CHILDBIRTH IN THE MANAWATU:

WOMEN'S PERSPECTIVES

A Thesis presented in fulfilment
of the requirements for the degree of
Master of Philosophy
in
Sociology
at
Massey University

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1986

ABSTRACT

In most western countries the management of childbirth is surrounded by controversy and debate. New Zealand is no exception. Much of the debate centres round the role of medicine in the management of the healthy birth and the powerful influence exerted by the providers of maternity services over policy in this area.

New Zealand research conducted on the management of childbirth, including consumer surveys, reflects the questions, methodologies and experience of the providers. Women's experiences of childbirth have not usually been considered legitimate data.

This 'invisibility' of women in the research data has produced a body of knowledge about childbirth that is androcentric, reflecting male experience. Women, until recently, have been powerless to challenge this version of the reality of childbirth because they lacked access to medical knowledge and technology and because of the existence of an ideology of motherhood that imbued women with an expectation of self-sacrifice and nurturance impelling them to give priority to the perceived needs of the baby. The medical profession has been able to maintain control of the management of childbirth by requiring women's passivity and dependence 'for the sake of the baby'. In this way, medicine might be said to act as an agent of social control of women, reproducing the unequal relations of gender by confirming women in their dependent roles of motherhood and domesticity.

The pregnancy and birth experiences of 48 Manawatu women are explored in depth. The sample consisted of rural and urban women who, when pregnant, were expecting to have a normal labour and birth. Perinatal care was provided either by a specialist obstetric unit at the regional base hospital or by low technology, general practitioner (obstetric) units (GPU's) in the peripheral areas.

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Management of childbirth was found to be generally consistent with an obstetric or medical model of childbirth and similar in both high and low technology hospitals. Women's priorities for a quality service were more akin to a model of childbirth based on traditional midwifery.

Women wanted a more 'holistic' form of maternity care; one that recognised and incorporated the socio-emotional dimensions of pregnancy and birth. Most women rejected the passive role expected of them in medical encounters and during the birth process. Women were likely to reject the association of childbirth with illness, preferring antenatal and perinatal services that were autonomous of general medical services. Few women, however, felt that the home could provide the ideal conditions for giving birth. The physical difficulty of labour and the level of medical intervention in the birth process were less likely to influence women's satisfaction with labour and birth that the quality of the emotional support women received from birth attendants and the level of the mothers' active participation in labour.

Greater approval was found for the GPU as a place of birth, than for the specialist unit.

Such findings challenge some of the current assumptions and directions of policy on maternity services in New Zealand.

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ACKNOWLEDGEMENTS

A number of people and organisations have made significant contributions towards the successful completion of this thesis. I would particularly like to thank my research supervisor, Bev James, for her unceasing support, encouragement and enormously valuable criticism.

To Professor Graeme Fraser I owe a debt of thanks for his support and for smoothing the way, in the early days of negotiation, with various institutions and organisations.

I would also like to thank Miss Sylvia Eagle, Nurse Adviser, The Royal New Zealand Plunket Society Inc., Manawatu, for permitting access to Plunket mothers in the region. The fieldwork in this research would have been a great deal more difficult without her very willing cooperation. Thanks also go to the ten Plunket Nurses in the region, whose enthusiastic help and advice were invaluable.

I acknowledge, with gratitude, a generous grant from the Medical Research Council of New Zealand.

To Dave Alton, my heartfelt thanks for his faith in me and for the practical support that I so often needed.

Barbara Roberts was also an important contributor to the practical production of this thesis. I am most grateful for her superior skills in typing and administrative knowhow.

Finally, I wish to thank the 48 Manawatu women who so willingly and generously gave me much of their valuable time and shared with me some of the joys and sorrows of childbirth.

