave me a bottle".

(Case No. 18A, Parity 3, Hindu)

"I want to feed him milk from the packet.... I came to know from the hospital when I first had my son and that's how I learnt to feed it from the packet milk".

(Case No. 23A, Parity 3, Sikh)

Two (8%) multiparous British women decided to bottle feed because they thought the other child(ren) might be jealous:

"It might make the others that little bit jealous, so I've decided to bottle feed".

(Case No. 11B, Parity 4, WC)

TABLE LXI

REASONS GIVEN FOR NOT WANTING TO BREASTFEED

	<u>Asian</u> No.	<u>British</u> No.	<u>Total</u> No.
Embarrassed/repulsed	8	5	13
Husband against	4		4
Not prepared to observe dietary restrictions	2		2
Previous hospital experience	3		3
Sibling jealousy		2	2
Inconvenient		3	3
Advice given at or by:-			
Parentcraft classes	2		2
midwife		1	1
friend		1	1
relative		2	2
Returning to work/going abroad	2		2
Total number of reasons women gave for not wanting to breast feed <sup>1</sup>	<u>21</u>	<u>14</u>	<u>35</u>

<sup>1</sup>Three Asian women and four British women cited two reasons for not wanting to breast feed.

Returning to work, convenience, and going abroad were mentioned by two (8%) Asian women and three (11%) British women as reasons for not breast feeding. While a further six (23%) women said they had been advised not to breast feed by health care workers, friends or relatives (see Table LXI).

"In the exercise class, we were told that morning and evening we should breast feed and in the afternoon bottle feed, so as to form a habit of bottle feeding...my mother said that mother's own milk is the best for the baby, but the doctor told me otherwise".

(Case No. 5A, Primipara, Hindu)

"I was going to breast feed, but I've changed my mind. Noticing that you can decide how much a baby is taking bottle feeding than you can breast feeding...Also the midwife said 'It's awkward if at the same time you want to go anywhere'...You may want to go out and you can't say 'Can you do it?' or say to the child 'Just wait till I get back'."

(Case No. 14B, Parity 1, WC)

While these women cited numerous reasons for not wanting to breast feed, other women who were either undecided about how to feed the baby or wanted to breast feed, commented on the lack of professional advice they received (particularly at the ante-natal clinic):

"At the very beginning she (clinic midwife)...asked if I'd decided and I said I hadn't really thought about it at that stage, but I thought I would breast feed if possible you know. And a grin came on her face, as if she agreed with that method you know. Um, but since then no-one's mentioned it".

(Case No.6B, Primipara MC)

"When I first went to the ante-natal clinic,... they asked me (about feeding) and I said I was breast feeding. And they examined my breasts and they didn't say anything (about inverted nipples). Well I must admit, it **hadn't** really occurred to me, you know, that I would have difficulties. And I couldn't feed her. They should have said to me 'You should do this, you should do that'. I just assumed it was all-right".

(Case No. 25B, Parity 1 MC - recounting previous experience)

British women who attended Parentcraft classes were generally encouraged to breast feed, although five (19%) women who did not want to breast feed expressed annoyance at this:

"At the mothercraft there was a great deal of pressure, they wanted the whole class to breast feed...But if you don't want to do it, I don't see that they should make you".

(Case No. 22B, Parity 1, MC)

"The midwives tried to persuade us to breast feed...there's only two of us out of all of them who are going to bottle feed. The midwife gets ever so funny with us because we're going to bottle feed".

(Case No. 3B, Primipara, WC)

Women who approached motherhood with set ideas about feeding the baby were unlikely to change their mind whatever advice they were given. While women who were undecided about the method of feeding were more influenced by advice given by friends, relatives and health care workers, even though **this** may have been contradictory.

Multiparous women did not necessarily choose to feed their babies by the same method. For instance, two (8%)



women were deterred from breast feeding as they had previously experienced difficulties, and two (8%) decided to breast feed the forthcoming baby because the recent controversy surrounding dried milk, made them question its quality.

### Summary

There is a distinct division of labour among the social network in terms of the amount and nature of support (and advice) male partners and female relatives give to women during pregnancy, at childbirth and post-natally. This support and advice varies according to the woman's social class, family organisation and ethnic background.

In the social network the most commonly quoted source of information was the woman's mother or mother-in-law. Her advice was traditional in nature and often based on her own experience and was most often proffered to primiparous women, working class British women and Asian women living in extended families or adjacent to the older woman. Similarly, sisters and aunties (būa's) gave advice based on tradition and experience and were particularly supportive to Asian women and working class British women. Friends tended to impart knowledge of their own experience, while middle class women often had professional friends who provided information of a more "scientific" nature. Asian and working class British

male partners tended to reflect traditional advice, while middle class Asian and British men were more likely to reinforce scientific views about pregnancy and childbirth.

Relatives and friends often proffered advice without being consulted and in other instances certain information was actively sought out by the pregnant woman. The main avenues for this information were Parentcraft classes, literature and television, and each of these were used differently by the women according to their social class, parity and ethnic background. Television was the most universal in its appeal, while literature (other than that provided by the clinic) was used predominantly by middle class white women, and Parentcraft classes were most attractive to primiparous English-speaking and middle class white women.

The information given is used selectively (often in conjunction with knowledge gained from personal experience) which makes it difficult to isolate which specific facets of knowledge direct pregnant women's action.<sup>1</sup>

---

<sup>1</sup>Stimson (1974) notes how patients can be active and make their own treatment decisions.

## CONCLUSIONS

This thesis has explored the different expectations and experiences of two groups of pregnant women. South Asian women were compared with indigenous women in an attempt to determine whether there were any significant differences in the way they perceived the maternal health services, the resources they used and the nature and extent of support given by the social network. While several notable distinctions between the two samples have emerged there is a fundamental similarity in the pregnancy experience of all the women.

This similarity indicates the universality of certain phenomena encountered by all the women studied in their transition to motherhood, which can be related to their position not only as women, but as women in male dominated societies. For instance, we have seen the extent to which taboos surrounding female reproduction persist among women of different social class and ethnic background (pages 235-249); there is the belief that menstruation and childbirth are polluting which affects the management (sic) of reproduction (for example, the seclusion of the labouring woman from the rest of society); while doctors are seen to break sexual taboos when performing internal examinations (pages 254-259) and restrict access to resources for fertility control.

Furthermore, cravings during pregnancy commonly occur but are differently perceived depending on the woman's social class and family organisation. Fears about the well-being

of the forthcoming baby were seen to occupy the minds of pregnant women, and the extent to which these fears were expressed largely depended on the nature of the lay support system.

Wide-ranging folk remedies for maintaining health during pregnancy were utilised by both groups of women. Moreover, the dominant conceptualisation of pregnancy (held by Asian and British women alike) was that of a healthy state. (See pages 323, 324, 351). This is despite the fact that all women suffered from discomforts during pregnancy. The incidence of discomforts was comparable for both samples and there were remarkable similarities between the Asian and British traditional recipes for alleviating indigestion and heartburn. What is interesting is that these recipes emanated from two different cosmologies (cf. pages 358-359).

All the women interviewed (because they had presented for consultant ante-natal care) were exposed to a medical regime designed to detect and cure pathology. In the clinic (or hospital) setting, their social identity was overlooked, a point which irritated British middle class women in particular.

Although there are fundamental similarities between the experiences of Asian and British women in advanced capitalist societies, I must re-iterate what was stated at the outset of this thesis (Introduction, page i) that is, women's experiences are not sufficiently alike for them to constitute a separate social (or sex) class. Additionally it must be stated that the differences between the two samples of women are not solely

related to ethnic origin. Some of the most significant distinctions between the women studied were related to other social factors, for example, parity, social class, length of education, religion, and family organisation.

Women having their first babies tended to lack confidence within the hospital setting and to be initially uncritical of services received (cf. pages 394-395, 429-431). Social class and material conditions in many instances determined the way the women used the maternal health services (cf. pages 404, 412) and their ability to comply with medical advice. Women's length of education affected their state of cognitive knowledge; women with minimal education faced difficulty in comprehending medical advice and some of the literature. Religion was an important factor in shaping attitudes towards the "ideal" number of children to have, and women's knowledge of menstruation and sexual relations. Muslim women were seen to be most "traditional" in these respects. (cf. pages 230, 242-244).

The differences in family organisation between Asian and British people, while culturally based, are not static. Exposure to western, industrial, urban life has involved changes in the traditional Indian family structure. The adoption of nuclear family life-style by Asians has led to substantial alterations in the relationship between men and women (cf. pages 200-202, 519-522, 537-538) and the amount of support women in such families can expect to receive from older female relatives (cf. pages 317-318, 524-529).

Evidence in this thesis illustrates the extent to which Asians in Britain form part of the working class and suffer from the same disadvantages as working class people, for example, poor housing, manual employment, low income. As far as the Asian women were concerned their most critical disadvantage was their lack of the English language, for this restricted their access to services (for example, Parentcraft classes - see page 551) and perpetuated their low involvement in clinic doctor-patient encounters.<sup>1</sup>

Two main themes emerge from this discussion 1) that the similarities in women's pregnancy experience are related to the status of women in society and ii) the differences encountered graphically portray the extent to which the social arrangements of the maternal health services in Britain reproduce dominant values in our society.

Throughout the thesis we have seen the ambiguities present in the pregnant woman's status. In general, women are accorded low status vis-a-vis men, yet when they are pregnant certain concessions are accorded, provided the women concur with certain ideals (for example, are married).

Ambiguities in the woman's status become clearly marked when she is newly married. At this time the woman is expected

---

<sup>1</sup>The Asian women felt more confident negotiating with their GP who often spoke one of the Asian languages (pages 484-485).

to become pregnant and contribute towards the reproduction of the species. The age of the woman and the number of children she is expected to have, are largely socially and culturally determined and are often strongly related to the political and economic situation. In general though, women grow up to believe that motherhood is a desirable state which every woman should aspire to. (The differing importance of this belief among the Asian and British women was referred to p.267-273). To be a married woman and childless is not an enviable status, while to have a large number of children (unless very wealthy) is usually despised. The social importance of being pregnant for some women is clearly illustrated in the quote on page 272 and in the following example:

"I was heartbroken, absolutely heartbroken, and I got that every time after I saw a pregnant woman, I got a physical pain, a real ache in my side. 'Cos I desperately wanted to be pregnant and have a baby and I'd lost the first one. Now if I'd lost the second one, it wouldn't have been nearly so bad - it was just the fact that I thought 'Can I do it?' Perhaps I can never have one'."

(Case No. 24B, Parity 2 MC)

Further ambiguities in women's status become overt when a woman who is professionally qualified becomes a mother. In these instances, the professional woman may derive higher status from her paid employment than she does from her unpaid labour as mother. The tensions women experienced between their role as mother and as worker were discussed in detail earlier (pages 273-278), but it is worth re-iterating that women who had higher status jobs experienced the most tension. The rank ordering of jobs and the

differential values attached to them, effectively reproduces the class nature of society and women's ambiguous status within it. The low value attached to child care and housework and the unpaid nature of this work, ensures that mothers are dependent on male partners or meagre allowances from the State.

Pregnancy, the social transformation to motherhood, may be a time when the woman who was previously financially independent, becomes aware of her impending dependent status. Women who have never been in paid employment or questioned their dependency on men (i.e. Asian women in traditional families) may find these tensions less acute.

Moreover, the meaning of pregnancy is different for various social groups. For example, for the woman it marks her social transition to motherhood and involves fears and uncertainties about the future. The woman's main aim is to give birth to a healthy baby and she is prepared to undergo discomforts and pain to do so. Significant others in the social network (primarily the male partner, mother or mother-in-law) also have a vested interest in the birth of a healthy baby. They therefore restrict the parturient woman's activities in certain ways according to custom, and encourage her to engage in behaviour which will be beneficial to the developing foetus. These prohibitions, prescriptions and concessions strongly reproduce ideas about the social role of women and in particular the importance of boy babies for certain social groups (for instance, Asians).



The meaning of pregnancy to members of the medical profession is very different, although they are equally concerned about the birth of a live baby to a healthy mother. The main pre-occupation of the medical profession is to prevent death and it is widely accepted that a training in clinical medicine is a means to this end. Moreover, the efficiency of medical techniques and the skill of doctors is largely judged by current mortality rates. Obstetricians therefore consider that a low perinatal mortality rate is an index of "good" obstetric care. Coterminous with this, is the persistent belief (based on inadequate evidence, see pages 87-94) that the number of ante-natal visits does have an influence on the outcome of pregnancy. However, it is naive to assume this is a direct relationship, for to do so obscures the fundamental correlation between peri-natal mortality and social class.<sup>1</sup>

Despite the tenuousness of the relationship between the number of ante-natal visits and outcome of pregnancy, this relationship has become a taken-for-granted assumption of the present day. Thus concern about high peri-natal mortality rates is often deflected onto ante-natal care, the assumption being that certain women need more of it. The problem is thus seen to be one of utilisation, and how to educate women to attend their GP early in pregnancy. Differentials in GP referral rates are overlooked (see page 188) along with variations in hospital provision.

---

<sup>1</sup>A social class analysis can be extended to include members of ethnic minority groups who often form part of the working class.

One of the shortcomings of the utilisation approach (discussed earlier pages 104-108) is that it is premised on the belief that women exercise autonomy over their actions. Attendance at the clinic, like health care in pregnancy, is regarded as a matter of individual responsibility (see pages 350, 506-507) and women who do not attend, and those who fail to follow the medically prescribed "Do's and Don'ts in pregnancy",<sup>1</sup> are deemed irresponsible.

However, throughout this thesis we have seen the extent to which women's autonomy over their actions is restricted. The many factors which militate against women's self-determination in reproduction have been outlined (particularly in Chapter Five). One of the main constraints to women's autonomy is their assumed dependence on men. The dominant belief is that women are intellectually and physically inferior to men and held back by their "reproductive function". This belief is perpetuated through the nuclear family where often women are financially dependent on a male breadwinner, and through unequal access to high status jobs.

Women may be denied knowledge about their body and its reproductive function in an effort to retain male control over women. This is most marked among women from an overtly patriarchal society where virginity at marriage is the norm. Male partners,

---

<sup>1</sup>You and Your Baby, Part I, pages 21-26, outlines these.

older women, religious ideology, material resources and access to medical services all restrict women's ability to control their fertility.

Moreover, in relation to food and diet in pregnancy, it is apparent that this is a very complex subject which is inextricably bound up with traditional rites and rituals, notions of reciprocity, male/female relations and material conditions.

Women with children, and women in employment during pregnancy, may experience difficulty in finding the time to adhere to medical prescriptions. The tension between medical advice and the assumption that women can control their partner's sexual activity was made clear on pages 252-253.

Logically, it is a condition of women's individual responsibility for their health care in pregnancy, that they should be able to determine their actions. This implies they should have equal access to resources and State benefits (no discrimination on the basis of marital status); they should be informed about their entitlements and what the medical transition to motherhood entails. At present, it is the Asian women and some working class women who are most disadvantaged in determining their existence. Asian women who have migrated from countries with deeply entrenched ideas of collective responsibility and little individualised health care, are unfamiliar with the

premise of individual responsibility. They are more likely to be fatalistic and Muslim women, in particular, attribute misfortune to the will of Allah.

The ideology of individualism is an expression of middle class values and consequently middle class women are most likely to subscribe to this belief and assume that they are responsible for their health care during pregnancy. They are most likely to shun traditional advice given by older women and to be well-informed about physiology and modern techniques in pregnancy and childbirth.

Although the recent emphasis has been on individual responsibility for health,<sup>1</sup> this appears to apply only to situations outside the clinic or hospital setting. In the medical setting, the pregnant woman becomes a patient and the health care staff assume responsibility for her health. In this environment, middle class women experience the most tension (pages 391-395, 437-440); they are used to asserting their independence and questioning decisions. In the clinic, however, they are not expected to question decisions made by members of the medical profession who "know best". Women who question medical decisions are told they have been reading too many books and often their individual rights are not respected.

---

<sup>1</sup>There has been an increasing trend over the last few years towards individual responsibility for health. This is clearly reflected in the Health Education campaign "Look After Yourself" and posters in doctors' surgeries urging people not to consult unnecessarily. These moves have taken place in a political and economic climate which has seen cuts in the National Health Service.

Women who persist in challenging medical decisions are informed that procedures are performed for "the sake of the baby". The woman who refuses to comply is accused of endangering the baby's life - a very effective threat (see pages 432-433).

It is the British middle class women who complain most vociferously about de-personalisation and lack of individual attention in the medical setting (see pages 415-417). Asian women and working class women from traditional families are more likely to subscribe to a collective ideology in which the needs of the social group (caste or family) are put before those of the individual. These women are therefore less annoyed at being treated as one of a population sample in the clinic. Privatisation, individual autonomy, and personal attention are not familiar concepts to women originating from rural villages in South Asia.

An ideal of individual responsibility for health care can only be met when there is no disparity between social groups, and all women are equally knowledgeable. The erosion of social class differences would mean that the medical profession would be accountable to the population, rather than at present representative of one strata of the population. For this to happen, medical knowledge which currently is esoteric and based on science and rationality, would need to be de-mystified and accessible to all.

This transformation does not seem imminent, in fact the converse is more descriptive of the present trend with increasing social class differentials in morbidity and mortality,<sup>1</sup> increasing specialisation within medicine<sup>2</sup> and a greater dependence on high technology medicine.<sup>3</sup> The recent growth of private health care services is perpetuating differential access to resources based on the ability to pay.

Although these trends are continuing, the evidence suggests that health care workers are not necessarily in agreement. For instance, increasing specialisation and differentiation (an aspect of the division of labour in advanced capitalist societies) leads many workers to complain that their work boundaries are being eroded and their autonomy restricted (midwives and health visitors are particular examples of this). The training of these workers in scientific medicine further divorces them from the majority of women they treat - especially if the women are working class or belong to an ethnic minority group. The differentials between health care staff which reproduce the social class, sexual and racial divisions of society, also reproduces a health service which is most appropriate to a white middle class clientele. However, the well established medical hierarchy with men at the top tends to be unsympathetic to the needs of all pregnant women.

The focus on clinical aspects of pregnancy overlooks the social meaning of pregnancy to the woman and fails to address the woman's anxiety about the impending birth and well-being of the

<sup>1</sup>The Black Report Inequalities in Health HMSO 1980.

<sup>2</sup>Freidson (1970; 1971; 1977); Johnson (1972).

<sup>3</sup>Doyal (1979); Huntingford (1978).

child. During pregnancy it is often members of the lay support system who dispel the woman's anxieties. As we have seen, traditional women have a more co-ordinated social support network which is based on deeply entrenched notions of reciprocity. Traditional women also have a wider knowledge of folk medicine.

The concern of members of the social network in the well-being of the expectant mother can be seen to relate to changes in their own social status. When the woman becomes a mother, the status of her relatives changes to father, grandparent, aunt/uncle etc. Their interest in the future baby and the mother's health is likely to be long term, which can be contrasted with the clinicians' immediate concern - the saving of life.

In addition to the different time span of interest between the social network and members of the medical profession, there is also an assumption that medical knowledge is superior to lay knowledge and women are often advised to reject lay knowledge (see pages 504-511). It has been argued that health care professionals tend to underrate the importance of lay knowledge to the pregnant woman. We have seen the extent to which women derive support and advice from their social network (and cultural and social class differences have been outlined). The social support system sustains the woman during the transition to motherhood and for this support to continue, the usefulness of lay knowledge should be recognised by health care professionals. This is particularly important for

Asian women who are very dependent on the joint family for support, and who have little experience of urban, individualistic life.

Ironically, women with the least experience of British life and the organisation of the maternal health services, are most dependent on them. They are the least likely to challenge medical decisions or question the efficacy of medical procedures in pregnancy. Inconsistencies in medical advice are most likely to confuse these women who apparently believe there is a monolithic body of medical knowledge. Women who have been educated to question decisions, to be presented with conflicting view points and to make up their mind on the basis of evidence available, are the least likely to be concerned with conflicting information. Some of these women are annoyed at the lack of information they are given (see pages 422-429) and the difficulty they experience in obtaining knowledge about certain medical procedures.

Given the conditions in the ante-natal clinic, why are pregnant women so uncritical? First time pregnant women are seen to lack experience and (together with most Asian women) do not have a developed consciousness of the situation. Women with experience have a more developed consciousness, but this is not in any collective sense. The privatisation of the nuclear family and the individual nature of ante-natal care work against women developing into a "class-for-itself" (cf Marx 1910, The Poverty of Philosophy)



although they are fully aware of the problems they face, as the following two examples show:

"I think the whole system from the beginning of pregnancy to the end - till when you're discharged from hospital - needs changing. It's a typical man's world that's what annoys me. But in pregnancy the only thing that's got to do with the man is right at the beginning. He hasn't got to carry it or do anything".

(Case No. 11B, Parity 4 WC)

"One gets back to this old paternalist class biased system whereby the only way you are going to get anything done, is by challenging it. And I don't really see why I should in a sense, pull status to get information".

(Case No. 26B, Parity 1 MC)

These two experienced women saw the maternal health services reproducing class and sexual divisions in society. These women were critical of the treatment they received throughout their pregnancy and voiced their complaints. However, the individual nature of their pregnancy experience (and the temporary nature of their condition) meant they had not developed a collective consciousness of the situation.

The Asian women were peculiarly deferential to the care they received, feeling they should be grateful for whatever services were offered. Their deference can be related to their migrant status in this country and their subservience to their men folk. Their lack of language and poor knowledge of British health services further undermines their confidence.