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GLOSSARY

ARM	Artificial Rupture of Membranes (Amniotomy)
BHS	Base Hospital Sample
LHS	Local Hospital Sample
GPU	General Practitioner (maternity) Unit
MSC	Maternity Services Committee (of the Board of Health)
PCB	Parents Centre Bulletin
PCM	Parents Centre Movement
SROW	Soceity for Research on Women in New Zealand Inc.
Primipara(e)	A woman who has undergone a first pregnancy and given birth to a viable fetus (or fetuses)
Multipara(e)	A woman who has given birth to two or more viable fetuses in separate pregnancies
Parity	Number of pregnancies continued to the period of viability
1st Stage of Labour	The exact point when labour begins is controversial, but a widely accepted definition is when the uterine contractions become strong enough to bring about progressive cervical effacement and dilatation and ending in full filatation of the cervix
2nd Stage of Labour	Full dilatation of the cervix to the birth of the infant
3rd Stage of Labour	The period following birth until the expulsion of the placenta
Puerperium	The days following birth when the mother's body progressively returns to its non-pregnant state
Obstetrician	Any doctor who undertakes obstetrical care
Specialist Gynaecologist	An obstetrician and gynaecologist with some years of postgraduate training
....	Pause
(....)	Passage edited out

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INTRODUCTION

In New Zealand, as in most western countries, the management of childbirth is surrounded by debate and controversy (Macintyre, 1977; Skuja et al, 1982; van Dongen, 1985). This debate is taking place within the professions of medicine and midwifery, within many of the paramedical and related professions, such as psychology, sociology and anthropology and amongst sections of the lay public. The largest and most well known New Zealand lay group contributing to the debate has been the Parents Centre Movement (PCM) with over 9,000 subscribers to its national magazine (Parents Centre Bulletin, 1984). Many other lay organisations have been involved in a critique of childbirth management (Larkin, 1983). In addition, ad hoc groups have formed to oppose closure of maternity hospitals (Capper & Bunkle, 1978; Ray, 1980; van Dongen, 1985). The subject has also received considerable coverage from the lay press.

Pregnancy and birth in all societies is an event of considerable emotional and cultural significance. The physiological and biological processes of birth create the images in which the individual's relation to the society is conceptualised. It has provided one of the most important and richest themes of all ritual. Anthropological evidence suggests that birth is rarely the casual 'dropping of the baby' it is popularly believed to be in simpler societies (Kitzinger, 1978). Above all it is a social process surrounded and shaped by ritual and myth, prohibitions, injunctions and taboos, reflecting the social values of each society (Lomas, 1978). How a society manages pregnancy and birth particularly reflects that soceity's view of female fertility and sexuality. In Western societies it is not surprising, therefore, that obstetrics, the branch of medicine that manages childbirth, comes under greater scrutiny than other medical specialities (Chalmers, 1978).

It should be emphasised at this point that most of the debate centres around the appropriateness of defining 'normal' childbirth as a

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medical event. Few would argue that medical intervention is useful and desirable when the physiological process falters.

Current policy on the management of childbirth in New Zealand emerged from the deliberations of the Maternity Services Committee (MSC) of the Board of Health (now incorporated into the Standing Committee on Women's Health). The MSC was responsible for the major planning document 'Maternity Services in New Zealand'(1976). The recommendations in this report set the direction for future maternity services. At the time of the report, the Committee was dominated by Obstetric and Gynaecology (O&G) specialists. This feature of health care planning in which the medical profession is the most powerful party in policy development has become a point of tension between planners/ providers and consumers (Mackay, 1980). Nowhere is this more marked than in the area of women's health. For example, the 1975 Report of the Select Committee on Women's Rights indicated that there was disquiet amongst women about the type of medical care available to them, especially in those areas relating to fertility, including childbirth and maternity care. The report found that women regretted that policy on these issues was largely in the hands of the providers who were predominantly male and whose interests did not always coincide with those of the consumers (New Zealand House of Representatives Select Committee on Women's Rights, 1975).

Nine years later, at the 1984 Women's 'Forums' held nationally, women felt this position remained unchanged. Maternity services ranked eighth in overall priority listing of all women's concerns outlined in the report of the forums. Most comment was reserved for the closure of small maternity hospitals and the decline in numbers and status of midwives, especially domicillary midwives. It was felt both of these trends severely restricted women's choices in childbirth (Office of the Minister of Women's Affairs, 1985). There was, however, an issue emerging in 1984 that was not so apparent in 1975. Previously, most concern centred around more recognition of women's psychological needs in childbirth and the need for greater flexibility in hospital routines. By 1984 women were also questioning

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the role of medicine in normal birth. For example, should the medical profession be the arbiters of healthy birth at all? Should not women be able to choose how, where and with whom they give birth? This trend apparently represents a distinct and radical departure from the reforming stance taken in 1975.

Some of this shift of focus from reform of specific policies and service provisions to critical appraisal of the power relations between the participants in the childbirth process, stemmed from analysis and debate that had developed over the intervening period. For example, it was being argued by New Zealand feminists and others that policy decisions in the management of childbirth, while ostensibly for the 'safety' of mother and child, were in reality primarily in the interests of the providers. Women were powerless to protest because they often lacked access to medical knowledge, but more particularly because their views were not considered 'legitimate' inputs in the decision making process (Daly-Peoples, 1977; Capper & Bunkle, 1978; Older, 1981).

The origins of this study lie in an observation arising from the 1976 MSC report. This report was the result of a national survey of maternity services; medical services that affect only women and their babies. Yet a notable feature of the report was the 'invisibility' of women in it. Women appear in the report only as statistics. The methodology of the survey was not designed, apparently, to take account of women's experiences of the services. It seems only the providers were interviewed and their problems examined. Throughout the study there appears to be the assumption that providing a high quality, efficient service by provider criteria would automatically benefit the consumer. While this may often be true where clearly unsafe procedures and practices exist, it is an assumption that fails to acknowledge that the standards and priorities of consumers and providers for a quality service do not necessarily coincide.

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The contribution of feminist literature to a radical critique of medicine has been to show how medicine reproduces the exploitive relations of gender. There have been two broad thrusts in the feminist critique. The first has been to reveal the androcentric nature of medical knowledge about women. The development of a feminist health movement has begun a process of reappropriation by women, of medical knowledge and technology. Studies by women in this area have revealed the unscientific and inaccurate beliefs the medical profession holds about women's bodily processes. The second thrust of the feminist critique of medicine has been to show how medicine acts as a form of social control of women. It is claimed that this is achieved by defining women's reproductive proceses as a medical area. Once these processes become 'legitimate' medical concerns, the logic of the medical paradigm means taht women's normal physiological functions such as menarche, childbirth, menapause and fertility control are treated 'as if' they are illnesses (Graham & Oakley, 1981) or 'just in case' they might become illnesses (Arms, 1977). Feminists challenge the medical justification for this control of such a large part of women's lives. They argue that such control is not a scientific objective but an ideological one that mirrors the ideological imperatives of a male dominated society, confirming and reinforcing women in their traditional, dependent roles of domesticity and motherhood (Ehrenreich & English, 1973; Smart & Smart, 1978; Fenwick, 1979; Oakley, 1980; Elston, 1981).

This study is situated within a framework that is principally, but not exclusively, influenced by such theory and research. Its main aim is to make 'visible' the consumer of maternity services so that policy planners of the future may appreciate the value of a broader approach; one that takes into account consumer priorities for a quality service. A descriptive account is an essential first step in understanding how women experience a social process. But a further aim of the study is to make some advance in understanding the social construction of childbirth by placing the experience of the women in the study in its social context. Towards this

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second aim some attempt is made to analyse the structural conditions under which childbirth takes place and how such conditions are perpetuated.

The study sketches some of the attitudes, views and opinions of mothers to the current management of childbirth, but it was felt equally important to attempt to capture the personal significance of childbirth for this group of New Zealand women. So little is known of New Zealand womens' views that this exercise can only be regarded as a pilot study, indicating some of the more urgent areas for further investigation.

The study examines the childbirth experiences of 48 Manawatu women who, when pregnant, were healthy and expecting a normal labour and birth. This category of women was chosen for the study because, as indicated above, much of the management of childbirth debate centres around the handling of the normal birth. The women were interviewed in depth in their own homes in the fifth month post partum (see Chapter II for a fuller discussion of the sample characteristics and the study methodology). The women in the study had two broad types of hospital experience and these will be compared. Half the women gave birth in a high-technology base hospital obstetric unit with relatively sophisticated medical facilities and specialists available. The remainder were booked for delivery in a low-technology general-practitioner unit (GPU). Five women in this group were transferred to the base hospital for delivery and returned to their local GPU for the puerperium. Although not a random sample, the women were broadly representative of Manawatu women with the exception of race. Maori and Pacific Island women were underrepresented.