The recent impact of feminism which argues that women should have knowledge of medical procedures and should be able to "control"

the outcome of their pregnancy is an attempt to develop women's critical understanding of their treatment in the medical setting. Since women feel so vulnerable during pregnancy and childbirth, they develop an acute dependence on high technology medicine operated by male obstetricians. This vulnerability is graphically described in terms of "losing control" and "making a fool of meself"<sup>1</sup> when in labour. A challenge is posed for women to increase control over pregnancy and childbirth so that they are conducted in a friendly and sympathetic environment. But it has to be acknowledged that pregnancy and childbirth are not processes which can be completely scientifically or rationally controlled. An element of uncertainty still persists and lay beliefs may be most appropriate for certain groups of women (and as we saw earlier, domiciliary health care workers).

The organisation of the maternal health services clearly reproduces dominant values in our society and the position of women in that society. If we are committed to an egalitarian provision of services then we should accept that this will not come about until we have eradicated distinctions based on class, sex and race, superiority of medical knowledge over lay, an ideology of individualism over collectivism, and the assumed superiority of men over women.

---

<sup>1</sup>"I've heard a lot of the girls say on the birth of a baby, you can feel yourself ripping. Now that terrifies me, being ripped, or cut". (Case No. 19B, Parity 1, MC previous caesarian).

"I'm afraid of making a fool of meself in hospital - shouting out and that, you know". (Case No. 14B, Parity 1, WC)

To do this involves a major social transformation in society - an alteration in male/female relationships so that women are no longer materially and socially dependent on men. The erosion of a strictly defined sexual division of labour and an increase in the status of domestic and child care activities would be a step in the right direction. Making motherhood a paid occupation would reduce the differentials between women who are financially dependent on their male partners and those who are dependent on State benefits.

An increase in the amount of knowledge available to women about menstruation, sex education (pregnancy and childbirth) in a format they can understand would help women to make informed decisions about their health care. Changes in the structure and organisation of the maternal health services are needed to decrease the status differential between male obstetricians and female midwives. Moreover, these workers would benefit from a training which is geared to the needs of the people they serve. A recognition of the importance of lay support and folk knowledge and ways this could be incorporated into health care practice would lessen some of the existing differentials between middle class health staff and working class or Asian women.

The provision of services (such as Parentcraft classes) which are appropriate and accessible, would increase their up-take by working class and ethnic minority women. Clinic sessions which recognise the social importance of mothers-to-be and offer supportive advice would be pleasanter places and enable the woman to feel that she was being "cared" for in the ante-natal setting.

## RECOMMENDATIONS

These recommendations have been compiled with both local and national needs in mind. They are intended as a specific guideline of what we should be working towards if we are committed to improving the lot of the pregnant woman. While the suggestions in the conclusion involved changes in the social structure of society, these recommendations are concerned with policy changes. Inevitably the recommendations relating to local policy can be dealt with by the appropriate local body (for instance, Area Health Authority, Health Education Department) and hopefully implemented sooner than those policies requiring Government ratification (for example, maternity benefits). To encourage the implementation of local and national policies it may be necessary for pressure to be exerted on the relevant policy making body. Pressure groups such as, AIMS (Association for Improvements in the Maternity Services); NCT (National Childbirth Trust); women's groups; National Council of One Parent Families; CHC's (Community Health Councils) and the CRE (Commission for Racial Equality) have an important part to play in ensuring the recommendations are incorporated into practice.

1. Maternity benefits to be made available to all women irrespective of marital and employment status. These benefits should be payable to the woman and linked to inflation. (Involves changes in government policy).

2. Interpreters should be employed at all points where non-English speaking people come into contact with the maternal health services (and ideally all other departments of the National Health Service). This can be implemented locally through the Area Health Authority.
3. Provide all teenagers with appropriate knowledge about menstruation, contraception, sex education and sexuality, in terms which are acceptable to their class and cultural background. Ideally, these topics should be incorporated into the school curriculum under the auspice of health education. This involves incorporating the Schools Council Health Education Project (SCHEP) into every school curriculum.
4. Supply women with knowledge of medical intervention in pregnancy and childbirth, so that they are aware of medical procedures and have the confidence to accept or reject them. This can be done through television programmes or through the Parentcraft classes which are the responsibility of Area Health Authority staff.
5. Ensure that Parentcraft classes are accessible and appropriate for all women. In areas with ethnic minority groups this means setting up classes specifically geared to the needs of the women in question. Information given at these classes should be couched in terms of the women's cultural background and interpreters involved

wherever necessary. Again the responsibility of Area Health Authority staff.

6. Parentcraft classes should take into account the specific needs of women who already have children and incorporate these needs into the teaching programme. Also there should be creche facilities for these women. The Area Health Authority would be responsible for implementing these recommendations.
7. For the latter four points to be realised, there is a need for all health care professionals and community workers to have incorporated into their training specific information about a) ethnic minorities; b) social class differences; and c) the needs of pregnant women.
  - a) Doctors, nurses and midwives would benefit from a detailed knowledge of the dominant beliefs held by Asian women and their attitudes towards pregnancy and childbirth. This could be fulfilled by extending the recommendations of the Todd Report (1968)<sup>1</sup> (which argues for a social science input into medical students' training) to include cross cultural material and data on ethnic minorities. Area and Regional Health Authorities either independently, or in conjunction with

---

<sup>1</sup>Report of Royal Commission on Medical Education, London, HMSO, Cmd 3569.

the Health Education Council, should take the initiative in organising in-service training about ethnic minorities for all levels of health care workers.

- b) An understanding on the part of the medical profession of the social meaning of pregnancy to the woman and her social network would encourage a more sensitive treatment of the pregnant woman. An awareness of social class differences in society and the implications this has for certain social groups, would enable health care workers to provide more realistic and appropriate advice.
  - c) Knowledge of lay beliefs about pregnancy; perceptions of health and illness during pregnancy; and the implications of certain forms of medical advice to pregnant women, should be incorporated into health workers' training so they are sensitive to the needs of pregnant women.
8. Women obstetricians should be available for all women who request them. In areas with large concentrations of Asian women it should be local policy to have women obstetricians permanently available.
9. A re-structuring of the way consultant ante-natal care is organised with women attending the consultant clinic only when there is a probability of pathology being detected,

would reduce the number of consultant visits made.

(cf page 381).

10. With fewer consultant visits being made, clinic conditions would be less rushed and crowded and would enable doctors to give women the personal attention they expect. In such a setting it is hoped that doctor-patient communication would be facilitated and patients would have time to raise their problems. Local pressure groups need to be more vociferous in demanding that pregnant women are given personal attention without unnecessarily lengthy waits. Community Health Councils should be aware of clinic waiting times and campaign that they are kept to a minimum. Constant monitoring is thus required.
11. Pregnant women should be permitted to be accompanied at every stage of their clinic (or GP) visit, if they should so wish. The companion may need to act as a mediator in certain situations.
12. Greater involvement of midwives in routine ante-natal care would develop (and in some instances, restore<sup>1</sup>) their skills and confidence. Increased involvement of midwives in this way would raise their status from that of assistant to the doctor (see pages 466, 492) and thereby reduce the

---

<sup>1</sup>Midwives in the past played a much more active part in ante-natal care and childbirth (Donnison, 1977; Oakley, 1976).



professional status differential between obstetricians (predominantly men) and midwives (almost universally women). This is also linked with point 9 about the restructuring of ante-natal care.

13. The consultant clinic should be organised at times which are convenient to women's other commitments (for instance, taking and collecting children from school). Facilities should be made for child care at clinics with adequate supervision and toys provided.
14. In any clinic where lengthy waits are likely to be involved there should be refreshments provided.
15. A tape-slide presentation (in the appropriate languages) could be shown in the consultant ante-natal clinic to inform pregnant women of the clinic procedure and identify different medical personnel. Such a presentation could also usefully contain material on maternity entitlements and information about the location of other local services, e.g. Parentcraft classes, lactation classes. The local Health Education Department should be responsible for making such audio-visual aids available.
16. The consultant ante-natal clinic should be used as a place where advice is given and knowledge disseminated. Topics such as diet, smoking during pregnancy and preparation for breastfeeding could usefully be included in the woman's visit. The provision of a separate health care worker

available to answer any queries would enable women in the clinic to ask questions as they arise and/or to clarify any aspect of medical advice given.

17. The literature given to women about pregnancy and child-birth needs to be in a format and language which is easily understood by all women. The Health Education Council has a role to play in ensuring that all women receive the information they need. Local Community Health Councils should also be active in informing patients of their rights within the National Health Service.
  
18. Further research needs to be undertaken into the differential uptake and use of services by ethnic minority and working class women. The findings of this thesis together with Cartwright's (1977) work indicate a lower incidence of induction of labour for Asian and working class women. A more detailed study of hospital practice in relation to medical interventions in childbirth, by social class and ethnic origin, might reveal some interesting findings.

BIBLIOGRAPHY

- ABLON, J. (1973) 'Reactions of Samoan Burn Patients and Their Families to Severe Burns', Social Science and Medicine, Vol.7, p.167-178.
- ACKER, J. (1973) 'Women and Social Stratification: A Case of Intellectual Sexism', American Journal of Sociology, Vol.78, No.4, p.936-943.
- AMAN, (1969) Mechanical Secrets of Your Food, Mysore, India, 1st Edition.
- ARMSTRONG, D. (30th September, 1979) 'Pathological Life and Death: medical spatialisation and geriatrics'. Paper presented at BSA Medical Sociology Group Conference, University of York.
- ARONOWITZ, S. (1973), False Promises - the shaping of the American working class consciousness, McGraw-Hill.
- ARTHURTON, M.W. (1972) Archives of Disease in Childhood, Vol.47, p.126.
- ASHFORD, J.R.  
FRYER, J.G. (1970) 'Perinatal Mortality, Birthweight and place of Confinement in England and Wales 1956-1965', in 'In the Beginning: Studies of Maternity Services', ed. Gordon McLachlan and Richard Shegog, Nuffield Provincial Hospital Trust: Oxford University Press.
- ASHFORD, J.R. (1978) 'Policies for Maternity Care in England and Wales: too fast and too far? in The Place of Birth, ed.Kitzinger, S. and Davis, J., Oxford University Press, p.14-43.
- AURORA, G.S. (1967) The New Frontiersmen A Sociological Study of Indian Immigrants in the U.K., Popular Prakashan, Bombay.
- BACON, L. (1973/74) 'Early Motherhood, Accelerated Role Transition and Social Pathologies', Social Forces, Vol.52, p.333.
- BAIRD, D. (1975) 'The Interplay of Changes in Society, Reproductive habits and obstetric practice in Scotland 1922-1972', B.J. of Preventive and Social Medicine, No.29, p.135.
- BALLARD, C. (17th November, 1976), Personal Communication.
- BALLARD, C. (1978) 'Arranged Marriages in the British Context', New Community, Vol.6, p.181-196.
- BALLARD, R. (Winter, 1972/73), 'Family Organization among the Sikhs in Britain', New Community, Vol.2, No.1.
- BAMFORD, F.N. (30th January, 1971) 'Immigrant Mother and her Child' British Medical Journal, No.1, p.276-280.

- BANNERMAN, R.H.O.,  
CUMMINS, A.,  
DJUKANOVIC; V., and  
KO KO, U. (1975), 'Indigenous Systems of Medicine: Ayurvedic Medicine in India', Alternative Approaches to Meeting Basic Health Needs in Developing Countries. A Joint WHO/UNICEF Study, Ed. Djukanovic, V. and Mach, E.P., WHO, Geneva.
- BARIC, L. and  
MACARTHUR, C. (1977), 'Health Norms in Pregnancy', British Journal of Preventive and Social Medicine, No.31, p.30-38.
- BARKER-BENFIELD, B. (1975), 'Sexual Surgery in Late 19th Century America', Int. Journal of Health Services, Vol.5, No.2, p.279-298.
- BARRON, R.D. and  
NORRIS, G.M. (1976), 'Sexual Divisions and the Dual Labour Market', in Dependence and Exploitation in Work and Marriage, Barker, D.L. and Allen, S. (Ed.), Longman.
- BARRY, K. (1973), 'How they turned the tables on us', in Proceedings of the First International Child-birth Conference, Connecticut, p.3-4.
- BAUMGARTNER, L. (1962), 'The Public Health Significance of Low Birth Weight in the USA', Bulletin of the World Health Organization, 26, p.175-182.
- BEALS, A.R. (1970), 'Gopalpur 1958-1960', in Being an Anthropologist, George, D., Spindler, (Ed.), Holt, Rinehart and Winston Inc.
- BECKER, H. (1963), Outsiders: Studies in the Sociology of Deviance, The Free Press.
- BEECHEY, V. (Autumn., 1977), 'Some Notes on Female Wage Labour in Capitalist Production', Capital and Class, No.3, Bulletin of the CSE.
- BEECHEY, V. (1979), 'On Patriarchy', Feminist Review, No.3, p.66-82.
- BEELS, C. (1974), 'Crisis in Childbirth', in Conditions of Illusion: Papers from the Womens' Movement, Feminist Books, p.8-18.
- BELL, C. and  
NEWBY, H. (1976), 'Husbands and Wives: the dynamics of the deferential dialectic', in Dependence and Exploitation in Work and Marriage, Barker, D.L. and Allen, S. (Ed.), Longman, London and New York, p.152-168.
- BERGSTROM-WALAN, M.B. (1963), 'Efficacy of Education for Childbirth', Journal of Psychosomatic Research, Vo.7, p.131-146.
- BEST, R. (1977), 'Girls into Wives', in Women into Wives: The Legal and Economic Impact of Marriage, Chapman, J.R. and Gates, M., (Ed.), Sage Publications, p.15-57.

- BEVERIDGE, W. (1942) 'Social Insurance and Allied Services', The Beveridge Report, Cmmd. 6404, London, H.M.S.O.
- BHASIN, K. (1972), The Position of Women in India: (Seminar held September 1972), Published (ed.) Arvind a Deshpande for Leslie Sawney Programme of Training for Democracy, Orient House, Nangalore Street, Ballard Estate, Bombay.
- BIGHAM, G.D. (September, 1964), 'To Communicate with Negro Patients', American Journal of Nursing, Vol.64, No.9, p.113-115.
- BIRMINGHAM HOUSEHOLD SURVEY: (1976) 'Summary of Interview', NOP Market Research Limited.
- BLANC, H. (1956), 'Multilingual Interviewing in Israel', American Journal of Sociology, LXII(2), p.205-209.
- BLAND, L. (3rd April, 1978) 'Women Ideologies and Theories et al. of Reproduction', Paper presented at BSA Conference, University of Sussex.
- BOGGS, J. (1970), Racism and the Class Struggle, Monthly Review Press.
- BOHANNAN, P. (1954), Tiv Farm and Settlement, H.M.S.O.
- BOSTON WOMEN'S HEALTH COLLECTIVE (1978), Our Bodies Ourselves, First Published, U.S.A.1971. British Edition Edited by Philips, A. and Rakusen, J., Penguin Books.
- BOTT, E. (1971) Family and Social Network, Tavistock Publications (1st published 1957).
- BOWLBY, J. (1951) Maternal Care and Mental Health, WHO.
- BRANCA, P. (1978), Women in Europe Since 1750, Croom Helm, London.
- BRAVERMAN, H. (1974), Labour and Monopoly Capital, Monthly Review Press, New York.
- BREEN, D. (1978), 'The Mother and the Hospital', in Tearing the Veil, ed. Lipshitz, S., Routledge and Kegan Paul.
- BRENNAN, M.E., and OPIT, L.J. (1974), 'The Unwanted Birth and the Family Planning Service', Journal of Biosocial Science, (6), p.407-415.
- THE BRITISH MEDICAL ASSOCIATION (1975), You and Your Baby, Part I: From Pregnancy to Birth. A Family Doctor Publication.
- BROOK, D. (1976), Nature birth, Penguin.

- BROWN, P.A. (1976), 'Differential Utilization of the Health Care Delivery System by Members of Ethnic Minorities', Journal of Sociology and Social Welfare, Vol.3, p.516-523.
- BROWN, G.W. & HARRIS, T. (1978), Social Origins of Depression: A Study of Psychiatric Disorder in Women, Tavistock Publications.
- BROWNE, F.J. & McCLURE BROWNE, J.C. (1960), Ante-natal and Post-natal Care, J. A. Churchill Ltd., London, First Edition, 1935, 9th Edition.
- BROWN, S. (1917) 'Women and Birth Control', in Population and Birth Control, eds. M.E. and Cedar Paul, New York.
- BROWNE, S. (1977), 'The Right to Abortion', in 'A New World for Women - Stella Browne Socialist Feminist', Rowbotham Sheila, (First Published 1935), Pluto Press.
- BUSFIELD, J. (1974) 'Ideologies and Reproduction', in 'The Integration of a Child into the Social World', ed. M.P.M. Richards, Cambridge University Press.
- BUTLER, N.R. & BONHAM, D.G. (1963), Perinatal Mortality, Edinburgh, E. & S. Livingstone.
- CSE PAMPHLET No.2. (1975) 'On the Political Economy of Women', Conference of Socialist Economists, Conference Papers.
- CALLAWAY, H. (1978), 'The Most Essentially Female Function of All: Giving Birth', in Defining Females: The Nature of Women in Society, ed. Shirley Ardener, Croom Helm, London.
- CANDLIN, S. 'A Survey of the Utilization of the Health and Welfare Services by Asian Immigrants During Pregnancy in Lancaster 1968-1969', Boston Institute of Technology, Health Visitors' Course 1969-1970 Project.
- CAPITAL and CLASS Bulletin of the Conference of Socialist Economists, Issues 2 and 6.
- CARLEBACH, J. (March 1966), 'Tribal Customs Associated with Pregnancy', Mother and Child, p.9-13.
- CARSTAIRS, G.M. (1955) 'Medicine and Faith in Rural Rajasthan', (South of Punjab), in 'Health, Culture and Community', ed. Benjamin D. Paul, Russell Sage Foundation, New York.
- CARTER, C.O. (1976) 'The Global Incidence of Genetic Disease', in 'Equalities and Inequalities in Health', ed. C.O. Carter and John Peel, Academic Press, London, New York, San Francisco.

- CARTWRIGHT, A. & O'BRIEN, M. (1976) 'Social Class Variations in Health Care and In The Nature of GP Consultations', in The Sociology of the NHS, ed. Stacey, M. Sociological Review Monograph 22.
- CARTWRIGHT, A. (30th July, 1977) 'Mothers' Experiences of Induction', Paper presented at 2nd Seminar on Human Relations and Obstetric Practice, University of Warwick
- CASTLES, S. & KOSACK, G. (1973) 'Immigrant Workers and the Class Structure in Western Europe', Oxford University Press for the Institute of Race Relations.
- CHALMERS, I. (30th July, 1977), 'International Comparisons of Obstetric Interventions and Outcome of Pregnancy'. Paper presented at Second Seminar on Human Relations in Obstetric Practice, University of Warwick.
- CHALMERS, I. (1978), 'Implications of the Current Debate on Obstetric Practice', in The Place of Birth, ed. Kitzinger, S. and Davis, J.A., Oxford Medical Publications, p.44-54.
- CHAMBERLAIN, G. (1976) 'The Usefulness of Ante-natal Care', in Prevention of Handicap through Ante-natal Care, ed. Turnbull, A.C. and Woodford, F.P., Associated Scientific Publishers.
- CHAMBERLAIN, R., CHAMBERLAIN, G., HOWLETT, B. and CLAIREAUX, A. (1975), British Births 1970, Vol.I, The First Week of Life, William Heinemann Medical Books, London.
- CHANDRASEKHAR, S. (1959), 'Infant Mortality in India 1901-1955', George Allen and Unwin.
- CHERTOK, L. (1973), Motherhood and Personality, Tavistock Publications.
- CHOLMONDELEY, C., COGAN, N. and LEARNER, E. (1971), 'Psychosocial characteristics of Illegitimate Pregnancy in England', in Psychosomatic Medicine in Obstetrics and Gynaecology, Pub. S. Karger, 3rd Int. Congress, London.
- CIBA FOUNDATION REPORT (1966), Immigration: Medical and Social Aspects, Churchill, London.
- CLAYTON, K. (18th April, 1974), 'Daylight Midwifery', Nursing Times, p.595-596.
- CLEARY, J. & SHEPPERDSON, B. (24/25th March, 1979), 'Fatherhood in Ffynone', Paper given at BSA Human Reproduction Study Group Conference on Fatherhood held at University of Warwick.

- COCHRANE, A.L. (1972) Effectiveness and Efficiency: Random Reflections on Health Services, Oxford University Press for the Nuffield Provincial Hospitals Trust, London.
- COCKBURN, F. (1976) 'How Much Does Nutrition in Pregnancy Matter?' 'Prevention of Handicap Through Ante-Natal Care' ed. A.C. Turnbull and F. Peter Woodford, Associated Scientific Publishers: Amsterdam, Oxford, New York.
- COMAROFF, J. (1976a), 'Communicating information about non-fatal illness: the strategies of a group of general practitioners'. The Sociological Review, Vol.24, No.2, p.269-290.
- COMAROFF, J. (February, 1976b) 'Conflicting Paradigms of Pregnancy: Managing Ambiguity in Ante-Natal Encounters'. Unpublished Paper.
- COMMON PRAYER BOOK Eyre and Spottiswoode Limited, London, p.232, n.d.
- COMMUNITY RELATIONS COUNCIL (May 1974) Ethnic Minorities in Coventry, Coventry Community Relations Council.
- COOPER, J.A. (March 1969), 'Obstetric Care in the First Pregnancy', British Journal of Clinical Practice, Vol.23, No.3, p.107-111.
- COULSON, M., MAGAS, B. & WAINWRIGHT, H. (January-February, 1975), 'The Housewife and her Labour Under Capitalism: A Critique', New Left Review, 89.
- COULSON, M. 'Sexual Divisions and Society', No date, Mimeograph.
- COVENTRY EVENING TELEGRAPH (6th October 1976) 'Pregnant Asian Women "too shy" to see Male Doctors'.
- COVENTRY EVENING TELEGRAPH (24th February, 1977), 'Can They Expect a Better Deal?'.
- COVENTRY FAMILY PRACTITIONER COMMITTEE (July 1977), Medical List, 24 New Union Street, Coventry CV1 2HH.
- CRAFT, I. (1976), 'Induction of Labour', Midwife, Health Visitor and Community Nurse, 12, p.42-44.
- CRANBROOK REPORT (27th November, 1958), Report of the Maternity Services Committee (32-455), H.M.S.O.
- CRISHNA, S. (1975) Girls of Asian Origin in Britain, YMCA of Great Britain, London.
- CRITIQUE OF ANTHROPOLOGY (1977), Woman's Issue, Vol.3, Nos. 9 and 10.
- CURTIS, E.M. (June 1959), 'Pregnancy in Sickle Cell Anaemia, Sickle Cell - Haemoglobin C disease and variants thereof'. American Journal Obstetrics and Gynaecology, p.1312-1323, Vol.77, No.6.