The experiences, attitudes and opinions of the study women are compared and contrasted with two 'models' of childbirth management. The first model is a representation of what might be termed the obstetric or 'medical' model and the second model is a representation developed from a feminist critique of medicine and has been called by some a 'midwifery' model (Rothman, 1982). The two models,

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it must be stressed, are heuristic tools of analysis and do not represent the views of any particular group. Nevertheless, an important assumption of this thesis is that there are conflicting views on the management of normal childbirth. These differences are not merely arguments over details of hospital routines or whether mothers should be giving birth on their backs or upright, but are conflicts about the definition of normal birth as a medical subejct at all. In proposing that two broad perspectives exist this thesis also assumes that they compete and conflict in key areas (Hubert, 1974; Comaroff, 1977). The major areas of conflict, it has been suggested, are over the nature and context of childbirth, how success is measured and who controls the process (Graham & Oakley, 1981). The two perspectives have been summarised by Macintyre (1977). Within the 'medical' perspective:-

> **'Pregnancy and childbirth are regarded as states and processes akin to illness, relatively divorced from a social and psychological context. It is seen as appropriate for women to cede control over the process to medical experts, to adopt a relatively passive role of acquiescence in medical instructions and to remain relatively ignorant of the basis of professional decisions. Childbirth is regarded as highly hazardous, with medical assistance and intervention being uniformly necessary. The physical experiences of childbirth are perceived negatively and, therefore, to be alleviated or removed from consciousness whenever possible.'**

Within the 'midwifery' perspective:-

> **'Pregnancy and childbirth are regarded as natural processes embedded in a social and psychological context, undergone by healthy women largely under their own control, and as positive and fulfilling experiences. Medical assistance is seen as minimally necessary as an insurance against complications, and medical intervention as only necessary in the event of particular complications. Unless such complications occur, the woman is not regarded as being in the sick or patient role, and her relationship with the medical profession is a relatively equalitarian one of active participation in, and full knowledge of, the process of childbearing.'**
>
> (Macintyre, 1977; pp477-484)

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The 'midwifery' model draws on a form of childbirth management that was practiced by the traditional midwife. Its main characteristics, then as now, were non-intervention and emotional support. Contrary to popular belief, traditional midwifery was based on sound empirical knowledge and not superstition, as has been claimed (Ehrenreich & English, 1973; Versluysen, 1981).

The 'medical' model draws on the traditions of the surgical speciality of obstetrics. As a branch of medicine, obstetrics views the body as a machine. Pregnancy and birth are predominantly mechanical processes. Technical intervention and 'active' management of labour are logical practice if deviations from the norm are to be prevented and corrected. Obstetrical knowledge is said to be scientific in that it is assessed by strictly comparable statistical standards (Samuel, 1983).

The arguments emanating from the two perspectives can be briefly summarised; the critique of obstetrics says the medical management of childbirth is often ritualistic (Haire, 1972; Lomas, 1978), potentially harmful (Chalmers & Richards, 1977; Taylor, 1979), poorly evaluated (Richards, 1975) and places women in a position of passive dependence which confirms and reinforces their already dependent position (Arms, 1977; Coney, 1979; Calvert, 1982). The obstetrician argues that optimal maternity care must take place in a hospital setting which can deal with unanticipated emergencies (Parry, 1980). Diagnosis of a normal birth can only be made in retrospect (Raymond, 1981; New Zealand Department of Health, 1985). Many obstetricians question the average mother's ability to make informed decisions about obstetric management (Cox et al, 1976; MSC, 1979; Bonham, 1980; Samuel, 1983).

The following chapter examines some of the theoretical issues that are involved in the critique of childbirth management both in New Zealand and in many other western countries. The assumptions of the two models of childbirth management are explored and set in their structural conditions. Chapter II examines some of the

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theoretical and methodological problems associated with researching women's perspectives of childbirth and examines previous New Zealand studies which have attempted this task. Chapters III to V set out the experiences of the study women. Chapter III deals with women's experiences of pregnancy, Chapter IV with labour and birth experiences, and Chapter V with post-natal experiences. Chapter VI compares and contrasts the study women's perspectives with the two models of childbirth management, and in doing so, challenges some of the current assumptions of present maternity service policy. Finally, areas for further research are suggested.

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CHAPTER I

SOME THEORETICAL ISSUES RAISED IN THE CRITIQUE OF CHILDBIRTH MANAGEMENT

In this chapter some of the feminist concepts and insights appropriate to a study of childbirth are set out. Some of the major assumptions and historical antecedents of the two 'models' of childbirth management, discussed in the introduction, are examined with particular reference to the New Zealand context of childbirth management.