- DHSS (1976) Health and Personal Social Services Statistics for England, 1975, H.M.S.O.
- DHSS (1976), On the State of Public Health, Report to the Chief Medical Officer for 1974, H.M.S.O., London.
- DHSS (1977), Prevention and Health reducing the risk: safe pregnancy and childbirth, H.M.S.O.
- D'SOUZA, A.A. (January-March 1972), 'The Indian Family in the 70's: An Integrated Family Policy', Social Action p.1-15.
- DALLA COSTA, M. & JAMES, S. (1972), The Power of Women and the Subversion of the Community, Falling Wall Press, Bristol.
- DALTON, M. (1959), 'Men Who Manage: Fusions of Feeling and Theory in Administration', John Wiley and Sons, New York.
- DANIEL, W.W. (1971), 'Racial Discrimination in England', Based on a P.E.P. Report, A Pelican Original.
- DARTINGTON, T. (1979), 'Fragmentation and Integration in Health Care: the referral process and social brokerage', Sociology of Health and Illness, Vol. No.1, p.12-39.
- DAVENPORT-SLACK, B. (June 1973), 'Physiological Correlates of Childbirth Pain', in Proceedings of the First International Childbirth Conference, ed. Hirsch, L., Connecticut, USA.
- DAVIDS, A., de VAULT, S. & TALMADGE, M. (1961), 'Anxiety pregnancy and childbirth abnormalities', Journal of Consultant Psychologists, Vol.28, p.74-77.
- DAVIES, T.B. et al. (1939), The Queen Charlotte's Text Book of Obstetrics, 5th Edition, Churchill.
- DAVIN, A. (Spring, 1978), 'Imperialism and Motherhood', History Workshop Journal, Vol.5, p.9-65.
- DAVIS, A. & HOROBIN, G. (1977), 'Medical Encounters', Croom Helm, London.
- DAVIS, A. & HOROBIN, G. (1977), 'Conclusion-Problems of Patienthood', in Medical Encounters, ed. Davis and Horobin, Croom Helm, London.
- DEAKIN, N. (1970), Colour Citizenship and British Society, Panther Modern Society.
- de BEAUVOIR, S. (1972), The Second Sex, 1st published in French 1949, Penguin Books.
- DELPHY, C. (1977) The Main Enemy: A Materialist Analysis of Women's Oppression, WRRRC Publications, Explorations in Feminism, No.3.

- DENNIS, N.,  
HENRIQUES, F.  
& SLAUGHTER, C. . (1956), Coal is Our Life: An Analysis of a  
Yorkshire Mining Community, London: Eyre &  
Spottiswoode.
- DESAI, A.R. (1969), Rural Sociology in India, Bombay:  
Popular Prakashan.
- DESAI, R. (1963), Indian Immigrants in Britain, Oxford  
University Press.
- DHANJAL, B. (Summer 1976), 'Sikh Women in Southall',  
New Community, Vol.5, No.1-2.
- DICK-READ, G. (1959), Childbirth Without Fear, Harper & Row,  
2nd Edition.
- DODGE, J.S. (ed.) (1969), The Field Worker in Immigrant Health,  
Staples Press.
- DOERING, S.G. &  
ENTWISLE, D.R. (1975), 'Preparation During Pregnancy and Ability  
to Cope with Labour and Delivery', American Journal  
of Orthopsychiatry, Vol.45, p.825-37.
- DOLTON, W.D. (1966), 'The Health and Welfare of the Immigrant',  
Royal Society of Health.
- DONABEDIAN, A.  
& ROSENFELD, L.S. (6th July, 1961), 'Some Factors Influencing Pre-natal  
Care', The New England Journal of Medicine, p.1-6.
- DONNISON, J. (1977), Midwives and Medical Men: A history of  
interprofessional rivalries and Women's Rights,  
Heinemann, London.
- DOTY, B.A. (1967), 'Relationships among Attitudes in Pregnancy  
and other Maternal Characteristics', The Journal  
of Genetic Psychology, III, p.203-17.
- DOUGLAS, M. (1966), Purity and Danger, Routledge and Kegan  
Paul.
- DOYAL, L., with  
PENNELL, I. (1979), The Political Economy of Health, Pluto  
Press.
- DUBOS, R. (1968), Man, Medicine and Environment, Penguin Book.
- DURKHEIM, E. (1964a), The Division of Labour in Society, Free  
Press Paperback Edition (first published 1933).
- DURKHEIM, E. (1964b), The Rules of Sociological Method,  
London: Free Press Paperback (first edition 1895).
- EATON, G. &  
WEBB, B. (1979), 'Boundary Encroachment: Pharmacists in the  
Clinical Setting', Sociology of Health & Illness,  
Vol.1, p.69-89.
- EDHOLM, F.,  
HARRIS, O. &  
YOUNG, K. (1977), 'Conceptualising Women', Critique of  
Anthropology, Vol.3, 9 and 10.

- EHRENREICH, B. & ENGLISH, D. (1973), Complaints and Disorders: the Sexual Politics of Sickness, Winters and Readers Publishing Co-operative, London.
- EHRENREICH, B. & ENGLISH, D. (1974), Witches, Midwives and Nurses: A History of Women Healers, Glass Mountain Pamphlet No.1, Compendium.
- EHRENREICH, B. & ENGLISH, D. (1979), For Her Own Good, Pluto Press.
- ELKIN, A.P. (1941), 'Native Languages and the Field Worker in Australia', American Anthropologist, Vol.43, p.89-94.
- ELSTON, M.A. (1977), 'Women in the Medical Profession: Whose Problem', in Health and the Division of Labour, ed. Stacey, M. et al., Croom Helm, London, p.115-138
- EMERSON, J. (1972), 'Behaviour in Private Places: Sustaining Definitions of Reality in Gynaecological Examinations', Recent Sociology No.2, ed. H. P. Dreitzel, Macmillan Company, New York.
- ENGLISH, D. (1973), 'Society Makes us Sick', in. Proceedings of the First International Childbirth Conference, ed. Hirsch, L., Connecticut, p.4-5.
- FAIRHURST, E. & LIGHTUP, R. (28 Sept.-1 Oct.79), 'Doing Research on the Climateric: Some Preliminary Observations on an "Sensitive" Issue'. Paper presented at Medical Sociology BSA Conference, York University.
- FAITHORN, E. (1975), 'The Concept of Pollution among the Kafe of the Papua New Guinea Highlands', in Toward an Anthropology of Women, ed. Reiter, R., Monthly Review Press, p.127-140.
- FIRESTONE, S. (1971), The Dialectic of Sex: The Case for Feminist Revolution, London: Jonathan Cape.
- FISH, D.G. (December, 1966), An Obstetric Unit in a London Hospital, Unpublished Ph.D. Thesis, LSE and Political Science.
- FLANAGAN, G.L. (1963), The First Nine Months of Life, Heinemann.
- FOLESHILL DISTRICT PLAN (1977), Issues in Foleshill, Coventry City Council.
- FORD, C.S. (1964), A Comparative Study of Human Reproduction Reprinted by Human Relations Area, Files Press, (from 1945 Edition).
- FORSTER, D.P. & DAVISON, C.M. (September, 1977), 'Medical Care Aspects of the Prenatal Diagnosis of Chromosomal Abnormalities', Social Science and Medicine, Vol.11, p.593-598.

- FOSTER, G.M. (1975), 'Medical Anthropology: Some Contrasts with Medical Sociology', Social Science and Medicine, Vol.9, p.427-432.
- FRANKFORT, E. (1973), Vaginal Politics, Bantam Book, New York.
- FREEDMAN, L.Z. & FERGUSON, V.M. (1949) 'The Question of "Painless Childbirth" in Primitive Cultures'. Yale University Annual Meeting.
- FREEMAN, C. (n.d.), 'When is a Wage not a Wage', Red Rag, No.5, p.16-19.
- FREIDSON, E. (1970), Profession of Medicine: A Study in the Sociology of Applied Knowledge, Dodd Mead and Company, New York.
- FREIDSON, E. (1971), Professional Dominance, Atherton Press, New York.
- FREIDSON, E. (1977) 'The Futures of Professionalisation', in Health and the Division of Labour, ed. Stacey, M. et al., Croom Helm, p.14-38.
- FREUD, S. (1931) 'Female Sexuality. The Standard Edition of the Complete Psychological Works of Sigmund Freud, Vol.XXI (p.227), Sigmund Freud Copyright Ltd., The Institute of Psychoanalysis.
- FRIDAY, N. (1977), My Mother/My Self, A Fontana Original.
- GADALLA, F.R.A. (1962) Study of motivational factors and barriers related to the utilisation of prenatal care by mothers delivered at Alameda County Hospital, Unpublished Doctor of Public Health Thesis, University of California.
- GARDEZI, H.N. & INAYATULLAH, A. (1969), The Dai Study: The dai-midwife - a local functionary and her role in Family Planning, The West Pakistan Family Planning Association, Lahore.
- GARDINER, J. (January-February, 1975), 'Women's Domestic Labour', New Left Review, 89.
- GARDINER, S.H. (March 1969), 'Motivation for Obstetric Care', Obstetrics and Gynaecology, Vol.33, No.3., p.306-312.
- GALLOWAY, J. (4th August 1967), 'Some Aspects of Immigration', The Medical Officer, p.69-70.
- GALLOWAY, J. (9th October, 1965), 'Immigration in the Midlands', Lancet, p.731.
- GALLOWAY, J. (26th October, 1968), 'Domiciliary Midwifery in Wolverhampton', Lancet, p.906.
- GARLAND, G.W., QUIXLEY, J.M.E. & CAMERON, M.D. (1976), Obstetrics and Gynaecology for Nurses, Unibooks Hodder & Stoughton, 3rd edition. (1st edition 1956).

- GIDDENS, A. (1972), Capitalism and modern social theory, Cambridge University Press.
- GIDEON, H. (1962), 'A Baby is Born in the Punjab', American Anthropologist, Vol.64, p.1220-1234.
- GILL, D.G.,  
ILLSLEY, R. &  
KOPLIK, L.H. (1970), 'Pregnancy in Teenage Girls', Social Science and Medicine, Vol.3, p.549-574.
- GISH, O. (1969), 'Nursing and Midwifery migration in Britain', Nursing Times, Vol.65, Part 18., p.69-71.
- GLASS, D.V. (ed.) (1954), Social Mobility in Britain, Routledge and Kegan Paul, London.
- GOFFMAN, E. (1971), Asylums, (First published Anchor Books, 1961) Pelican Books.
- GOLD, M. (1977), 'A Crisis of Identity: The Case of Medical Sociology', Journal of Health and Social Behaviour, Vol.18, p.160-168.
- GOLDTHORP, W.O.  
& RICHMAN, J. (September 1974), 'Re-organization of the maternity services - A comment on domiciliary confinements in view of the experience of the hospital strike 1973', Midwife and Health Visitor, Vol.10, p.265-270.
- GOLDTHORPE, J.H.  
& LOCKWOOD, D. (1963), 'Affluence and the British Class Structure', Sociological Review, Vol.11, No.2, p.133-163.
- GORDON, J.E.,  
SINGH, S., &  
WYON, J.B. (March, 1963a), 'Demographic Characteristics of Deaths in Eleven Punjab Villages', Indian Journal of Medical Research, Vol.51, No.2.
- GORDON, J.E.,  
CHITKARA, I.D., &  
WYON, J.B. (March 1963b), 'Preventive Medicine and Epidemiology', The American Journal of the Medical Sciences, p.345-377.
- GORDON, J.E.,  
GIDEON, H. &  
WYON, J.B. (1965), 'Midwifery Practices in Rural Punjab India'. American Journal of Obstetrics and Gynaecology, Vol.93,
- GORDON, J.E.,  
WYON, J.B. &  
GIDEON, H. (1971), The Khanna Study: Population Problems in the rural Punjab, Harvard University Press, Cambridge, Massachusetts.
- GOSHEN-GOTTSTEIN  
E.R. (1966), Marriage and First Pregnancy, Tavistock Publications.
- GOUGH, K. (1975), 'The Origin of the Family', in Toward an Anthropology of Women, ed. Reiter, R., Monthly Review Press, p.51-76.
- GRAHAM, H. (1976a), 'Images of Pregnancy in Ante-Natal Literature', in Health Care and Health Knowledge, ed. Dingwall, R. et al., Croom Helm.

- GRAHAM, H. (1976b), 'The Social Image of Pregnancy: Pregnancy as Spirit Possession', Sociological Review, No.24, p.291-308.
- GRAHAM, H. (1977), 'Women's Attitudes to Conception and Pregnancy', in Equalities and Inequalities in Family Life, ed. Chester, R. and Peel, J., Academic Press.
- GRAHAM, H. & McKEE, L. (1979), The First Months of Motherhood, Vol.1, Summary Report on Health Education Project, University of York.
- GRAY, A. (December, 1973), 'Can Labour Ever Be 'Natural'?', Midwife and Health Visitor, Vol.9, No.12, p.396-398.
- GUARDIAN (8th November, 1979), 'Sex Bias Sacking Claim Rejected'.
- HAIRE, D. (1972), The Cultural Warping of Childbirth, International Childbirth Education Association.
- HALL, C. & LLOYD, A. (December, 1976), 'The Ideology of Domesticity and the Subordination of Women', Unpublished Paper.
- HALL, D.J. (25th and 26th November, 1976), 'The Need and Demand for Health Care of Immigrants'. Centre for Extension Training in Community Medicine Advanced Seminar; The Use of Demography in Community Medicine.
- HALL, D.E. & MOHR, G. (April 1933) 'Prenatal Attitudes of Primiparae: A Contribution to the Mental Hygiene of Pregnancy', Mental Hygiene, Vol.17.
- HALSEY, A.H., FLOUD, J. & MARTIN, F.M. (1956), Social Class and Educational Opportunity, Heinemann.
- HANFORD, J.M. (1968), 'Pregnancy as a State of Conflict', Psychological Reports, 22, p.1 13-1342.
- HARRISON, J.F.C. (1973), The Early Victorians 1832-51, Panther.
- HARRISON, R.H. & KASS, E.H. (1967), 'Differences between Negro-White Pregnant Women on the MMPI', Journal of Consulting Psychology, Vol.31, No.5, p.454-463.
- HART, N. (1976), When Marriage Ends : A Study in Status Passage, Tavistock Publications, London.
- HART, N. (1977), 'Parenthood and Patienthood: A Dialectical Autobiography', Medical Encounters, ed. Davis and Horobin, Croom Helm.
- HARVEY, W.A. & SHERFEY, M.J. (1954), Psychological Medicine, Vol.16, p.1-9.

- HELMAN, C.G. (1978), 'Feed a Cold, Starve a Fever: Folk Models of Infection in an English Suburban Community and their relation to medical treatment'. Culture, Medicine and Psychiatry, Vol.2, p.107-137.
- HELPER, M.M., COHEN, R.L. & BEITENMAN, E.T. (1968), 'Life Events and Acceptance of Pregnancy', Journal of Psychosomatic Research, Vol.12, p.183-188.
- HENRY, J. (1940), 'A Method for Learning to talk Primitive Languages', American Anthropologist, Vol.42, p.635-41.
- HENSLIN, J. & BIGGS, M.A. (ed.) (1971), 'Dramaturgical Desexualisation: The Sociology of the Vaginal Examination', in Studies in the Sociology of Sex, Appleton Century, Crofts, Meredith Corp., New York.
- HENSON, H. (1974), British Social Anthropologists and Language, Clarendon Press, Oxford.
- HERN, W.M. (January, 1971), 'Is Pregnancy Really Normal', Family Planning Perspectives, Vol.13, p.5-10.
- HERN, W.M. (1975), 'The Illness Parameters of Pregnancy', Social Science and Medicine, Vol.9, p.365.
- HEWARD, J.A. & CLARKE, M. (15th May, 1976), 'Communications to an Ante-Natal Clinic', British Medical Journal, p.1202-1204.
- HIRO, D. (1969) The Indian Family in Britain, Community Relations Commission.
- HODGKIN, P., HINE, P.M., KAY, G.M. & LUMB, G.A. (1973), 'Vitamin D deficiency in Asians', Lancet, No.2, p.167.
- HOEBEL, E., & FROST, E.L. (1976), Cultural and Social Anthropology, McGraw Hill Book Company.
- HOMANS, H. (July 1979), 'The Full Circle: Imperialism, Medicine and Asian Women in Britain'. Paper given at CSE Conference, Leeds.
- HOPE, E., KENNEDY, M. & de WINTER, A. (1976), 'Homeworkers in North London', in Dependence and Exploitation in Work and Marriage, ed. Barker, D.L. and Allen, S., Longman, London, New York, p.88-108.
- HOROBIN, G. & McINTOSH, J. (1977), 'Responsibility in General Practice', in Health and the Division of Labour, ed. Stacey, M. et al., Croom Helm, London, p.88-111.
- HORTON, R. (1971), 'African Traditional Thought and Western Science', in Knowledge and Control, ed. Young, M. Collier MacMillan, London.

- HUBERT, J. (1974), 'Belief and Reality: Social Factors in Pregnancy and Childbirth', in The Integration of the Child into a Social World, ed. Richards, M. Cambridge University Press.
- HUNT, S. (1976), 'The Food Habits of Asian Immigrants', in Getting the Most out of Food, Produced by Van den Berghs and Jurgens Ltd.
- HOOVER-ANWAR, R.A. (1972), Coping with the Crisis of Pregnancy, Ph.D. Thesis, University of London.
- HUNTINGFORD, P. (18th December, 1975), 'Does the doctor know best? - a professional opinion', Listener.
- HUNTINGFORD, P. (1978), 'Obstetric Practice : Past, Present and Future, in The Place of Birth, ed. Kitzinger, S. and Davis, J.A. Oxford Medical Publications, Oxford University Press, p.229-250.
- HUSAR-DODER, M. & JUZNIC, M., et al. (1972), 'Psychosomatic Problems of Unmarried Mothers', Psychosomatic Medicine in Obstetrics and Gynaecology, 3rd Int. Congress, London, 1971, S. Karger.
- HUYGEN, F.J. (1976), 'Home Deliveries in Holland', Journal of Royal College of GPs, (26), p.244-248.
- ILIFFE, L. (1978), 'Estimated Fertility Rates of Asian and West Indian Immigrant Women in Britain 1969-1974', Journal of Biosocial Science, Vol.10, p.189-197.
- ILLICH, I. (1975), Medical Nemesis : The Expropriation of Health, Calder and Boyars.
- ILLSLEY, R. (24th August, 1956), 'The Duration of Ante-Natal Care'. The Medical Officer, p.107.
- ILLSLEY, R. (1966), 'Preventive Medicine in the Perinatal Period', Royal Society of Medicine Proceedings, Vol.59, Part 3, p.181-184.
- ILLSLEY, R. (1967), 'The Sociological Study of Reproduction and its Outcome', in Childbearing - Its Social and Psychological Aspects, ed. Richardson and Guttmacher.
- ILLSLEY, R. (1974), 'Developments in the Role of Medicine in Relation to Reproduction', in Health, Medicine, Society, ed. Sokolowska, M. Holowka and Ostrowska, A.
- ISLAM, M. (1976), The Social and Economic Position of Bengali Workers in Britain, University of Leeds, Unpublished Ph.D. thesis.
- JEWSON, N.D. (1976), 'The Disappearance of the Sick Man from the Medical Cosmology, 1770-1870', Sociology, Vol.10, No.2, p.225-244.



- JOFFE, J.M. (1969), Prenatal Determinants of Behaviour, Pergamon Press, Oxford, London.
- JOHNSTON, R.A. (April, 1964), 'Is Prenatal Care Beneficial or et al. Necessary?', Southern Medical Journal, Vol.57, p.399-402.
- JOHNSON, T. (1972), Professions and Power, MacMillan.
- JOLLY, C., (1st June, 1971), 'Research in the Delivery of HELD, B., Female Health Care: The Recipient's Reaction', CARAWAY, A.F. & American Journal of Obstetrics and Gynaecology, PRYSTOWSKY, H. Vol.110, No.3, p.291-294.
- JONES, K. & (1970), The Economic Impact of Commonwealth SMITH, A.D. Immigration, National Institute of Economic & Social Research, Cambridge University Press.
- JOSEPH, Sir, K. (19th October, 1974), Speech, Birmingham.
- KAKAR, D.N. (1972), 'The Health Centre Doctor and Spirit Medium in a North Indian Village', Eastern Anthropologist, Vol.25, p.249-258.
- KAKAR, D., (1972), 'People's Perception of Illness and MURTHY, S.K. & Their Use of Medical Care Services in Punjab', PARKER, R. Indian Journal of Medical Education, Vol.11, Part 4, p.286-98.
- KAPUR, P. (1976), Love, Marriage and Sex, Vikas Publishing House, PVT Ltd., Delhi, Bombay, London.
- KAREEM, R. (1979), Spare Rib, No.80, p.26-27.
- KATONA-APTE, J. (1975), 'The Relevance of Nourishment to the Reproductive Cycle of the Female in India', in Being Female: Reproduction, Power and Change, ed. Raphael, D., Mouton, The Hague, Paris.
- KERR, M.G. (25th November, 1975), 'Problems and Perspectives in Reproductive Medicine', University of Edinburgh, Inaugural Lecture No.61.
- KITZINGER, S. (1971), 'An Anthropological Approach to Education for Childbirth with the Underprivileged'. Psychosomatic Medicine in Obstetrics and Gynaecology, 3rd International Congress, London.
- KITZINGER, S. (1972), The Experience of Childbirth, Pelican Book, 1st published 1962, (3rd Edition).
- KITZINGER, S. (December, 1974), 'Speaking the Same Language: Working with West Indian Patients', Practitioner.
- KITZINGER, S. (1977), Education and Counselling for Childbirth, Bailliere Tindall Book, published by Cassell & Collier MacMillan, London.

- KITZINGER, S. & DAVIS, J.A. (1978), The Place of Birth, Oxford Medical Publications, Oxford University Press.
- KITZINGER, S. (1978), Women as Mothers, A Fontana Original.
- KITZINGER, S. (1979), The Good Birth Guide, Fontana
- KLASS, A. (1975), There's Gold in Them Thar Pills, A Penguin Special.
- KLOOSTERMAN, G.J. (1978), 'The Dutch System of Home Births', in The Place of Birth, ed. Kitzinger, S. and Davis, J., Oxford University Press, p.85-92.
- KLOOSTERMAN, G.J. (1973), 'The Midwife: Her Task and Her Responsibility in a Technologic World', in New Horizons in Midwifery, ed. Forman, Fischman, Woodville, International Confederation of Midwives.
- KOLLONTAI, A. (1977), Selected Writings, Translated by Holt, A., Allison and Busby, London.
- KOMAROVSKY, M. (1963), 'Class Differences in Family Decision-making on Expenditure', in Source Book in Marriage and the Family, ed. Sussman, M., Boston, Houghton Mifflin, p.261.
- LAND, H. (1976), 'Women: Supporters or Supported', in Sexual Divisions and Society: Process and Change, ed. Barker, D.L. and Allen, S. Tavistock Publications, p.108-132.
- LANG, R. (1972), Birth Book, Gensis Press, California.
- LATEEF, S. (1977), 'India: The Ground Lost', People, Vol.4, No.3.
- LEACH, E.R. (1976), Culture and Communication: The Logic by which symbols are connected, Cambridge University Press.
- LEESON, J. & FRANKENBERG, R. (1974), 'The Sociology of Health: Dilemmas in the Post-Colonial World', in Sociology and Development ed. de Kadt and Williams, London.
- LENNANE, K.J., & LENNANE, J.R. (8th February, 1973), 'Alleged Psychogenic Disorders in Women - A Possible Manifestation of Sexual Prejudice'. The New England Journal of Medicine, Vol.288, p.288-292.
- LESLIE, C. (ed.) (1976) Asian Medical Systems, University of California Press, Berkeley, Los Angeles and London.
- L'ESPÉRANCE, J. (1977), 'Doctors and Women in 19th Century Society', in Health Care and Popular Medicine in 19th Century England, ed. Woodward, J. and Richards, D., Croom Helm, London.

- LEVI-STRAUS, C. (1963), 'The Effectiveness of Symbols', in Structural Anthropology, New York, Basic Books.
- LEWIS, E. (18th September, 1976), 'The Management of Stillbirth Coping with an Unreality', Lancet, p.619-620.
- LEWIS, O. (1965), Village Life in Northern India, Vintage Books: A division of Random House, New York.
- LINCK, K. (June, 1973), 'Legalizing a Woman's Right to Choose', in Proceedings of the First International Childbirth Conference, Connecticut, U.S.A.
- LINDENBAUM, S. (1972), 'Sorcerers, Ghosts and Polluting Women: An Analysis of Religious Belief and Population Control'. Ethnology, II, No.3, p.241-253.
- LLEWELYN, D.M. (ed.) (1978), Maternity: Letters from Working Women, Virago, London (1st published 1915).
- LLEWELLYN-JONES, D. (1978), Every Woman, Faber and Faber, London Boston (1st published 1971).
- LOMAS, G. and MONCK, E. (1977), Employment and Economic Activity, 1971, The Runnymede Trust, London.
- LOMAS, P. (1966), 'Ritualistic elements in the management of childbirth', British Journal of Medical Psychology, 39, p.207-213.
- LOUDIS, D. (1978), 'Evidence of Declining Immigrant Fertility in the 1971 Census: a research note', New Community, Vol. 6 (2), p.310-313.
- LUBIC, R.W. (June 1972), 'What the Lay Person Expects of Maternity Care', Journal of Obstetrical-Gynaecological Nursing, Vol.1, p.25-31.
- LUSCHINSKY, M.S. (1962), The Life of Women in a Village of North India: A Study of Role and Status, Cornell University Ph.D. Thesis, Anthropology, University Microfilms Inc., Ann Arbor, Michigan.
- MAIR, L. (1972) An Introduction to Social Anthropology, Clarendon Press, Oxford, (2nd edition).
- MALINOWSKI, B. (1922), Argonauts of the Western Pacific, George Routledge & Sons, p.vii-xiv.
- MALINOWSKI, B. (1935), Coral Gardens and Their Magic, 2 volumes, George Allen and Unwin.
- MAMDANI, M. (1972) The Myth of Population Control: Family Caste and Class in an Indian Village, Monthly Review Press, N.Y., London.

- MANDELBAUM, D.G. (1974), Human Fertility in India, University of California Press, Berkeley, Los Angeles, London.
- MANSON, T. and TAYLOR, J. (26th October, 1976), 'Demand, Need and Efficiency - Organisation of the National Health Service', Paper given at the Medical Sociology Workshop, University of Warwick.
- MARRIOTT, M. (1955), 'Western Medicine in a Village of Northern India', in Health, Culture and Community, ed. Paul, B., Russell Sage Foundations, New York, 1955.
- MARSHALL, J.F. (1973), Culture and Contraception, Response determinants to a Family Planning Programme in a North Indian Village, D.Phil. Thesis in Anthropology, University of Hawaii.
- MARX, K. and ENGELS, F. (1970), The German Ideology, Arthur, C.J. (ed.), Lawrence & Wishart, London.
- MATERNAL AND CHILD CARE (June 1967), 'Late Booking', Monthly Journal, Vol.III, No.26.
- MATTHEW, G.K. (1971), 'Measuring Need and Evaluating Services', in Portfolio for Health, McLachlan, G. (ed.), London, Oxford University Press.
- MAXWELL, R. (1974), Health Care. The Growing Dilemma, McKinsey, New York.
- MAYER, J.E. and TIMMS, N. (1970), The Client Speaks: Working Class Impressions of Casework, Routledge and Kegan Paul, London.
- MEAD, M. (1935), Sex and Temperament in Three Primitive Societies, Routledge and Kegan Paul, London.
- MEAD, M. (1971), Male and Female, Pelican Book Reprint.
- MEHL, L.E. (1978), 'The Outcome of Home Delivery: Research in the United States', in The Place of Birth, Kitzinger, S. and Davis, J. (ed.), p.93-117.
- MEILLASSOUX, C. (1975), Femmes, Greniers et Capitaux, Paris; Maspero.
- MIDWIVES ACT 1902 (1975) in Documents on Health and Social Security, Watkin, B. (ed.), Methuen.
- MILIBAND, R. (1969), The State in Capitalist Society, Quartet Books.
- MILIO, N. (1975), 'Values, Social Class and Community Health Services', in A Sociology of Medical Practice, Cox, C. and Mead, A. (ed.), Collier-MacMillan, London.

- MILLET, K. (1972), Sexual Politics, 1st Abacus Edition.
- MINTURN, L. and LAMBERT, W.W. (1964), Mothers of Six Cultures, John Wiley & Sons Inc., New York, London.
- MITCHELL, J. (1975), Psychoanalysis and Feminism, Allen Lane, 1974, Pelican Books.
- MOORE, W.M.O. 'Antenatal Care and the Choice of Place of Birth', in Kitzinger, S. and Davis, J. (ed.), ibid, p.1-13.
- MORPETH, R. (1979), 'The Village Midwife in the Punjab', Unpublished Paper.
- MORRIS, N.M. et al. (1966), 'Deterrents and Well-Child Supervision', American Journal of Public Health, Vol.56, 1966, (p.1232-41).
- MOSER, C.A. and KALTON, G. (1972), Survey Methods in Social Investigation, Heinemann Educational Book Ltd., London, Reprinted.
- MOYES, B.A. (1976), Perceptions of Pregnancy, Unpublished Ph.D. Thesis, University of Edinburgh.
- MOYES, B. (10th November, 1977), 'A Doctor is a Doctor', New Society, p.289-291.
- MUECKE, M.A. (1976), 'Health Care Systems as Socializing Agents: Childbearing the North Thai and Western Ways', Social Science and Medicine, Vol.10, p.377-383.
- MYRDAL, A. and KLEIN, V. (1956), Women's Two Roles, Routledge, Kegan Paul.
- MacINTYRE, S. (1975), 'Decision Making Processes Following Pre-Marital Conception', Ph.D. Thesis, Aberdeen.
- MacINTYRE, S. (1976a), 'Obstetric Routines in Ante-Natal Care', Unpublished Paper, University of Aberdeen.
- MacINTYRE, S. (1976b), 'To Have or Have Not - Promotion and Prevention of Childbirth in Gynaecology Work', in Sociology of National Health Service, Stacey, M. (ed.).
- MacINTYRE, S. (1976c), 'Who Wants Babies?', in Sexual Divisions and Society: Process and Change, in Barker, D.L. and Allen, S. (ed.), p.150-173.
- MacINTYRE, S. (15th June, 1977a), 'Childbirth: The Myth of the Golden Age', World Medicine, p.17-22.
- MacINTYRE, S. (1977b), Single and Pregnant, Croom Helm.

- MacINTYRE, S. (November, 1979), 'Some Issues in the Study of Pregnancy Careers', The Sociological Review, Vol.27, No.4.
- McKEE, L. (March 24/25, 1979a), 'Fathers' Participation in Infant Care', Paper given at BSA Human Reproduction Study Group Conference on Fatherhood, University of Warwick.
- McKEE, L. (19th June, 1979b), 'Is Dad an Expert too? The Father's Role in Child Health Care'. Paper given to Warwickshire Human Relations in Obstetric Practice Group.
- McKINLAY, J.B. (1970a), 'A Brief Description of a Study on the Utilisation of Maternity and Child Welfare Services by the Lower Working Class Sub-Culture', Social Science and Medicine, Vol.4, p.551-556.
- McKINLAY, J.B. (1970b), Some Aspects of Lower Working Class Utilisation Behaviour, Ph.D. Thesis, University of Aberdeen.
- McKINLAY, J.B. (1972a), 'The Sick Role - Illness and Pregnancy', Social Science and Medicine, Vol.6, p.561-572.
- McKINLAY, J.B. & McKINLAY, S.M. (December, 1972b), 'Some Social Characteristics of Lower Working Class Utilizers and Under Utilizers of Maternity Care Services', Journal of Health and Social Behaviour, Vol.13, p.369-382.
- MACKINTOSH, M. (Summer, 1977), 'Reproduction and Patriarchy: A Critique of Claude Meillassoux "Femmes, Gremiers et Capitaux"', Capital and Class, Bulletin of Conference of Socialist Economists.
- MACLEAN, U. (1971), Magical Medicine, Allen Lane.
- NADEL, S.F. (1961), 'The Interview Technique in Social Anthropology', in 'The Study of Society', Bartlet, F.C., et al., (ed.), Lund Humphries, London-Bradford, 6th Edition.
- NARAIN, D. (ed.) (1975), Explorations in the Family and Other Essays, Thacker & Co. Ltd., Bombay.
- NASH, R. (1973), Classrooms Observed, Routledge, Kegan Paul.
- NATH, J. (1970), Some Aspects of the Life of Indians and Pakistans in Newcastle with Special Reference to Women, M.A. Thesis Anthropology, University of Durham.

- NETTLEBLADT, P.,  
FAGERSTROM, C.F. &  
ODDENBERG, N. (1976), 'The Significance of Reported  
Childbirth Pain', Journal of Psychosomatic  
Research, Vol.20, p.215-221.
- NEW SOCIETY (29th November, 1979), 'Meeting Maternity  
Costs', New Society.
- NEWMAN, L.F. (1964), Culture and Perinatal Environment in  
American Society, Ph.D. Thesis, University  
of California, Berkeley.
- NEWMAN, L.F. (April, 1969), 'Folklore of Pregnancy:  
Wives Tales in Contra Costa County,  
California'. Western Folklore, Vol.XXVIII,  
No.2.
- NEWMAN, L.F. (Spring, 1972), 'The Anthropology of Birth',  
Sociological Symposium, 'Childbirth and Infancy',  
Life Cycle Series, No.8.
- NEWMAN, L.F. (6th December, 1975), 'The Culture of Birth',  
American Anthropological Association Annual  
Meeting.
- NEWTON, J.R. (19th March, 1979), 'The Future of Gynaecology',  
Paper given at Human Relations in Obstetric  
Practice Seminar, University of Warwick.
- NEWTON, N. (1975), 'Birth Rituals in Cross-Cultural  
Perspective: Some Practical Applications',  
in Being Female: Reproduction, Power and  
Change, Raphael, D. (ed.), Mouton, The Hague,  
Paris.
- NICHTER, M. (1977), Health Ideologies and Medical Cultures  
in the South Kanara Areca Nut Belt. Unpublished  
Ph.D. Thesis, University of Edinburgh.
- NIEHOFF, A.H. and  
ANDERSON, J.C. (1966), 'Peasant Fatalism and Socio Economic  
Innovation'. Human Organization, Vol.25, p.273-283.
- NIXON, W. (1975), Childbirth, Penguin, 1961, 2nd edition.
- NORR, K.L.,  
BLOCK, C.R.,  
CHARLES, A.,  
MEYERING, S. and  
MEYERS, E. (1977), 'Explaining Pain and Enjoyment in  
Childbirth', Journal of Health and Social  
Behaviour, Vol.18, No.3, p.260-273.
- NORTHUMBERLAND  
COMMUNITY HEALTH  
COUNCIL (July, 1975), 'Maternity Services in Northumberland'.
- OAKLEY, A. (1972), Sex, Gender and Society, London, Temple  
Smith.

- OAKLEY, A. (1974a), 'The Ideology of Sex Differences', in Conditions of Illusion, Feminist Books.
- OAKLEY, A. (1974b), Housewife, Penguin.
- OAKLEY, A. (18th December 1975), 'The Trap of Medicalized Motherhood', New Society, p.639-641.
- OAKLEY, A. (1976), 'Wise Woman and Medicine Man', in The Rights and Wrongs of Women, Oakley, A. and Mitchell, J. (ed.), Penguin.
- OAKLEY, A. and GRAHAM, H. (30th June, 1977), 'Competing Ideologies of Reproduction: Medical and Material Perspectives on Pregnancy and Birth'. Paper presented at 2nd Seminar on Human Relations and Obstetric Practice, University of Warwick.
- OAKLEY, A. and OAKLEY, R. (1979), 'Sexism in Official Statistics', in Demystifying Social Statistics, Irvine, J., Miles, I. and Evans, J. (ed.), Pluto Press.
- OAKLEY, A. (1980), Women Confined: Towards a Sociology of Childbirth, Martin Robertson.
- OBEYESEKERE, G. (2nd April, 1963), 'Pregnancy Cravings (Dola-Duka) in Relation to Social Structure and Personality in a Sinhalese Village'. American Anthropologist, Vol.65, No.2, p.323-342.
- OFFICE OF HEALTH ECONOMICS (July, 1968), Without Prescription, OHE, London, No.27.
- OFFICE OF HEALTH ECONOMICS (August, 1975), The Health Care Dilemma, OHE, London.
- OFFICE OF MANPOWER ECONOMICS (1972), Report on Equal Pay, H.M.S.O.
- OKELEY, J. (1977), 'Gypsy Women: Models in Conflict', in Perceiving Women, Ardener, S. (ed.), J.M. Dent & Sons Ltd. A Halstead Press Book, 1st published 1975.
- O'LAUGHLIN, B. (1974), 'Mediation of Contradiction: Why Mbum Women Do Not Eat Chicken', in Women, Culture and Society, Rosaldo, M.Z. and Lamphere, L. (eds.) Stanford University Press.
- OLESEN, V.L. (1975), 'Convergences and Divergences: Anthropology and Sociology in Health Care', Social Science and Medicine, Vol.9, p.421-425.
- OPCS MONITOR (25th January, 1977), 'Births by birthplace of parents, 1975', Reference FMI 77/1.



- OPCS MONITOR (27th January, 1976), 'Births by birthplace of parents', Reference FM1 76/1.
- OPLER, M.E. (1961), 'The Cultural Definition of Illness in Village India'. Human Organization, Vol.20, p.32-35.
- ORTNER, S.B. (1974), 'Is Female to Male as Nature is to Culture?', in Rosaldo, M.Z. and Lampere, L. (eds.), ibid.
- OSBORN, A.F. & MORRIS, T.C. (March, 1979), 'The rationale for a composite index of social class and its evaluation', British Journal of Sociology, No. 1, p.39-60.
- PAHL, J.M. & PAHL, R.E. (1972), Managers and their Wives, Penguin.
- PAIGE, K.E. & PAIGE, J.M. (1973), 'The Politics of Birth Practices: A Strategic Analysis'. American Sociological Review, 38, p.663-677.
- PAIGE, K.E. (1977), 'Sexual Pollution: Reproductive Sex Taboos in American Society'. Journal of Social Issues, Vol.33, No.2, p.144-165.
- PARK, R. (1950), Race and Culture, Free Press.
- PARSONS, T. (1951), The Social System, Routledge Kegan Paul: London.
- PASAMANICK, B. & KNOBLOCH, H. (1957-58), 'Race, Complications of Pregnancy and Neuropsychiatric Disorder'. Social Problems, Vol.15, p.267-278.
- PAUL, L. (1974), 'The Mastery of Work and the Mystery of Sex in a Guatemalan Village', in Rosaldo, M.Z. and Lampere, L. (eds.), ibid.
- PAWSON, M. & MORRIS, N. (1972), 'The Role of the Father in Pregnancy and Labour'. Psychosomatic Medicine in Obstetrics and Gynaecology, 3rd International Congress, London, 1971, S. Karger.
- PEARSE, I.H. & CROCKER, L.H. (1943), The Peckham Experiment: A Study of the Living Structure of Society, George Allen and Unwin.
- PEARSON, J.F. (1973), 'Social and Psychological Aspects of Extramarital First Conceptions', Journal of Bio - Social Science, p.453-496.
- PECK, E. (1973), The Baby Trap, London: Heinrich Hanau Ltd.
- PEEL REPORT (1970), 'Domiciliary Midwifery and Maternity Bed Needs'. Report of the Sub-Committee, H.M.S.O.

- PERKINS, E. (13th December, 1979), 'Monitoring Ante-Natal Classes', Nursing Times, p.2163-2167.
- PETTIGREW, J. (1972), 'Some Observations on the Social System of the Sikh Jats'. New Community, Vol.1, No.5.
- PHILLIPS, H.P. (1960), 'Problems of Translation and Meaning in Field Work', in Human Organisation Research, Adams, R.N. and Preiss, J.J. (Eds.), Dorsey Press Inc.
- PICKERING, W.S.F. (1974), 'The Persistence of Rites de Passage: Towards an Explanation'. British Journal of Sociology, Vol.25, p.63-78.
- PILGRIM TRUST (1938), Men Without Work, Cambridge: The University Press.
- PILLSBURY, B. (1978), 'Doing the Month: Confinement and Convalescence of Chinese Women after Childbirth'. Social Science and Medicine, Vol.12, p.11-22.
- PILOWSKY, I. (1972), 'Psychological Aspects of Complications of Childbirth: A Prospective Study of Primiparae and their Husbands'. Psychosomatic Medicine in Obstetrics and Gynaecology, 3rd International Congress, London, 1971, S. Karger.
- PINES, D. (1972), 'Pregnancy and Motherhood: Interaction Between Fantasy and Reality'. British Journal of Medical Psychology, Vol.45, p.333-343.
- POLSKY, N. (1971), Hustlers, Beats and Others, Pelican Books.
- PORTER, A.M.D. (1971), Planning Maternity Care, M.Phil. Thesis. University of Durham.
- POULANTZAS, N. (1973), Political Power and Social Class, London, New Left Books.
- POWELL, E. (1969), Freedom and Reality, Paperfronts, Elliot Right Way Books, Surrey, p.307-308.
- QUESADA, G.M. (1976), 'Language and Communication Barriers for Health Delivery to a Minority Group'. Social Science and Medicine, Vol.10, p.323-327.
- RADCLIFFE-BROWN, A.R. (1940), 'On Joking Relationships', Africa, Vol.13, p.195-210.
- RAMANAMURTHY, P.S.V. (1969), Journal of Nutrition and Diet, Vol.6, p.187.

- RANKIN, G. (1976), 'Preparation for Childbirth - a Chance to Change', Medical Sociology Newsletter, BSA, Vol.3, No.2, p.7-8.
- RAPHAEL, D. (1975), 'Matrescence, Becoming a Mother: A "New/Old" Rite de Passage', in Being Female: Reproduction Power and Change, Raphael, D. (ed.), Mouton, The Hague.
- RAPOPORT, R. and (1971), Dual Career Families, Penguin.  
RAPOPORT, R.N.
- RATHBONE, B. (1973), Focus on New Mothers, (A Study of Antenatal Classes). Royal College of Nursing and National Council of Nurses of the U.K.
- RAYNER, C. (1973), Child Care Made Simple, Made Simple Books, W.H. Allen, London.
- REITER, R. (ed.) (1975), Toward an Anthropology of Women, Monthly Review Press.
- REPORT OF THE (1948) Ministry of Health, Government of India.  
COMMITTEE ON  
INDIGENOUS SYSTEMS  
OF MEDICINE
- REX, J. and (1967), Race, Community and Conflict: A Study of  
MOORE, R. Sparkbrook, Oxford University Press for the  
Institute of Race Relations.
- REX, J. (1973), Race, Colonialism and the City, Routledge,  
Kegan, Paul.
- RHODES, P. (1972), 'Sex and the Gynaecologist'. Psychosomatic  
Medicine in Obstetrics and Gynaecology, 3rd  
International Congress, London, 1971, S. Karger,
- RICH, A. (1975), The Theft of Childbirth, Review Article.
- RICHARDS, A.I. (1961), 'Field Work Methods in Social Anthropology',  
in The Study of Society, F.C. Bartlett, et al.,  
(ed.), Lund Humphries, London-Bradford, 6th Edition.
- RICHARDS, M.P.M. (1975), 'Innovation in Medical Practice:  
Obstetricians and the Induction of Labour in GB'.  
Social Science and Medicine, Vol.9, p.595-602.
- RICHARDS, M.P.M. (1977), 'Effects on Infant Behaviour of Analgesic and  
Anaesthetics Used in Obstetrics'. Paper presented  
at the 5th Conference of European Teratology Society,  
Italy.
- RICHARDS, M.P.M. (1978), 'A Place of Safety . An Examination of the  
Risks of Hospital Delivery', in Kitzinger, S. and  
Davis, J.A. (eds.), ibid.

- RICHMAN, J. and GOLDTHORP, W.O. (1976), 'When was your last period? Temporal Aspects of Gynaecological Diagnosis', in Health Care and Health Knowledge, Dingwall, R. et. al., (eds.), Croom Helm, p.160-182.
- RICHMAN, J. and GOLDTHORP, W.O. (1978), 'Fatherhood: the Social Construction of Pregnancy and Birth', in Kitzinger, S. and Davis, J.A. (eds.), ibid.
- ROBERTSON, J.S. and CARR, G. (1970), 'Late Bookers for Ante-natal Care', in In the Beginning: Studies of Maternity Services, McLachlan, G. and Shegog, R. (eds.), Nuffield Provincial Hospital Trust, Oxford University Press.
- ROBERTS, P.D., JAMES, H., PETRIE, A., MORGAN, J.O., HOFFBRAND, A.V. (14th July, 1973), 'Vitamin B<sub>12</sub> Status in Pregnancy Among Immigrants and Britain', British Medical Journal, p.67-72.
- RONALDS, C., VAUGHAN, J.P. and SPRACKLING, P. (May, 1977), 'Asian Mothers' Use of General Practitioner and Maternal/Child Welfare Services', Journal of the Royal College of G.P.'s p.281-283.
- ROSALDO, M. and LAMPERE, M. (eds.) (1974), Women, Culture and Society, Standford.
- ROSE, E.J.B. et al. (1969), Colour and Citizenship, Institute of Race Relations Report, Oxford University Press.
- ROSE, H. and HANMER, J. (1976), 'Women's Liberation, Reproduction and the Technological Fix', in Sexual Divisions and Society : Process and Change, Barker, D.L. and Allen, S. (eds.), Tavistock Publications, p.199-223.
- ROSENGREN, W.R. (1961-62), 'Social Instability and Attitudes toward Pregnancy as a Social Role'. Social Problems, Vol.9, p.371-378.
- ROSENGREN, W.R. and de VAULT, S. (1963), 'The Sociology of Time and Space in an Obstetrical Hospital', in The Hospital in Modern Society, Freidson, E. (ed.), Free Press.
- ROSSER, C. and HARRIS, C.C. (1965), The Family and Social Change, Routledge and Kegan Paul.
- ROSSER, J.E. (1978), 'Sexual Identity on Becoming a Mother: Same Cultural Contradictions'. Paper given at BSA, Medical Sociology Conference, York.
- ROWBOTHAM, S. (1972), Women, Resistance and Revolution, Allen Lane, The Pelican Press.

- ROWBOTHAM, S. (1973a) Woman's Consciousness, Man's World, (Penguin), Pelican.
- ROWBOTHAM, S. (1973b) Hidden From History, Pluto Press.
- ROYAL COLLEGE OF GENERAL PRACTITIONERS (1972), The Future General Practitioner Learning and Teaching, B.M.A. House, London.
- ROYAL COLLEGE OF MIDWIVES (1966) Preparation for Parenthood, The Royal College of Midwives, London, W.1.
- ROYAL COMMISSION ON MEDICAL EDUCATION (1968), Todd Report.
- RUBIN, G. (1975), 'The Traffic in Women: Notes of the "Political Economy" of Sex', in Reiter, R. (ed.), ibid.
- RUSSELL, I. and CLAYTON, S. 'The Preferences of Maternity Patients for Place of Confinement: Their Interpretation and Role'. Synopsis of Paper. Durham University.
- RYAN, J., SUMMERHILL, A., YOUNG, S. (1977), 'Women, Capitalism and Sexuality'. Paper given at Socialist Feminist Conference on Feminism, Sexuality and Abortion, Coventry.
- SACKS, K. (1975), 'Engels Revisited : Women, the Organisation of Production and Private Property', in Reiter, R. (ed.), p.211-234, ibid.
- SAIFULLAH-KHAN, V. (1974), Pakistani Villagers in a British City 'The World of the Mirpuri Villager in Bradford and in his Village of Origin'. Ph.D. Thesis, Bradford.
- SAIFULLAH-KHAN, V. (1975), 'Asian Women in Britain : Strategies of Adjustment of Indian and Pakistani Migrants', in Women in Contemporary India, de Souza, A. (ed.), Delhi, Manohar.
- SAIFULLAH-KHAN, V. (1976), 'Purdah in the British Situation', Dependence and Exploitation in Work and Marriage, Barker, D.L. and Allen, S. (eds.), Longman, London and New York, p.224-245.
- SWALLOWAY, J.C. and DILLON, P.B. (1973), 'A Comparison of Family Networks and Friend Networks in Health Care Utilization. Journal of Comparative Family Studies, p.131-142.
- SAUNDERS, I. (1954), Cultural Difference and Medical Care, Russell Sage Foundation, New York.
- SCARLET WOMEN COLLECTIVE Scarlet Women No.5, North Shields.

- SCHONFIELD, J.  
et al. (September, 1962), 'Variations in Pre-Natal Care and Well-Child Supervision in a New England City', The Journal of Paediatrics, 61, p.430-7.
- SCHWARTZ, L.R. (1969), 'The Hierarchy of Resort in Curative Practives: The Admiralty Islands, Melanesia'. Journal of Health and Social Behaviour, 10, p.201-209.
- SCOTT, E. and THOMPSON, A.M. (1956), 'A Psychological Investigation of Primigravidae IV - Psychological Factors and the Clinical Phenomena of Labour'. Journal of Obstetrics and Gynaecology of the British Empire, Vol.63, p.502-508.
- SEYAL, M.A. (17th December, 1966), 'Ante-natal Care', British Medical Journal, (2), p.1526.
- SHAH, P.M. (1975), Indian Paediatrics, Vol.12, p.73.
- SHAPIRO, S., WEINER, L. and DENSEN, P.M. (February, 1958), 'Comparison of Prematurity and Perinatal Mortality in a General Population of a Pre-paid Group Practice, Medical Care Plan'. Medical Care, p.170.
- SHARMA, U. (1971), Rampal and his Family, London: Collins.
- SHARPE, S. (1976), 'Just Like a Girl'. How Girls Learn to be Women. Penguin Books.
- SHAW, N.S. (1974), 'Forced Labour: Maternity Care in the United States', Pergamon Press, Oxford.
- SHIPMAN, M.D. (1972), The Limitations of Social Research, Longman.
- SIBISI, H. (1975), 'Some notions of "purity" and "impurity" among the Zulu'. Journal of the Anthropological Society of Oxford, Vol.6, No.1.
- SINGH, S.A. (1972), The Changing Concept of Caste in India, Vikas Publications, Delhi, Bombay, Bangalore, Kanpur, London.
- SINGH, S.; GORDON, J.E. and WYON, J.B. (November, 1962), 'Medical Care in Fatal Illnesses of a Rural Punjab Population : Some Social, Biological and Cultural Factors and their Ecological Implication'. Indian Journal of Medical Research, Vol.50, No.6, p.865-880.
- SJÖSTRÖM, H. and NILSSON, R. (1972), Thalidomide and the Power of the Drug Companies, A Penguin Special.
- SKONE, J.F. (February, 1968), Public Health Aspects of Immigration. National Committee for Commonwealth Immigrants.

- SMALLEY, C. and  
BISSENDEN, J. (October, 1977), 'The Asian Mother and Baby at Sorrento'. The Journal of Maternal and Child Health, p.408-412.
- SMITH, A. (1970), 'Progress in the 1960's and Problems for the 1970's. in 'In the Beginning: Studies of Maternity Services, McLachlan, G. and Shegog, R. (eds.),
- SMITH, E. (1864), Practical Dietary for Families, Schools and the Labouring Classes, Walton and Maberly: London, p.199-201.
- SOCIETY TO SUPPORT HOME CONFINEMENTS (17th July, 1974), Information Sheet.
- SOICHET, S. (1972), 'Psychodynamic Approach to Pregnancy and its Complications'. Psychosomatic Medicine in Obstetrics and Gynaecology, 3rd International Congress, London, 1971, S. Karger.
- SOUTH TYNESIDE COMMUNITY HEALTH COUNCIL (29th March, 1976), 'Patient Satisfaction With Maternity Care'.
- STACEY, M. (1960), Tradition and Change, Oxford University Press.
- STEINMETZ, S.K. (August, 1974), 'The Sexual Context of Social Research'. The American Sociologist, Vol.9, p.111-116.
- STEVENS, B. (1971), 'Psychoses Associated with Childbirth: A Demographic Survey'. Social Science and Medicine, Vol.5, p.527-543.
- STIMSON, G.V. (1974), 'Obeying Doctors' Orders : A View From the Other Side'. Social Science and Medicine, Vol.8, p.97-104.
- STORM-CLARK, C. (Spring, 1978), 'Some Technical Means for Higher Quality : Recording in Oral History'. Oral History : The Journal of the Oral History Society, Vol.6, No.1, p.114-119.
- STRAUS, R. (1957), 'The Nature and Status of Medical Sociology'. American Sociological Review, 22, p.200-204.
- STROUD, C.E. (1971), British Journal of Hospital Medicine, Vol.5, p.629.
- STROUD, E.C. (1965), 'The New Environment', Post Graduate Medical Journal, No.41, p.599.
- SWANSEA WOMEN AND HEALTH GROUP (1974), 'Having Your Baby', mimeo.

- TAYLOR, C. and LESLIE, C. (1973), 'Asian Medical Systems'. Social Science and Medicine, Vol.7, p.307-318.
- TEW, M. (1978), 'The Case Against Hospital Deliveries : The Statistical Evidence', in Kitzinger, S. and Davis, J.A. (eds.), ibid, p.55-65.
- THE TIMES (3rd November, 1977), Article by Reid, S., p.1.
- THAKKUR, C.G. (1975), Introduction to Ayurveda : Basic Indian Medicine, Published by Shri Gulabkunverba Ayurvedic Society, Jammager (India), (1st Edition, 1965), 2nd Edition.
- THOMPSON, B. (29th September, 1967), 'Childbirth and Infant Care in a West African Village'. Nursing Mirror.
- THOMPSON, B. and BAIRD, D. (1967), 'Some Impressions of Childbearing in Tropical Areas'. The Journal of Obstetrics and Gynaecology of the British Commonwealth, Vol.74, No.3, p.499-522.
- THOMPSON, B. (May, 1979). Personal Communication.
- THOMPSON, L.J. (1942), 'Attitudes of Primiparae as Observed in a Prenatal Clinic'. Mental Hygiene, Vol.26, p.243-256.
- THOMPSON, M.A. (1970), A Study of Generation Differences in Immigrant Groups with Particular Reference to Sikhs. M.Phil. Thesis, University of London.
- TRETHOWAN, W.H. and DICKENS, G. (1972), 'Appetite Disorders in Pregnancy'. Psychosomatic Medicine in Obstetrics and Gynaecology, 3rd International Congress, London, 1971, S. Karger.
- TULSKY, A.S., TULSKY, K.G. and FEINBERG, J. (1972), 'An interdisciplinary approach to the problem of the unwed mother, a joint venture between the obstetrician and social worker in the supervision and management of her pregnancy and delivery and post-partum state'. Psychosomatic Medicine in Obstetrics and Gynaecology, 3rd International Congress, London, 1971, S. Karger.
- UCCA (1975), Annual Report.
- UDAPA, K.N. (1975), 'The Ayurvedic System of Medicine in India', in Health by the People, Newell, K.W. (ed.), W.H.O., Geneva.
- VAHIA, N.S. (1962), 'Cultural Differences in the Clinical Picture of Schizophrenia and Hysteria in India and the U.S. Review in Transcultural Psychiatric Research, April, 1963, No.14, Bombay, India,



- VALABREGA, J.P. (1973), 'La relation therapeutique : malade et medecin', Paris: Flammarion 1962, quoted in Chertok, ibid.
- VAN DEN BERGHS AND JURGENS (1976), Asians in Britain. Nutrition Publication.
- VAN GENNEP, A. (1960), The Rites of Passage, The University of Chicago Press (English Translation), 1908 1st Edition.
- VINCENT, J. (25th March, 1979), 'Fatherhood and the Illegitimate Child'. Paper given at BSA Human Reproduction Study Group Conference, University of Warwick.
- WADDINGTON, I. (1973), 'The Role of the Hospital in the Development of Modern Medicine'. Sociology, Vol.7, p.211-224.
- WADDINGTON, I. (1977), 'General Practitioners and Consultants in early nineteenth century England: The Sociology of an Intra-Professional Conflict', in Health Care and Popular Medicine in 19th England, Woodward, J. and Richards, D. (Eds.), Croom Helm, London.
- WADE, P.M. (1972), 'Preparing the Unmarried Mother for Childbirth'. Psychosomatic Medicine in Obstetrics and Gynaecology, 3rd International Congress, London, 1971, S. Karger.
- WAITZKIN, H. and WATERMAN, B. (1974), Exploitation of Illness in Capitalist Society, Bobbs-Merril, New York.
- WALKER, J.F. (1976), 'Midwife or Obstetric Nurse? Some Perceptions of Midwives and Obstetricians of the Role of the Midwife'. Journal of Advanced Nursing, Vol.1, p.129-38.
- WARD, B.E. (ed.) (1963), Women in the New Asia, UNESCO.
- WARNES, G. (1962), 'A Comparative Study of Infant Feeding Habits of Fifty Asian and Fifty European Mothers in Bradford with Reference to the Infant's State of Nutrition'. Unpublished Paper, Bradford.
- WATKINS, E.L. (April, 1968), 'Low Income Negro Mothers - Their Decision to Seek Prenatal Care'. American Journal of Public Health, p.655-667.
- WATSON, W.B. and BARTH, E.A.T. (Spring, 1964), 'Questionable Assumptions in the Theory of Social Stratification'. Pacific Sociological Review, p.10-16.
- WEARE, T. (January, 1979), 'Round in a Flat World'. Spare Rib, No.78, p.15-17.

- WEEKS, J.R. (1976), 'Infant Mortality and Premarital Pregnancies'. Social Science and Medicine, Vol.10, p.165-169.
- WEISS, K. (April/May, 1975), 'What Medical Students Learn About Women'. Off Our Backs, p.24-25.
- WEST, J. (1978), 'Women, Sex and Class', in Feminism and Materialism : Women and Modes of Production, in Kuhn, A. and Wolpe, A. (Ed.), Routledge and Kegan Paul.
- WESTERMARCK, E. (1936), 'Methods in Social Anthropology', Journal of the Royal Anthropological Institute, Vol.66, p.223-48.
- WHYTE, W.F. (1960), 'Interviewing in Field Research', in Human Organisation Research, Adams, R.N. and Preiss, J.J. (Eds.), Dorsey Press Inc.
- WHYTE, W.F. (1973), Street Corner Society, University of Chicago Press, Fourteenth Impression.
- WILLSON, J.R., BEECHAM, C.T., and CARRINGTON, E.R. (1971), Obstetrics and Gynaecology, C.V. Mosby Co., St. Louis, 4th Edition.
- WILSON, A. (1978), Finding a Voice : Asian Women in Britain, Virago.
- WILSON, E. (1977), Women and the Welfare State, Tavistock Publications.
- WINCH, R.F. (1967), 'Another Look at the Theory of Complementary Needs in Mate Selection'. Journal of Marriage and Family, Vol.29, p.756-62.
- WINSBERG, B. and GREENLICK, M. (1967), 'Response in Negro and White Obstetrical Patients'. Journal of Health and Social Behaviour, Vol.8, Part 3, p.222-227.
- WINSHIP, J. (Autumn 1978),  
Paper presented to Coventry-Birmingham Feminist Research Workshop.
- WISE, T.A. (1845), Hindu System of Medicine. Calcutta, Printed at the Baptist Mission Press.
- WOLFE, D.M. (1962), 'Power and Authority in the Family', in Selecto Studies in Marriage and the Family, in Winch, R.F.; McGinnis, R. and Barringer, H.R. (Ed.), London, Holt Rinehart.
- WORLD HEALTH ORGANISATION (1951), 'Export Committee on Mental Health'. Report on the second session. WHO Technical Report series, No.31, Geneva.

- WORLD HEALTH ORGANISATION (1951), 'Expert Committee on Mental Health'. Report on the second session. WHO Technical Report Series No.31, Geneva.
- WORLD HEALTH ORGANISATION (1952), 'Expert Committee on Maternity Care: first report, a preliminary survey'. WHO Technical Report Series No.51, P.46-60. Geneva.
- WORLD HEALTH ORGANISATION (October, 1954), 'Expert Committee on Health Education of the Public'. WHO Technical Report Series No.89, Geneva.
- WORLD HEALTH ORGANISATION (1957), 'Administration of Maternal and Child Health Services'. WHO Technical Report Series No.115.
- WORLD HEALTH ORGANISATION (1966), 'The Midwife in Maternity Care'. WHO Technical Report Series No.331.
- WRIGHT, E. (1968), The New Childbirth, Hart Publishing Company.
- WYNN, M. & WYNN, A. (1974), The Protection of Maternity and Infancy, Council for Children's Welfare, London.
- WYON, J.B. and GORDON, J.E. (1971), The Khanna Study : Population Problems in the Rural Punjab, Harvard University Press, Cambridge, Massachusetts.
- YOUNG, M. and WILLMOTT, P. (1960), Family and Class in a London Suburb, Routledge, London.
- YOUNG, M. and WILLMOTT, P. (1973), The Symmetrical Family, Routledge and Kegan Paul.
- YUDKIN, Dr. S. (1970), Health and Welfare of the Immigrant Child, Community Relations Commission.
- ZANDER, L.; LEE-JONES, M. and FISHER, C. (1978), 'The role of the primary health care team in the management of pregnancy', in Kitzinger, S. and Davis, J.A. (Eds.), ibid.
- ZAX, M.; SAMEROFF, A.J. and FARNUM, J.E. (1975), 'Childbirth Education, Maternal Attitudes and Delivery'. American Journal of Obstetrics and Gynaecology, Vol.123, Part 2, p.185-90.
- ZBOROWSKI, M. (1966), 'Cultural Components in Response to Pain', in A Sociological Framework for Patient Care, Folta, J.R. and Deck, E.S. (Eds.), Wiley.

APPENDIX A - METHODOLOGY

INFORMANTS USED

In the preliminary stages of the research informants were used extensively and many of these contacts were maintained throughout the research and some are still ongoing. These informants can be divided into three main areas: a) those working in the maternal health services or related health care professionals; b) those concerned with the Asian population specifically; c) individual members of the Asian community. All these informants lived locally.

- a) Health workers - domiciliary Midwives; Health Visitors; Nursing Officers; Asian GPS; the Area Health Education Officer; Asian receptionist at the maternity hospital; staff of all levels at the ante-natal clinic and maternity hospital; interpreter (Asian) at the Family Planning clinic in the Asian "area"; members of the Area Health Authority and Community Health Council.
- b) Those concerned with the Asian population specifically, for example, Community Relations Officers in Coventry and Leamington Spa; Indian Ladies Reform Association secretary; English Language Co-ordinators; English language class tutors; Educational Advisors; Home tutors; Community Worker at Foleshill Road Information Centre; Asian teachers.

- c) Members of the Asian community - these were usually contacted through b) and include the pupils at the English language classes, the tutees in the Home tutor scheme, friends, neighbours and relations of the above.

Other contacts were made with researchers working in the area of the maternal health services or the Asian population in Britain. This latter group were mainly social anthropologists who had worked in South Asia and could provide information on the conditions there. Further contacts were made with organisations interested in the area of study, for example, the Association for Improvements in the Maternity Services (AIMS); the National Childbirth Trust (NCT) particularly the Reading group who produced an Asian translation of a leaflet giving advice to women about to have a baby; National Association of Indian Youth (NAIY - now Asian Youth); the Pathway Industrial Unit, which runs courses on communication skills for health care workers dealing with ethnic minority groups.

#### VISITS

These are referred to in the context of a visit to an establishment rather than an individual person, but many contacts did result from an initial visit, for example, a visit to the Community Relations office provided many contacts. These visits

can be divided into those concerned with maternal health services and those concerned with the Asian population:

1. Visits to Parentcraft classes in Coventry were an important part of the research. These classes are organised by the local authority for all pregnant women in the city. However, not all the classes are situated in a convenient location or presented in a manner acceptable to all women. Moreover, some of the women were not informed of the existence of these classes. This was particularly the case as far as Asian women were concerned.

Access to these classes was granted through the Nursing Officer in whose district they took place, but contacting the Nursing Officer and gaining permission did not automatically mean that the staff running the classes were notified. Thus the researcher turned up at one clinic having been informed there were no objections to her visit only to find that the midwife refused to let her enter. Later, when the Nursing Officer arrived at the clinic, permission was granted, but not until there had been a heated discussion between the midwife and Nursing Officer. The midwife was extremely upset she had not been informed of the visit, and because she did not know who I was thought I might be from the press. Hostility between midwives and administrators was evident at some of the clinics and this in part was due to the new series

of Parentcraft classes being organised (see chapter 9).

The whole course of Parentcraft classes (including Father's Night) was attended at different clinics throughout the city. In many of these classes the researcher was mistaken for a pregnant woman (particularly if wearing a loose smock top) and often had to explain her role to the other mums-to-be. The women tended to accept the researcher as one-of-them and they provided a rich source of information about the classes and their ante-natal care. This was a valuable source of back-up information obtained by informal means.

2. Visits to English language classes were carried out over a period of time. These were very important because they informed the researcher about the Asian women, while at the same time the women themselves would expect to be taught English by the researcher. Often there would only be one voluntary teacher for ten to fifteen women of differing abilities; some of them were Kenyan Asians who had learnt some English in Africa, others had come from urban India and been taught English at school, while others came straight to Britain from rural villages and did not know any English at all. These classes were also used to try the questionnaire out. We would have a group discussion around the questions and everyone participated. Another

of classes was organised around a Mothers and Toddlers Club and this was run by an Asian tutor with the help of some local students. The students looked after the children while the mums learnt English. The tutor was married to an Asian doctor and much of what she taught was related to diet and health care. This particular group provided much useful information about what it was like to give birth in the Punjab - the tutor acting as an interpreter for the researcher.

The language class co-ordinator was able to supply a list of names of the home tutors whose Asian tutees had recently given birth or were pregnant at the time. These women were followed up and visited in their own homes with the tutor - all of the women were consulted and agreed to the visit. Through visiting Asian women in this way it was possible to talk generally about pregnancy and childbirth in both Britain and Asia in a relaxed and informal atmosphere. These informal interviews were very important in widening the researcher's knowledge and confirming certain facts.

One of the Asian tutees accompanied the researcher to the gurdwara (Sikh Temple) ramgarhia (for skilled artisans). Also at the Temple were some women from the English language classes and a lively discussion followed the service. The Temple is an important congregational place for Sikh women and they have their own afternoon



service on two days of the week. After the service food and a cup of tea is provided and many children come from school to meet their mothers.

These visits were important for the research and formed an integral part of it. Many of the visits took place over an extended period of time, while others, such as a visit to the National Childbirth Trust (NCT) classes in Reading were one-off and not followed up. These visits were not separate from the rest of the interviewing as was shown by the incident when one of the British women in the sample accompanied me to the Maternity hospital to look around as part of the Parentcraft class.

#### MEDIA

While visiting and contacting people was an integral part of the research, it was also important to keep a record of all the media the women might be exposed to for the period of their pregnancy. The following discussion falls into two parts, one dealing with the television programmes on pregnancy shown during the study and the other concerned with the written word, i.e. anything that was written and readily available to the pregnant woman.

- i) Television - At the time of interviewing there were two television series on pregnancy and childbirth. This was unusual and meant that some women who had watched them were more informed than they would have been otherwise (see chapter Ten). Also the ATV programme All About Babies had been partly filmed in Coventry and women were

able to identify some of the clinic staff in the programme. The other television series on pregnancy was shown on BBC 2 twice weekly (Thursday evening and Sunday lunchtime). This programme was called Having a Baby.

To be able to analyse the women's responses on the media it was necessary to watch both series for the length of their run. The ATV programmes had been video-taped by Coventry Health Education department and they were readily accessible for viewing. The BBC 2 programmes presented more of a problem for it meant having access to a television at a set time each week.

- ii) Slides - Through contact with AIMS information was received about some slides produced by the Medical Recording Service Foundation called Having Your Baby. These slides were made specifically for immigrant women showing Asian and West Indian women at the ante-natal clinic and following them through pregnancy until after the birth. Accompanying the slides was an English commentary plus five Asian language translations. The slides were obtained and I showed them to the interpreter for her opinion. The Area Health Education Officer was also notified about the slides and she decided to discuss their potential use with the English language co-ordinator.

iii) Books - The books the women mentioned having read at the clinic interview (see page 562 ) were referred to before the second interview and any further books the women may have read were obtained and studied. These were books like Hugh Jolly's The Book of Childcare, which incidentally was advertised on the ATV television programme and Claire Rayner's Childcare Made Simple. Interestingly Claire Rayner was involved in the BBC 2 programme.

iv) Leaflets - All pregnant women should be given leaflets at their first ante-natal clinic attendance. These leaflets include You and Your Baby books, Part 1 and 2, and a leaflet on Maternity Benefits and National Insurance.

At the local Parentcraft classes a paper called Maternity and Mothercraft was distributed free along with another leaflet on Diet for Expectant and Nursing Mothers.

(Not all pregnant women attend these classes, see p. 550-553).

The Health Education offices in the city centre hold a wide variety of publications for the pregnant mother, many of them being produced by the Health Education Council. These include New Baby, The Baby Book, You and Your New Baby, Now You're a Family, When You've had Your Baby and leaflets on breastfeeding and smoking in pregnancy. Some of these leaflets were also available at the Parentcraft classes.

Boots store also supply free leaflets on pregnancy and childcare which are mainly produced by baby food producers such as Cow and Gate.

The most difficult leaflet to obtain was the Department of Employment publication on the 1975 Employment Protection Act, New Rights for the Expectant Mother - this leaflet took three weeks to obtain from the local Employment Office as they were out of stock and had to send away for more. All the other leaflets were readily available. As some of the women in the sample had seen these leaflets during their pregnancy it was essential that the researcher was familiar with the contents before re-interviewing.

- v) Asian translations - There were not any Asian translations of the literature available locally. The Divisional Nursing Officer at the maternity hospital said Hindi and Urdu translations of information about the maternal health services were stocked in the past but they had been discontinued because so few of them were used. (One reason for the low up-take of this literature could be that most of the women who cannot speak English also cannot read in their own language).

Translated material which was not available locally and had to be requested were DHSS leaflets, Red Cross cards and an Urdu translation of the Reading NCT leaflet.

None of the Asian women had seen any of these leaflets.

LITERATURE/DOCUMENTS USED

Most of the works referred to are detailed in Chapter Two. After the interviewing, the researcher found it necessary to refer back to some of these works and look more deeply at areas, such as, traditional Hindu and folk medicine in India. This exercise provided background information on perceptions of health and illness among the Asian women.

Census statistics; OPCS Monitor; DHSS and RHA statistics were consulted and used throughout the study.

Documents relating to local population studies were also used. For example, information provided by the Community Relations Office and Planning Department.

The local press was followed closely for articles on the maternity services and the health care problems of the Asian population.

Community Health Council reports on the maternal health services were also a valuable source of information.

HOSPITAL RECORDS

The hospital records for the women interviewed were made available to the researcher. These records were used in the clinic when the woman was first interviewed and again before her follow-up interview to check the number of hospital ante-natal attendances

and record any medical remarks about her pregnancy, and then finally after the woman had given birth to note the outcome of the delivery. The women who failed to keep their ante-natal appointment (DNA's) were contacted by obtaining their address from the records and writing to their home address.

The records were used mainly as a source for checking the details given by the women and they were not relied on as the sole source of information. Often the records were incomplete and some of the information provided was imprecise and of little use. For example, the records are supposed to show the woman's husband's or boyfriend's occupation - often this is recorded as "Engineer" or "Factory worker" - this does not tell one whether the man is skilled or not, and certainly is not accurate enough to base a class analysis on. Moreover, some of the Asian women were unable to speak English and their husband's occupation is recorded as the factory where he works, e.g. Alfred Herberts. Perkins (1979) makes a similar observation and criticises the nursing staff for keeping incomplete details of patients' social class.

Some records state the woman is a "non-smoker" while others record the number of cigarettes smoked per day and a few records do not refer to cigarette smoking at all. With this information there is no basis for an adequate analysis of smoking patterns.

Bearing in mind the incomplete nature of the records they could only be used as a source of background information. One area of interest was the consultants' and doctors' comments noted in the records. The doctors were not interviewed on a systematic basis

and these comments provide an insight into their attitudes towards pregnant women. They also provide an explanation for the woman's comments about the doctors, the clinic and her treatment. (Some of these comments are referred to in Chapter Five).





I N T R O D U C T I O N   T O   I N T E R V I E W

---

Hallo, my name is Hilary Homans. I am a research student at Warwick University and would like to ask you some questions about your pregnancy and ante-natal care. I am not in any way associated with the hospital, and the answers you give me will be treated as confidential and used solely for the purpose of my work.

The interview should not take long and I would be most grateful if you would help me.

---

First question to determine whether it is a first pregnancy or not.

\* Have you had a baby before? Yes/No

IF YES

then ask questions relating to previous pregnancies, Sheet I

IF NO

then ask 'clinic' questions.

ASIAN SAMPLE ONLY

1 What is your own language?

Bengali Gujerati Hindi Punjabi Urdu

2 Do you speak any other Indian languages?

Bengali Gujerati Hindi Punjabi Sanskrit Urdu

3 Can you speak English? Yes/No

If yes, how much? A lot  
A little

4 Who taught you to speak English?

How long have you been learning? [Actual number of years]

5 Did you have any difficulty understanding what the clinic staff were saying to you today?

Yes  
No  
A little

6 Would it help you if there was an interpreter at this clinic?

Yes/No

7 Have you brought anyone with you today to help you understand the language?

Yes/No

PREVIOUS PREGNANCIES ONLY

- 1 Is this the first time that you have received your ante-natal care from this clinic?  
Yes/No
- 2 Can you remember the number of times you went to the clinic or your general practitioner in your last pregnancy?  
[Actual response] Many times  
Don't know
- 3 How many times did you miss an appointment?  
[Actual response]
- 4 [If any appointments were missed] Why did you miss your appointment(s)?
- 5 How many times have you been pregnant before?  
Once Four times  
Twice Five times  
Three times More than five times
- 6 How many of your babies did you have in hospital?  
None Five  
One More than five  
Two  
Three  
Four
- 7 How many of your babies did you have at home?  
None Four  
One Five  
Two More than five  
Three
- 8 Which do you prefer, having your babies at home, or in hospitals?  
Don't mind Home Hospital
- 9 How many children do you have?
- 10 Have you brought any of your children with you today?  
Yes/No
- 11 Is it awkward for you to bring your children with you to this clinic?  
Yes/No

12 If children not brought with mother, who is looking after them?

At school

Husband

Mother

Mother-in-law

Neighbour

Boyfriend/fiance

Other relative (specify) .....

Other .....

TO BE ADMINISTERED TO ALL WOMEN

Clinic

1 Is this the first time you have been to this clinic? -

Yes/No

2 Did you have to make special arrangements in order to get here today?

Yes/No

If so, what were they? [Read out] Time off work  
Someone to look after other children  
Travel arrangements  
Other (specify).....

3 How did you travel here today?

Bus Car Walk Other (specify).....

4 How long did it take you to get here today - from the time you left home, until the time you arrived?

- Less than five minutes
- 5 - 9 minutes
- 10 - 14 minutes
- 15 - 19 minutes
- 20 - 24 minutes
- 25 - 29 minutes
- More than thirty minutes

5 Will you come this way for your other appointments?

Yes/No

If no, how do you think you will travel here in the future?

6 What time is your appointment here today?

7 At what time did you arrive?

8 How long do you expect to be at this clinic today?

- Less than fifteen minutes
- 15 - 30 minutes
- 30 - 45 minutes
- 45 - 60 minutes
- One to one-and-a-half hours
- One-and-a-half to two hours
- More than two hours

9 Do you know anyone who has been to this clinic?

Yes/No

If yes, did they tell you what it was like?

Yes/No



If yes, who told you?

- Friend
- Husband
- Fiance/boyfriend
- Mother
- Mother-in-law
- Other relative (specify) .....

22 Do you think that there is a correct time to go to your G.P. when you are pregnant?

Yes/No

If yes, when do you think that this is, how many weeks pregnant?

23 Do you think that it makes a difference to your health if you go to the G.P. any later than you did?

Yes/No

Don't know

24 What advice did your G.P. give you when she/he told you that you were pregnant?

25 Did your G.P. tell you about relaxation/mothercraft classes at a local clinic?

Yes/No

26 Do you intend going to any of these classes?

Yes/No

If yes or no, what were your reasons?

27 Will you have all your ante-natal care from this clinic, or will you go to your own G.P. and this clinic together?

All clinic

Shared

28 Would you prefer to have all your ante-natal care from your own G.P.?

Yes/No

Don't mind

29 What reason did your G.P. give you for sending you to this clinic?

[Check if G.P. is on the Obstetrics List] Yes/No

30 Are you working at the moment? Yes/No

If yes, has your G.P. or anyone at the clinic advised you to give up work?

Yes/No

Who advised you?

G.P.

Clinic staff - specify

31 When does your G.P. or the clinic staff think that you should give up work?

Number of weeks \_\_\_\_\_ or months \_\_\_\_\_ pregnant

32 Who was the first person you told when you knew you were pregnant?

Husband

Fiance/boyfriend

Mother

Mother-in-law

Female friend

Other relative (specify) .....

33 How would you describe your state of health at the moment?

Good

The same as usual

Poor

34 Do you think that there are things that you should do during pregnancy to keep healthy?

Yes/No

Don't know

If yes, what are they?

35 Can you think of anything you should avoid doing during pregnancy?

Yes/No

If yes, what are they?

36 Has anyone told you to eat certain foods during pregnancy?

Yes/No

If yes, who told you?

What did they recommend?

If no, do you think that special foods are needed by pregnant women?

Yes/No

If yes, which foods?

Are you eating any of these foods?

37 Have you ever seen anything written about pregnancy?

Yes/No

If yes, what was it?

A book

A leaflet

An article in a magazine

Other - specify .....



38 Did you read it, or have it read to you?

Yes/No

If yes, was it useful to you? Yes/No

39 Since you have known you were pregnant this time, has anyone given you anything to read about pregnancy or ante-natal care?

Yes/No

If yes, what was it? [Name of book, etc]

Who gave it to you?

40 Would you read (or get someone to read to you) information about pregnancy, if it was given to you?

Yes/No

If no, why not?

41 Have you ever seen anything on television about pregnancy and ante-natal care?

Yes/No

If yes, did it help you at all Yes/No

Did it worry you at all Yes/No

Would you like to see more programmes about this?

Yes/No

If no, is this because you do not have a television set?

Yes/No

If you had the chance would you like to see a programme about ante-natal care?

Yes/No

NOW, JUST BEFORE YOU GO, I WOULD LIKE TO ASK SOME THINGS ABOUT YOUR EXPERIENCES AT THE CLINIC TODAY.

42 Do you understand what is meant by taking your blood pressure?

Yes/No

Do you know why it is done? Yes/No

Do you think that it is useful, or not useful?

Useful

Not useful

Don't know

Did anyone here today explain to you why it was done?

Yes/No

If yes, who explained?

Did anyone here today tell you that your blood pressure was high, low, or normal?

Yes/No

Or did they not comment on it?

Not comment

43 Is there anything today that you think ought to have been done to you in terms of looking after you during pregnancy?

Yes/No

Don't know

If yes, specify .....

44 Was there anything today that you thought was unnecessary, a waste of your time?

Yes/No

If yes, specify .....

45 Did you ask the nurse any questions this afternoon about your pregnancy?

Yes/No

If yes, what questions did you ask?

46 Did you ask the doctor any questions this afternoon about your pregnancy?

Yes/No

If yes, what did you ask?

47 Who in the clinic this afternoon did you find it easiest to speak to?

48 Do you prefer a man or a woman doctor?

Man

Woman

Don't mind

49 Which do you prefer for internal examinations?

Man

Woman

Don't mind

50 Is there anything else you want to say about the clinic that you think is important?

TO BE SAID AT THE END OF THE INTERVIEW

---

Thank you very much for answering these questions. There are a few further questions I would like to ask you when you are about 8 months pregnant, just to see how your pregnancy has progressed.

Let me see...that will be in \_\_\_\_\_ [month], would it be possible for me to visit you at your home for this interview? Yes/No

Could you give me your address then please

What would be the most convenient time of day to visit you? Have you a telephone number so that I can contact you about one week before the interview to make sure that it is convenient for you. Telephone no ..... Otherwise, I will write or call in one week before the interview just to check the arrangements.

---

Coventry CV4 7AL

Telephone Coventry (0203) 24011

Department of Sociology

Dear

I would like to thank you for helping me with my research work and remind you that the answers you have given me will be treated as confidential and used solely for the purposes of my work.

In order to complete my research I need to interview you when you are eight months pregnant and I will therefore contact you again nearer that date.

If you have any queries regarding this work please contact me (Hilary Homans) or Professor Margaret Stacey at the Sociology Department of the University of Warwick.

Please could you make a note of the number of times that you attend the ante-natal clinic so that you can tell me about it when I visit you.

Thanking you once again,

Yours sincerely,



Hilary Homans

LETTER SENT TO WOMEN WHO DID NOT ATTEND (DNA) THE CLINIC

1977

Dear

I am a research student at Warwick University, and am currently looking into the way in which the ante-natal care services are used in Coventry. The research is centred at the Coventry and Warwick Hospital Ante-Natal Clinic and I am eager to determine the reasons why women find it difficult to keep their appointments at this clinic.

On the enclosed piece of paper I have listed a number of possible reasons why you could not attend your recent appointment (there is also a space left for you to fill in your reason in case it is not included in the list).

I would greatly appreciate your help in this matter, and have enclosed a stamped addressed envelope for your reply. Also, I should point out that I am not in any way associated with the hospital and the answers you give me will be treated as confidential.

Thanking you in advance for your help.

Yours sincerely,

Hilary Homans (signed)

REASON WHY YOU COULD NOT ATTEND YOUR RECENT APPOINTMENT AT THE ANTE-NATAL CLINIC

Please tick one of the following, or complete space at the bottom

Forgot about the appointment

Unable to get time off work

Was ill

Child ill

Other member of the family was ill (who) \_\_\_\_\_

No-one to look after the children

No-one to give lift to clinic

Car broke down

Missed bus

Could not afford the bus fare

Miscarriage

Other reason (specify) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

VERBATIM RESPONSES TO (DNA) LETTER

1. "My husband was helping out in Bakery, so I got late"  
Asian woman - no ante-natal care
2. "Away on holiday when appointment card arrived, did not return to Coventry until later than appointment date".  
British woman - three ante-natal visits
3. "Was not informed of any appointment - am still waiting"  
British woman - nine ante-natal visits
4. "Daughter was poorly with broncle asma and flue at time I was to go to hospital and my husband is still poorly with ulcers and is still to poorly to managed children. Thanking you for taking interest we appreciate very much"  
British woman - two ante-natal visits  
and seven DNA's
5. "I am so sorry I forgot about the appointment, and I would be so grateful if I could have another appointment. Thank you".  
British woman - four ante-natal visits  
and two DNA's
6. "I am sorry for not answering this before now - but I am not living at above address now. The reason I did not get to the clinic was my friend's car broke down and as I am a spinal Bifida and my own inva car was broke down at the same time, so now I go by Ambulance".  
British woman - seven ante-natal visits and  
two DNA's
7. "Forgot about the appointment"  
Asian woman - seven ante-natal visits
8. "Had already booked a week's holiday for the appointment week"  
British woman - five ante-natal visits

9. "With May being my first visit to the hospital of this pregnancy I knew it would take longer than normal owing to details being checked in, full examination by the doctor and blood tests. I decided to change this appointment until my husband was able to accompany me and look after our daughter. Normally I have a neighbour that would look after her".

British woman - nine ante-natal visits

10. Telephoned to say she could not make the appointment as she had a small child at home - no letter sent.



CHECK LIST USED FOR IN-DEPTH INTERVIEWING

1. Residence - length of, in Coventry, Britain; at this address.
2. GP - number of, in Coventry; attitudes towards them; differences in practice; convenience of GP; number of visits in pregnancy; comparison with consultant clinic.
3. Consultant clinic - number of visits; number of times seen by consultant, same doctor, midwives; attitude towards clinic, clinic staff; perceived need for more/fewer attendances.
4. Knowledge of maternal health services - extent to which used, e.g. Parentcraft classes; lactation clinic; NCT.
5. Knowledge of entitlements - claimed or not, e.g. maternity grant, allowance; dental; vitamins, free milk.
6. Previous pregnancy(ies) - comparisons with current one.
7. Primiparae's expectations of care; experiences.
8. Discomforts - perception and treatment of.
9. Miscarriage - what causes, treatment.
10. Fears; worries - how dealt with.
11. Feeding baby - proposed method; reasons for choice.
12. Smoking - attitude of woman, clinic, GP, relatives.
13. Hospitals - previous experience of, generally, for pregnancy and childbirth; preference for location of birth.
14. Education - length of; further education.
15. Literature on pregnancy - clinic; other.
16. T.V. - programmes watched; attitude towards.
17. Menstruation, sex education - knowledge of; attitudes towards.

18. Diet - cravings; prohibitions; information on.
19. Traditional remedies - knowledge and use of.
20. Folk lore/old wives tales - knowledge of; belief in.
21. Desired sex of child - reasons for choice.
22. Other children - attitude towards pregnancy, forthcoming baby.
23. Social network - support and advice from male partner; mother/mother-in-law; other female relatives; friends/peer group.
24. Religion - importance of.
25. Employment - past, present; advice on when to give up in pregnancy; plans to return.
26. Desire for more children - family size.
27. Future use of ante-natal services.

APPENDIX B - TABLES

Tables	I - XIV	B1 - B9
	XXI - XXVIII	B10 - B14
	XXXV - XXXVI	B15
	XXXVIII - XXXXI	B16 - B18
	XXXIV - XXXV	B18 - B19
	XXXVII - XXXXIX	B20 - B21
	XXXXXI	B22
	XXXXXIIIa) - XXXXXV	B23 - B24
	XXXXXX	B25

**TABLE II**      WALSGRAVE OBSTETRICS 1976

TOTAL BIRTHS BY PLACE OF BIRTH OF MOTHER

Place of birth of mother	No.	%
Great Britain and Northern Ireland	3307	75.2
India; Pakistan; Bangladesh	479	10.9
Eire and Europe	349	7.8
Africa	72	1.6
West India	43	1
Other Asia	21	0.5
Australia; New Zealand; Canada; U.S.A.	10	0.2
Other and not known	123	2.8
<u>Total</u>	<u>4404</u>	<u>100</u>

Source: Regional Health Authority Statistics 1976.

**TABLE I**      WALSGRAVE OBSTETRICS 1976-1978

PERCENTAGE OF CONFINEMENTS BOOKED, BY PLACE OF BIRTH OF MOTHER  
(Home births excluded)

	Asian <sup>1</sup>	British <sup>2</sup>	Other <sup>3</sup>	Total
<u>1976</u>				
Consultant Unit	75%	67%	70.5%	68%
GP Unit	25%	32%	28%	31%
Not booked	-	1%	1.5%	1%
N	473	3273	608	4354
<u>1977</u>				
Consultant Unit	77%	69%	75%	71%
GP Unit	22%	29%	23%	28%
Not booked	1%	1%	2%	1%
Other	-	1%	-	-
N	428	3290	557	4275
<u>1978</u>				
Consultant Unit	78%	70%	73%	71%
GP Unit	21%	29%	25%	28%
Not booked	1%	1%	2%	1%
N	450	3358	556	4364

<sup>1</sup> Women born in India, Pakistan, Bangladesh.  
<sup>2</sup> Women born in Great Britain and Northern Ireland.  
<sup>3</sup> Other includes women who were born in Eire and Europe; other Asia; West Indies; Australia; New Zealand; Canada and U.S.A.; Africa; not known.

Source: Regional Health Authority statistics.

TABLE IV RESPONDENTS' LENGTH OF RESIDENCE IN COVENTRY

	Asian		British		Total	
	No.	%	No.	%	No.	%
<b>a) Final sample</b>						
Less than one year	4	15			4	7.7
One to five years	13	50	1	3.8	14	27
Six to ten years	6	23	1	3.8	7	13.5
More than ten years	2	8	2	7.7	4	7.7
All life	1	4	22	84.6	23	44
<u>Total</u>	26	100	26	99.9	52	99.9
<b>b) Asian sample only - length of residence in Britain</b>						
Less than one year	3	11.5				
One to five years	9	35				
Six to ten years	10	38				
More than ten years	3	11.5				
All life	1	4				
<u>Total</u>	26	100				
<b>c) Asian sample only - reason for migration to</b>						
	1) Britain		2) Coventry			
	No.	%	No.	%		
With, or to join, husband	6	23	6	23		
With parents	8	31	3	11.5		
On "arranged" marriage	12	46	17	65.5		
<u>Total</u>	26	100	26	100		
<b>d) Asian sample only - other cities in Britain lived in before moving to Coventry</b>						
	No.	%				
Leicester	4	44.4				
Bradford	2	22.2				
London	2	22.2				
Cardiff	1	11.1				
<u>Total</u>	9	100				

TABLE III LIVE BIRTHS BY BIRTHPLACE OF MOTHER, BRITAIN 1971-75<sup>1</sup>

Birthplace of mother	Percentage of all live births				
	1971	1972	1973	1974	1975
<u>Total</u> =	783,200	725,400	676,000	639,900	603,400
United Kingdom <sup>2</sup>	88.1	88.2	88.3	88.2	87.9
Total outside U.K.	11.3	11.4	11.5	11.6	11.9
Irish Republic <sup>3</sup>	2.8	2.6	2.4	2.3	2.1
Australia, Canada New Zealand	0.3	0.3	0.4	0.4	0.4
New Commonwealth <sup>4</sup>					
Bangladesh, India, Pakistan	2.8	2.9	2.0	2.1	2.2
Africa	0.6	0.7	0.8	0.9	1.0
West Indies <sup>5</sup>	1.6	1.5	1.3	1.3	1.3
Malta, Gibraltar, Cyprus	0.4	0.4	0.4	0.4	0.5
Remainder of New Commonwealth	0.4	0.4	0.5	0.5	0.5
Pakistan	-	-	1.0	1.1	1.2
Other foreign	2.5	2.6	2.6	2.7	2.8
Not stated	0.6	0.3	0.2	0.2	0.1

<sup>1</sup>Source: OPCS Monitor Reference FM1 77/1, 25 January 1977.

<sup>2</sup>Including Isle of Man and Channel Isles.

<sup>3</sup>Including Ireland, part not stated.

<sup>4</sup>Pakistan is included in the New Commonwealth before 1973.

<sup>5</sup>Including Guyana and Belize (formerly British Honduras).

TABLE V  
LIVE BIRTHS BY BIRTHPLACE OF MOTHER - COVENTRY 1971-1975

Area of usual residence of mother	Total live births	Birthplace of mother outside U.K. <sup>1</sup>							
		Irish Republic <sup>2</sup>		New Commonwealth and Pakistan		Other Countries <sup>3</sup>		Outside U.K.	
		No.	%	No.	%	No.	%	No.	%
Coventry <sup>4</sup>	5,930	528	9	754	13	97	2	1,379	23
	5,371	432	8	775	14	105	2	1,312	24
	4,925	408	8	717	15	74	2	1,199	24
	4,559	339	7	676	15	76	2	1,091	24
	4,191	328	8	638	15	74	2	1,036	25

<sup>1</sup>Excluding mothers with birthplace not stated.

<sup>2</sup>Including Ireland, part not stated.

<sup>3</sup>Foreign (excluding Pakistan) and Old Commonwealth countries.

<sup>4</sup>Figures for 1971-1973 are estimates relating to the new areas, which in some cases differ substantially from the old areas of the same name for which figures have been previously published.

Source: OPCS Monitor Reference PM1 77/1 25 January 1977.

TABLE VI                      TYPE OF HOUSE LIVED IN BY RESPONDENTS

Final sample	Asian		British		Total	
	No.	%	No.	%	No.	%
Terraced	19	73	8	31	27	52
Semi-detached	6	23	8	31	15	29
Flat	1	4	7	27	8	15
Detached	-		3	11	2	4
	<u>Total</u>		<u>26 100</u>		<u>26 100</u>	

b)                      Tenure of property - British final sample only<sup>1</sup>

Council	8	31
Private rented	4	15
Owner-occupied <sup>2</sup>	14	54
	<u>26 100</u>	

<sup>1</sup>It was considered insensitive to ask the Asian women this question. None of the Asian women lived in Council housing.

<sup>2</sup>National average for owner-occupation is 54%.

**TABLE VII** OCCUPATION OF RESPONDENTS' HUSBAND/BOYFRIEND  
AT TIME OF SECOND INTERVIEW

	Asian		British		Total	
	No.	%	No.	%	No.	%
a) <u>Final sample</u>						
<u>Professional</u>						
Medical	1	4			1	2
Teaching			1	4	1	2
Higher technical			2	8	2	4
Managerial			4	15	4	8
<u>Service</u>						
Bus conductor	2	8			2	4
<u>Skilled manual</u>						
Electrician	1	4			1	2
Engineering - tool maker, machinist, mechanic	6	23	7	27	13	25
Driver	1	4	2	8	3	6
<u>Other manual</u>						
Factory	5	19	1	4	6	11
Labourer	5	19	1	4	6	11
Stores	2	8			2	4
<u>Unemployed</u>	3	11	3	11	6	11
<u>Student</u>			1	4	1	2
<u>Woman self-supporting</u> <sup>1</sup>			4	15	4	8
<u>Total</u>	26	100	26	100	52	100
b) <u>Summary</u>						
Professional	1	4	7	27	8	15
Service	2	8			2	4
Skilled manual	8	31	9	35	17	33
Manual	12	46	2	8	14	27
Unemployed	3	11	3	11	6	11
Student			1	4	1	2
Woman self-supporting			4	15	4	8
<u>Total</u>	26	100	26	100	52	100

<sup>1</sup> These women were not living with a male partner.

**TABLE VIII**

RESPONDENTS' PRESENT OR LAST OCCUPATION (IF  
NOT IN PAID EMPLOYMENT) AT TIME OF FIRST  
INTERVIEW

	Asian		British		Total	
	No.	%	No.	%	No.	%
a) <u>Final sample</u>						
<u>Professional</u>						
Teaching/lecturing	1	4	3	11	4	8
Nursing			2	8	2	4
<u>Service</u>						
Clerical/secretarial			7	27	7	13
Hairdressing			2	8	2	4
Shop assistant	1	4	2	8	3	6
Barmaid/domestic			2	8	2	4
<u>Manual</u>						
Factory-unskilled and manual sewing	2	8	5	19	7	13
Never in paid employment	6	23	1	3	7	13
<u>Total</u>	26	100	26	100	52	100
b) <u>Summary</u>						
Professional	1	4	5	19	6	11
Service	1	4	13	50	14	27
Manual	8	31	6	23	14	27
Never in paid employment	16	61	2	8	18	35
<u>Total</u>	26	100	26	100	52	100



TABLE IX SEX OF GENERAL PRACTITIONER OF WOMEN STUDIED

Final sample	Asian		British		Total	
	No.	%	No.	%	No.	%
Male	25	96	25	96	50	96
Female	1	4	1	4	2	4
<u>Total</u>	<u>26</u>	<u>100</u>	<u>26</u>	<u>100</u>	<u>52</u>	<u>100</u>

TABLE X NATIONALITY OF GENERAL PRACTITIONER OF WOMEN STUDIED

Final sample	Asian		British		Total	
	No.	%	No.	%	No.	%
Asian	20	77	4	15	24	46
British	6	23	21	81	27	52
Polish			1	4	1	4
<u>Total</u>	<u>26</u>	<u>100</u>	<u>26</u>	<u>100</u>	<u>52</u>	<u>100</u>

NB. Approximately 18% of General Practitioners in Coventry are of Asian origin (Medical List - Coventry Family Practitioner Committee July 1977)

TABLE XI PERCENTAGE OF WOMEN IN SAMPLE PRESENTING AT GP IN EACH TRIMESTER OF PREGNANCY

	Asian		British		Total	
	No.	%	No.	%	No.	%
a) <u>Initial sample</u>						
First trimester	23	59	27	69	50	64
Second "	15	38	12	31	27	35
Third "	1	3 <sup>2</sup>	-	-	1	1
<u>Total</u>	<u>39</u>	<u>100</u>	<u>39</u>	<u>100</u>	<u>78</u>	<u>100</u>
b) <u>Final sample</u>						
First Trimester	15	58	18	69	33	63
Second "	10	38	8	31	18	35
Third "	1	4 <sup>2</sup>	-	-	1	2
<u>Total</u>	<u>26</u>	<u>100</u>	<u>26</u>	<u>100</u>	<u>52</u>	<u>100</u>

<sup>1</sup>Trimester = 13 weeks.  
<sup>2</sup>Arrived in Britain from India in third trimester.

TABLE XII NUMBER OF WEEKS PREGNANT RESPONDENTS FIRST WENT TO THEIR G.P.

	Asian		British		Total	
	No.	%	No.	%	No.	%
a) <u>Final sample</u>						
Under 1 month	1	3.9	2	7.7	3	5.8
4-7 weeks	7	27	6	23	13	25
8-11 weeks	6	23	7	27	13	25
12-15 weeks	5	19	7	27	12	23
16-19 weeks	3	11.5	3	11.5	6	11.5
20-23 weeks	2	7.7	-	-	2	3.8
24-27 weeks	1	3.9	1	3.9	2	3.8
28-31 weeks	-	-	-	-	-	-
32-35 weeks	1	3.9	-	-	1	1.9
36-39 weeks	-	-	-	-	-	-
	26	99.9	26	100.1	52	99.8
b) <u>Final sample</u>						
Under 1 month	-	-	-	-	-	-
4-7 weeks	3	33.3	3	33.3	6	33.3
8-11 weeks	3	33.3	3	33.3	6	33.3
12-15 weeks	1	11.1	1	11.1	2	11.1
16-19 weeks	1	-	2	22.2	2	11.1
20-23 weeks	-	-	-	-	1	5.6
24-27 weeks	-	-	-	-	-	-
28-31 weeks	-	-	-	-	-	-
32-35 weeks	1	11.1 <sup>1</sup>	-	-	1	5.6
	9	99.9	9	99.9	18	100
	<u>Total</u>		<u>Total</u>		<u>Total</u>	

<sup>1</sup> Arrived in Britain from India at 32 weeks pregnant.

TABLE XIII      WALSGRAVE OBSTETRICS 1976-1978

MATURITY ON FIRST ANTE-NATAL VISIT BY PLACE OF BIRTH  
OF MOTHER BY TRIMESTER

	Asian <sup>1</sup>		British <sup>2</sup>		Total <sup>3</sup>	
	No.	%	No.	%	No.	%
<u>1976</u>						
1st Trimester	99	21	903	28	1151	26
2nd Trimester	273	58	1698	52	2284	53
3rd Trimester	63	13	400	12	553	13
Did not attend (DNA)	38	8	272	8	366	8
<u>Total</u>	<u>473</u>	<u>100</u>	<u>3273</u>	<u>100</u>	<u>4354</u>	<u>100</u>
<u>1977</u>						
1st Trimester	75	17	937	28.5	1127	26.4
2nd Trimester	234	55	1659	50	2188	51.2
3rd Trimester	93	22	446	14	643	15
Did not attend (DNA)	26	6	248	7.5	317	7.4
<u>Total</u>	<u>428</u>	<u>100</u>	<u>3290</u>	<u>100</u>	<u>4275</u>	<u>100</u>
<u>1978</u>						
1st Trimester	105	23	1024	31	1265	29
2nd Trimester	260	58	1778	53	2320	53
3rd Trimester	64	14	351	10	507	12
Did not attend (DNA)	21	5	205	6	272	6
<u>Total</u>	<u>450</u>	<u>100</u>	<u>3358</u>	<u>100</u>	<u>4364</u>	<u>100</u>

<sup>1</sup>Women born in India, Pakistan, Bangladesh.

<sup>2</sup>Women born in Great Britain and Northern Ireland.

<sup>3</sup>Total number of pregnant women.

Source: Regional Health Authority statistics.

TABLE XIV NUMBER OF WOMEN IN SAMPLE PRESENTING AT CONSULTANT ANTE-NATAL CLINIC IN EACH TRIMESTER

	Asian		British		Total	
	No.	%	No.	%	No.	%
<u>Initial sample N = 78</u>						
1st Trimester	5	13	10	26	15	19
2nd Trimester	18	46	20	51	38	49
3rd Trimester	16	41	9	23	25	32
	39	100	39	100	78	100
<u>Final sample N = 52</u>						
1st Trimester	1	4	4	15	5	10
2nd Trimester	11	42	16	62	27	52
3rd Trimester	14	54	6	23	20	38
	26	100	26	100	52	100

TABLE XXI      RESPONDENTS' PREFERENCE FOR LOCATION OF ANTE-NATAL CARE

	Asian		British		Total	
	No.	%	No.	%	No.	%
<u>a) Initial sample</u>						
All GP	19	49	20	51	39	50
All clinic			10	26	10	13
"Shared" care <sup>1</sup>	9	23			9	12
All either one but no preference for which			1	3	1	1
Don't mind	11	28	8	20	19	24
<u>Total</u>	<u>39</u>	<u>100</u>	<u>39</u>	<u>100</u>	<u>78</u>	<u>100</u>
<u>b) Final sample - First interview</u>						
All GP	15	58	15	58	30	58
All clinic			5	19	5	9.5
"Shared" care <sup>1</sup>	4	15			4	7.5
Don't mind	7	27	6	23	13	25
<u>Total</u>	<u>26</u>	<u>100</u>	<u>26</u>	<u>100</u>	<u>52</u>	<u>100</u>
<u>c) Final sample - Second interview</u>						
All GP	3	12	10	39	13	25
All clinic	13	50	16	61	29	56
"Shared" care <sup>1</sup>	4	15			4	7.5
Don't mind	6	23			6	11.5
<u>Total</u>	<u>26</u>	<u>100</u>	<u>26</u>	<u>100</u>	<u>52</u>	<u>100</u>
<sup>1</sup> "Shared" care means clinic and GP care combined.						

TABLE XXII

AGE OF RESPONDENTS AT FIRST INTERVIEW

	Asian		British		Total	
	No.	%	No.	%	No.	%
<u>1. Initial sample</u>						
20 or under	7	18	5	13	12	15
21 - 25	13	33	8	20	21	27
26 - 30	9	23	17	44	26	34
31 - 35	4	10	7	18	11	14
36 +	6	16	2	5	8	10
<u>Total</u>	<u>39</u>	<u>100</u>	<u>39</u>	<u>100</u>	<u>78</u>	<u>100</u>
<u>2. Final sample</u>						
20 or under	4	15	3	12	7	13
21 - 25	10	39	6	23	16	31
26 - 30	6	23	11	42	17	33
31 - 35	2	8	5	19	7	13
36 +	4	15	1	4	5	10
<u>Total</u>	<u>26</u>	<u>100</u>	<u>26</u>	<u>100</u>	<u>52</u>	<u>100</u>

TABLE XXIII

AGE OF RESPONDENTS AT FIRST PREGNANCY

	Asian		British		Total	
	No.	%	No.	%	No.	%
<u>Final sample</u>						
20 or under	16	61	8	31	24	46
21 - 25	7	27	6	23	13	25
26 - 30	2	8	10	38	12	23
31 - 35	-	-	2	8	2	4
36 +	1	4	-	-	1	2
<u>Total</u>	<u>26</u>	<u>100</u>	<u>26</u>	<u>100</u>	<u>52</u>	<u>100</u>

TABLE XXIV  
AGE OF RESPONDENTS AT MARRIAGE

	Asian		British		Total	
	No.	%	No.	%	No.	%
<u>Final sample</u>						
20 or under	20	77	8	31	28	54
21 - 25	3	11	8	31	11	21
26 - 30	2	8	5	19	7	13
31 - 35	1	4	1	4	2	4
Never married	-	-	4	15	4	8
	<hr/>		<hr/>		<hr/>	
<u>Total</u>	26	100	26	100	52	100
	<hr/>		<hr/>		<hr/>	





TABLE XXVII  
NUMBER OF PREVIOUS PREGNANCIES WHICH DID NOT  
RESULT IN A LIVE BABY

	Asian		British	
	No.	%	No.	%
<u>Initial sample</u> N = 39				
Miscarriage	13	17	11	21.5
Abortion	2	3		
Still birth	3	4	3	6
Neo-natal death	3	4	1	2
<u>Total number of pregnancies</u>	75	100	51	100
Total number of non-viable pregnancies as a percentage of total number of pregnancies	15	20	11	21.6
Total number of pregnancies not resulting in a live baby as a percentage of total number of pregnancies	21	28	15	29
<u>Final sample</u> N = 26				
Miscarriage	10	17.5	7	21
Abortion	2	3.5		
Still birth	3	5	1	3
Neo-natal death			1	3
<u>Total number of pregnancies</u>	57	100	34	100
Total number of non-viable pregnancies as a percentage of total number of pregnancies	12	21	7	21
Total number of pregnancies not resulting in a live baby as a percentage of total number of pregnancies	15	26	9	26

TABLE XXVIII  
MARITAL STATUS OF RESPONDENTS AT TIME OF  
FIRST AND SECOND INTERVIEW<sup>1</sup>

	Asian		British		Total	
	No.	%	No.	%	No.	%
<u>Initial sample</u>						
First interview						
Married	38	97	28	72	66	85
Never married	1	3	8	20	9	11
Divorced/Widowed/Separated			3	8	3	4
<u>Total</u>	39	100	39	100	78	100
<u>Final sample</u>						
Second interview						
Married			26	100	20	77
Never married			4	15	4	8
Divorced/Widowed/Separated			2	8	2	4
<u>Total</u>			26	100	26	100

<sup>1</sup>Three British women were married between the first and final interview, two for the first time and one woman remarried

TABLE XXXVI - WALSGRAVE OBSTETRICS 1976

BIRTH WEIGHT OF BABY BY COUNTRY OF ORIGIN OF MOTHER

1976	Indio/Pakistan		G.B. & N. Ireland		Total	
	No.	%	No.	%	No.	%
below 2 kg	16	3.34	103	3.11	132	2.99
2-2.49 kg	52	10.85	151	4.55	236	5.33
2.50-2.99 kg	158	32.99	629	18.96	916	20.69
3.0-3.49 kg	171	35.7	1285	38.74	1703	38.47
3.5-3.99 kg	67	13.99	889	26.8	1114	25.16
4-4.49 kg	10	2.09	222	6.69	271	6.12
4.50-4.99 kg	4	0.83	83	0.99	42	0.95
5 kg +	1	0.21	5	0.15	13	0.29
	<b>479</b>	<b>100</b>	<b>3317</b>	<b>99.99</b>	<b>4427</b>	<b>100</b>

Other countries of origin included in analysis, but omitted from this Table are:

- Eire/Europe
  - Other Asian
  - West Indies
  - Australia, New Zealand, Canada, U.S.A.
  - Africa
  - Other
- Source: Regional Health Authority Statistics.

TABLE XXXV - BIRTH WEIGHT OF BABIES BORN TO WOMEN STUDIED

Average birth weight	Asian	British	Total
Initial sample <sup>1</sup>	3.13 kg	3.34 kg	3.29 kg <sup>3</sup>
Final sample <sup>2</sup>	3.095 kg	3.42 kg	3.27 kg <sup>4</sup>
<u>Birth weights</u>	No.	%	No.
<u>Initial sample</u>			%
below 2 kg	1	3	2
2.0 - 2.49 kg	2	6	3
2.5 - 2.99 kg	11	31	15
3.0 - 3.49 kg	15	43	28
3.5 - 3.99 kg	5	14	19
4.0 - 4.49 kg	1	3	1
4.5 - 4.99 kg	-	-	1
<b>Total</b>	<b>35</b>	<b>100</b>	<b>69</b>
			<b>100</b>
<u>Final sample</u>			
below 2 kg	1	4	1
2.0 - 2.49 kg	2	8	2
2.5 - 2.99 kg	6	23	9
3.0 - 3.49 kg <sup>5</sup>	11	42	21
3.5 - 3.99 kg	5	19	17
4.0 - 4.49 kg	1	4	1
4.5 - 4.99 kg	-	-	1
<b>Total</b>	<b>26</b>	<b>100</b>	<b>52</b>
			<b>100</b>

<sup>1</sup>N = 34 British and 35 Asian (Records incomplete for 5 British and 4 Asian)

<sup>2</sup>N = 26

<sup>3</sup>N = 69

<sup>4</sup>N = 52

<sup>5</sup>One Asian baby still born weighing 3.48 kg

TABLE WALSGRAVE OBSTETRICS 1976-1978  
XXXVIII  
PERCENTAGE OF SPECIAL CARE BABY UNIT ADMISSIONS OF  
TOTAL LIVE BIRTHS BY PLACE OF BIRTH OF MOTHER

	Asian <sup>1</sup>		British <sup>2</sup>		Other <sup>3</sup>		Total <sup>4</sup>	
	No.	%	No.	%	No.	%	No.	%
<u>1976</u>								
No. of SCU admissions	125	26	657	20	137	23	919	21
Total number of live births	473	100	3273	100	585	100	4331	100
<u>1977</u>								
No. of SCU admissions	90	21	517	16	103	18	710	17
Total number of live births	425	100	3252	100	553	100	4240	100
<u>1978</u>								
No. of SCU admissions	93	20	408	12	91	15	592	14
Total number of live births	467	100	3339	100	566	100	4372	100
<sup>1</sup> Women born in India, Pakistan, Bangladesh. <sup>2</sup> Women born in Great Britain and Northern Ireland. <sup>3</sup> Women born in Eire and Europe; other Asia; West Indies; Australia, New Zealand, Canada, USA; Africa; not known. <sup>4</sup> Total number of live births.								
<u>Source:</u> Regional Health Authority statistics.								

TABLE XXXIX NUMBER OF INDUCTIONS AS PERCENTAGE OF TOTAL NUMBER OF HOSPITAL BIRTHS - 1966-1976

Year	Total No. of hospital births	No. of inductions	% of births induced
1966	2377	277	11.6
1967	4767	693	14.5
1968	5446	830	15.2
1969	5880	908	15.4
1970	5805	1220	21
1971	6273	1568	25
1972	5705	2210	38.7
1973	5244	1938	37
1974	4934	1652	33.5
1975	4500	1778	39.5
1976	4423	1530	34.6

Source: Coventry Maternity Hospital Statistics.

NB. Coventry Maternity hospital opened 19th June, 1966, the figures given for 1966 are therefore for only half the year.

TABLE XXXX NUMBER OF RESPONDENTS WHO HAD MEDICAL INTERVENTION AT TIME OF DELIVERY

Nature of intervention	Asian		British		Total	
	No.	%	No.	%	No.	%
<u>Initial sample N = 78<sup>1</sup></u>						
Induction	10	29	14	41	24	35
Caesarian section	4	11	2	6	6	9
Forceps	2	6	6	18	8	11.5
Epidural			1	3	1	1.5
<u>Total</u>	<u>16</u>	<u>36</u>	<u>23</u>	<u>68</u>	<u>39</u>	<u>57</u>
<u>Final sample N = 52<sup>2</sup></u>						
Induction	7	27	11	42	18	35
Caesarian section	3	11.5	2	8	5	10
Forceps	2	8	5	19	7	13
Epidural	-	-	1	4	1	4
<u>Total</u>	<u>12</u>	<u>46.5</u>	<u>19</u>	<u>73</u>	<u>31</u>	<u>62</u>

<sup>1</sup> Records incomplete for 4 Asian and 5 British women.  
<sup>2</sup> Record incomplete for 1 British woman.  
Source: Hospital Maternity Records

TABLE XXXXI

WALSGRAVE OBSTETRICS 1977-1978

METHOD OF DELIVERY BY PLACE OF BIRTH OF MOTHER

	Asian <sup>1</sup>		British <sup>2</sup>		Other <sup>3</sup>		Total <sup>4</sup>	
	No.	%	No.	%	No.	%	No.	%
<u>1977</u>								
Spontaneous	321	75	2630	80	444	80	3395	80
Forceps	54	12.6	415	13	57	10	526	12
Caesarian	37	8.6	179	5	46	8	262	6
Other	16	3.8	66	2	10	2	92	2
<u>Total</u>	<u>428</u>	<u>100</u>	<u>3290</u>	<u>100</u>	<u>557</u>	<u>100</u>	<u>4275</u>	<u>100</u>
<u>1978</u>								
Spontaneous	344	76	2726	81	444	81	3514	80.5
Forceps	54	12	410	12	67	12	531	12
Caesarian	45	10	165	5	31	5	241	5.5
Other	7	2	57	2	14	2	78	2
<u>Total</u>	<u>450</u>	<u>100</u>	<u>3358</u>	<u>100</u>	<u>556</u>	<u>100</u>	<u>4364</u>	<u>100</u>
<sup>1</sup> Women born in India, Pakistan, Bangladesh. <sup>2</sup> Women born in Great Britain and Northern Ireland. <sup>3</sup> Women born in Eire and Europe; other Asia; West Indies; Australia, New Zealand, Canada, U.S.A.; Africa; not known. <sup>4</sup> Total number of deliveries.								
Source: Regional Health Authority statistics.								

TABLE XXXIV

NUMBER OF WOMEN BREASTFEEDING IN COVENTRY MATERNITY HOSPITAL 1966-1976

Year	Consultant Unit			GP Unit			Special Care Baby Unit		
	Total No.	No. breastfeeding	%	Total No.	No. breastfeeding	%	Total No.	No. breastfeeding	%
1966	2296	857	37	-	-	-	234	6	2.6
1967	4193	1004	24	306	78	25.5	756	12	1.6
1968	4544	732	16	830	138	16.6	765	9	1.2
1969	4707	704	15	1059	190	18	903	24	2.7
1970	4397	820	18.6	993	247	25	765	34	4.4
1971	5003	934	18.7	1209	270	22	1009	52	5.2
1972	4418	757	17	1259	263	21	771	26	3.4
1973	4036	932	23	1089	245	22.5	773	55	7.1
1974	3817	1052	27.6	1187	271	22.8	864	78	9
1975	3703	1311	35.4	751	308	41	894	138	15.4
1976	3501	1417	40.5	826	415	50	939	219	30.4
Source: Coventry Maternity Hospital Statistics.									
N.B. Hospital opened 19 June 1966, so figures for 1966 are for half year only. GP Unit did not open until 1967.									

TABLE XXXV      RESPONDENTS' SOURCE OF INFORMATION ABOUT PREGNANCY AND CHILDBIRTH AT TIME OF FIRST PREGNANCY

Final sample	Asian <sup>1</sup>		British <sup>2</sup>		Total	
	No.	%	No.	%	No.	%
School	6	23	15	39.5	21	33
Friends	3	11.5	15	39.5	18	28
Books	2	8	4	10.5	6	9
Mother			4	10.5	4	6
Didn't know	11	42			11	17
Other sources <sup>3</sup>	3	11.5			3	5
Not asked <sup>4</sup>	1	4			1	2
	<hr/>		<hr/>		<hr/>	
<u>Total</u>	26	100	38	100	64	100
	<hr/>		<hr/>		<hr/>	

<sup>1</sup>N = 26

<sup>2</sup>N = 26 but the British women gave 38 sources of information

5 women had learnt from school and friends  
2 " " " " friends and books  
2 " " " " books and mother  
1 " " " " mother and friends  
1 " " " " mother, friends and school

<sup>3</sup>These three Asian women learnt about pregnancy and childbirth from observation and living in a household with a pregnant relative.

<sup>4</sup>Husband present so woman not asked

TABLE XXXVII SEX OF DOCTOR RESPONDENTS WOULD PREFER IF THEY HAD THE CHOICE

	Asian		British		Total	
	No.	%	No.	%	No.	%
a) <u>For ordinary care</u>						
<u>Final sample</u>						
Male	2	8	5	19	7	13.5
Female	13	50	7	27	20	38.5
Don't mind	11	42	13	50	24	46
No choice			1	4	1	2
<u>Total</u>	26	100	26	100	52	100
b) <u>For internal examinations</u>						
<u>Final sample</u>						
Male			4	15.4	4	8
Female	18	69	7	27	25	48
Don't mind	8	31	11	42.2	19	36
No choice			4	15.4	4	8
<u>Total</u>	26	100	26	100	52	100

TABLE XXXVIII TIME INTERVAL BETWEEN RESPONDENTS' MARRIAGE AND BIRTH OF FIRST CHILD

Final sample	Asian		British		Total	
	No.	%	No.	%	No.	%
<u>Pregnant and not married</u>	4	15	4	15	8	.8
<u>Number of years after marriage woman gave birth</u>						
Same year as marriage	5	19	3	12	8	15
One year after marriage	17	65	5	19	22	42
Two years after marriage	1	4	4	15	5	10
Three years after marriage	2	8	4	15	6	11
Four years after marriage			1	4	1	2
More than five years after <sup>1</sup> marriage	1	4	5	20	6	12
<u>Total</u>	26	100	26	100	52	100

<sup>1</sup>The Asian woman had been temporarily separated from her husband when he migrated to Britain where she joined him after three and a half years.  
Three of the British women in this group were treated for infertility and one woman was awaiting an appointment with the Gynaecologist when she conceived.

TABLE XXXIX      WOMEN'S INTENTION TO STAY AT HOME OR ENGAGE IN PAID EMPLOYMENT AFTER THE BIRTH OF THE BABY

Final sample	Asian		British		Total	
	No.	%	No.	%	No.	%
<u>Reason for decision</u>						
1. <u>Will engage in paid employment</u>						
Economically necessary	4	15	3	11.5	7	13
Social reasons - career, lonely	3	12	5	19	8	15
2. <u>Do not intend to engage in paid employment</u>						
No one to look after children	6	23	0	0	6	12
Their duty to stay at home	5	19	8	31	13	25
Husband won't let them	3	12	0	0	3	6
Like it at home	0	0	3	11.5	3	6
Want more children	1	4	2	8	3	6
Had baby because lonely at home	0	0	1	4	1	2
3. <u>No plans at the moment</u>						
	4	15	4	15	8	15
<u>Total</u>	<u>26</u>	<u>100</u>	<u>26</u>	<u>100</u>	<u>52</u>	<u>100</u>



TABLE LIa) WOMEN'S RESPONSE TO QUESTION: HOW WOULD YOU DESCRIBE YOUR STATE OF HEALTH AT THE MOMENT ?

		Asian		British		Total	
		No.	%	No.	%	No.	%
a) <u>Initial sample</u>							
Positive responses	( Same as usual	2	5	4	10	6	7.7
	( Good/fine	7	19	9	23	16	20.5
	( Allright	19	48.7	7	18	26	33.3
	( Very good/very well	-	-	11	28	11	14
Negative responses	Poor	6	15	1	2.6	7	9
	Not very well	2	5	1	2.6	3	3.8
	Rotten/terrible	1	2.6	2	5	3	3.8
	Suicidal	-	-	1	2.6	1	1.3
	Bit depressed	1	2.6	1	2.6	2	2.6
	Better now	1	2.6	2	5	3	3.8
<u>Total</u>		<u>39</u>	<u>100.5</u>	<u>39</u>	<u>99.4</u>	<u>78</u>	<u>99.8</u>
Positive responses		28	73	31	79	59	75.5
Negative responses		11	27	8	21	19	24.5
<u>Total</u>		<u>39</u>	<u>100</u>	<u>39</u>	<u>100</u>	<u>78</u>	<u>100</u>

TABLE LIb) WOMEN'S RESPONSE TO QUESTION: HOW WOULD YOU DESCRIBE YOUR STATE OF HEALTH AT THE MOMENT?

		Asian		British		Total	
		No.	%	No.	%	No.	%
b) <u>Final sample</u>							
Positive responses	( Same as usual	1	4	4	15	5	10
	( Good/fine	5	19	6	23	11	21
	( Allright	15	58	2	7.7	17	33
	( Very good/very well	-	-	8	31	8	15
Negative responses	Poor	3	11	-	-	3	6
	Not very well	1	4	-	-	1	2
	Rotten/terrible	-	-	2	7.7	2	3
	Suicidal	-	-	1	4	1	2
	Bit depressed	-	-	1	4	1	2
	Better now	1	4	2	7.7	3	6
<u>Total</u>		<u>26</u>	<u>100</u>	<u>26</u>	<u>100</u>	<u>52</u>	<u>100</u>
Positive responses		21	81	20	76.7	41	78
Negative responses		5	19	6	23.4	11	22
<u>Total</u>		<u>26</u>	<u>100</u>	<u>26</u>	<u>100</u>	<u>52</u>	<u>100</u>

TABLE  
LIII a)

COMPLAINTS RESPONDENTS MENTIONED SUFFERING  
FROM DURING THEIR PREGNANCY

Final sample	Asian		British		Total	
	No.	%	No.	%	No.	%
Vomits/sickness	15	58	15	58	30	58
Weakness )	14	54			14	27
Tiredness )	6	23	3	11.5	9	17
Heartburn	4	15	16	61.5	20	38
Indigestion			8	31	8	15
Constipation	2	8	4	15	6	11.5
Sleeplessness	2	8	3	11.5	5	10
Varicose veins	1	4	3	11.5	4	8
Faint/giddy	2	8	2	8	4	8
Difficulty moving	4	15	2	8	6	11.5
Depressed	2	8	3	11.5	5	10
Aches/pains	4	15	9	35	13	25
Swelling			1	4	1	2
Palpitations			1	4	1	2
Skin rash	1	4			1	2
	<u>Total<sup>1</sup></u>		<u>57 220</u>		<u>70 270.5</u>	
			<u>127 245</u>			

<sup>1</sup>Numbers total more than 100% as:-  
Fifteen Asian and eleven British women suffered from two complaints.  
Eight Asian and five British women suffered from three complaints.  
Six British women suffered from four complaints.  
One British woman suffered from six complaints.  
Thus, twenty-six Asian women suffered with fifty seven complaints.  
" " British " " " seventy "

TABLE  
LIII b)

NUMBER OF RESPONDENTS SUFFERING FROM MEDICALLY DEFINED  
COMPLAINTS

Final sample	Asian		British		Total	
	No.	%	No.	%	No.	%
Toxaemia	1	4			1	2
High blood pressure	1	4	3	11.5	4	8
	<u>Total</u>		<u>3 11.5</u>		<u>5 10</u>	

N = 52

TABLE LV  
 WOMEN'S RESPONSE TO THE QUESTION: "DO YOU  
 THINK THERE IS A "CORRECT" TIME TO GO TO  
 YOUR GP WHEN PREGNANT?"

Final sample	Asian		British		Total	
	No.	%	No.	%	No.	%
Yes	23	88	22	85	45	86.5
No	2	8	4	15	6	11.5
Don't mind	1	4	-	-	1	2
<u>Total</u>	<u>26</u>	<u>100</u>	<u>26</u>	<u>100</u>	<u>52</u>	<u>100</u>

If the response is yes, when?

When you miss your first period	8	35	7	32	15	33.3
Before 2 months	7	30.4	3	14	10	22.2
Up to 3 months	7	30.4	9	41	16	36
Up to 4 months	-	-	1	4	1	2
Up to 6 months	1	4.2	-	-	1	2
Depends how eager you are	-	-	2	9	2	4.4
<u>Total</u>	<u>23</u>	<u>100</u>	<u>22</u>	<u>100</u>	<u>45</u>	<u>99.9</u>

TABLE LIV  
 WOMEN'S RESPONSE TO QUESTION "DID ANYONE TELL  
 YOU TO GO TO YOUR GP WHEN YOU DID,"

Final sample	Asian		British		Total	
	No.	%	No.	%	No.	%
No	18	69	21	81	39	75
Yes	8	31	5	19	13	25
<u>Total</u>	<u>26</u>	<u>100</u>	<u>26</u>	<u>100</u>	<u>52</u>	<u>100</u>

If the response is yes, who told you?

Husband <sup>1</sup>	5	62.5	1	20	6	46
GP <sup>2</sup>	-	-	2	40	2	15
BPAS	-	-	1	20	1	8
Mother	-	-	1	20	1	8
Mother-in-law	1	12.5	-	-	1	8
Sister-in-law	2	25	-	-	2	15
<u>Total</u>	<u>8</u>	<u>100</u>	<u>5</u>	<u>100</u>	<u>13</u>	<u>100</u>

<sup>1</sup>Two women said their husbands had told them to go to the doctor as they were not feeling well.  
 One woman's husband advised her to go to the GP because she was sick a lot.

<sup>2</sup>Two women had been told by the GP to go to him as soon as they missed a period because of previous history of miscarriage.

TABLE WOMEN'S EXPOSURE TO TELEVISION PROGRAMMES ON  
LX PREGNANCY AND CHILDBIRTH AT THE TIME OF FIRST  
INTERVIEW

Final sample	Asian		British		Total	
	No.	%	No.	%	No.	%
<u>All respondents seen programme</u>						
Yes	18	69	23	88	41	79
No	8	31	3	12	11	21
<u>Total</u>	<u>26</u>	<u>100</u>	<u>26</u>	<u>100</u>	<u>52</u>	<u>100</u>
<u>Of those who had seen programmes, was the programme any help?</u>						
Yes	15	58	15	58	30	58
No	3	11	8	30	11	21
<u>Total</u>	<u>18</u>	<u>69</u>	<u>23</u>	<u>88</u>	<u>41</u>	<u>79</u>
<u>Did the programme worry you?</u>						
Yes	6	23	7	27	13	25
No	12	46	16	61	28	54
<u>Total</u>	<u>18</u>	<u>69</u>	<u>23</u>	<u>88</u>	<u>41</u>	<u>79</u>
<u>All respondents:</u>						
<u>Would you like to see more television programmes on ante-natal care?</u>						
Yes	21	81	14	54	35	67
No	5	19	9	35	14	27
Don't mind	-	-	3	11	3	6
<u>Total</u>	<u>26</u>	<u>100</u>	<u>26</u>	<u>100</u>	<u>52</u>	<u>100</u>
<u>No. of respondents without television</u>						
	7	27	1	4	8	15
	N = 26		N = 26		N = 52	



We had spent the night without a wink of sleep  
(sung happily\*)

Singing together: We won't forget this first encounter of how  
we spent our wedding night. (refrain together\*)

\*Translator's comment.

Song supplied and translated by Jayashree Sondhi.

APPENDIX D

THINGS TO BE AVOIDED DURING PREGNANCY MENTIONED BY INITIAL  
SAMPLE N = 39<sup>1</sup>

Asian sample

Lifting heavy things - mentioned by 22 women)  
Doing heavy work " " 2 " ) 26 women  
Straining the body " " 2 " )  
Running  
Sitting during an eclipse - must walk around and  
not look at it otherwise it will affect the  
baby  
Having tight clothing around the waist - may affect  
the baby  
Eating "hot" curries  
" "hot" stuff - particularly chillies, peppers  
" "hot" food - may lose the baby  
" "sour" things  
" fried foods

British sample

Lifting heavy things - mentioned by 16 women)  
Doing heavy work " " 3 " ) 24 women  
Anything strenuous " " 5 " )  
Stretching  
Running about  
Overdoing it  
Horse-riding  
Netball  
Putting on too much weight  
Excesses of food and drink  
X-rays  
Drugs  
Smoking

Fried foods  
Blighted potatoes  
Violent sex  
Wearing high-heeled shoes

<sup>1</sup>Some women advocated "avoiding" more than one thing, whilst a few women considered that they should "carry on as normal" when pregnant.

Note: The similarity between the two samples in terms of not lifting heavy things or doing heavy work.



APPENDIX E

CLASSIFICATION OF FOODS ACCORDING TO THE AYURVEDIC TRADITION

"Hot" foods

Chilli  
Tumeric  
Wheat  
Mustard seeds  
Garlic  
Chicken  
Honey  
Potato  
Fish  
Horse gram  
Groundnut  
Drumstick  
Bitter gourd  
Carrot  
Radish  
Fenugreek  
Green mango  
Paw-Paw  
Dates  
Coffee  
Ginger  
Egg

"Cold" foods

Boiled rice  
Blackgram  
Cow milk  
Buffalo milk  
Butter milk  
Ghee  
Banana  
Black pepper  
Tea  
Onion  
Peas  
Oranges  
Pumpkin  
Green tomatoes  
Spinach  
Guava  
Greengram

Sources

- AMAN, (1969) 'Mechanical Secrets of Your Food'. 1st Ed., Mysore, India.
- NICHTER, M. (1977) 'Health Ideologies and Medical Cultures in the South Kanara Areca-Nut Belt'. Ph.D. Thesis, Edinburgh.
- RAMANAMURTHY, P.S.V. (1969) Journal of Nutrition and Diet. Vol.6, p.187.
- SHAH, P.M. (1975) Indian Paediatrics, Vol.12, p.73.