An important contribution of recent feminist theory has been its criticism of scientific knowledge. It is argued that women's experiences have been inadequately conceptualised because of the 'androcentric' nature of theories and paradigms of traditional disciplines. As a result, assumptions about the human condition that are made are in reality male assumptions about women's experience; assumptions that obscure and leave unquestioned the subordinate position of women. Women, it is claimed, remain largely 'invisible' (Smith, 1974). Oakley has shown that this argument is true of sociology. Even areas where women are most visible, such as the sociology of the family, they are entirely encapsulated within the 'feminine' role, 'invisible' because their experience is ignored. Oakley claims that the denial of women's experience has constituted a structural weakness rather than a superficial flaw in the discipline (Oakley, 1974). Feminist scientific paradigms make women's lived experience the subject matter. First-hand accounts are substituted for what Oakley calls 'the pretentious dicta of science' (Oakley, 1980: p93). This approach is essential if women are not to remain 'invisible', for as Barnsley (1982) says, in order to answer 'why' a particular problem exists it is necessary to do the more practical work of discovering how a problem or issue is experienced by women and how it is perpetuated.

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The 'invisibility' of women in scientific knowledge is part of a wider feminist critique of the production of scientific knowledge, for this critique also challenges the scientific paradigm that claims objectivity and denial of value judgements (Roberts, 1981A). For example, Fee (1981) suggests that science has been characterised by its 'objectivity', its very lack of values. In the scientific paradigm values, feelings, political commitments, etc., are subjective and as such are sources of individual bias. The methods and procedures of scientific research are so constructed to exclude such sources of error. Fee disects and examines the different ways in which science claims to be neutral. Four major relationships emerge as characterising the 'objectivity' of scientific knowledge. These are the divorce between the production of knowledge and its social uses, the divorce between thinking and feeling, between subject and object and between science and society. At each of these levels Fee demonstrates that such distancing is more a myth than reality. The idea of scientific 'objectivity' is more to do with the ideology of science than the scientific process she claims. Part of that ideology is the identification of 'objectivity' with male ways of relating to the world and the identifying of women as emotional and 'subjective'. This is not an argument for the wholesale rejection of the scientific method, the idea that forms of knowledge can be subjected to critical evaluation and empirical testing, but for a more rigourous identification of those ideological aspects of the production of scientific knowledge which need to be exposed and rejected. For example, because the production of scientific knowledge is embedded in the existing structural relations of a society, we need to examine carefully the role of the scientist in reproducing the social relations of that society, for only then will it be understood why particular kinds of knowledge are produced and particular kinds of questions are asked and others are rendered invisible. In other words, the way a society selects, classifies, distributes, transmits and evaluates knowledge reflects the distribution of power and the relations of social control (Bonder, 1982).

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The concept of ideology has been an extremely important one for the feminist analysis of women's oppression. Particularly useful for the feminist analysis has been Althusser's theoretical formulation which Marxist feminists have developed and elaborated. According to Althusser, ideology is construed as a force for securing the reproduction of the relations of production; that is, the continual renewal of the relations of property/ownership by which classes and constituted. The state has 'apparatuses' for ensuring the reproduction of the relations of production. Some are repressive, for example, the army, the police, the courts, and some are ideological, for example, the education system, the family, the political organisation. The ideological state apparatuses (ISA's) operate at the level of meaning for individuals. Althusser describes ideology as a 'representation' of the 'imaginary' relationship of individuals to their real conditions of existence. It refers to those processes which have to do with consciousness, motive and emotionality. Individuals conceive of themselves and their place in the world within the limits and possibilities of the ideology. In this way ISA's obscure the real relations of production, allowing the individual to 'recognise' the existing state of affairs. Because ideology is inscribed within a set of social relations, practices, and rituals, it is said to have a material existence (Althusser, 1971; McDonough & Harrison, 1978). In other words, it is embedded historically in material practice although it is not itself material (Barrett, 1980).

Feminists have argued that gender relations are produced ideologically as well as materially (Mitchell, 1975, McDonough & Harrison, 1978; Barrett, 1980). Concepts such as 'motherhood' and 'feminity' have been examined and found to be largely ideological constructs rather than the manifestations of natural sex differences (Ehrenreich & English, 1976; Oakley, 1980; Wearing, 1984). Such ideological constructions of women's natures are a major source of social control of women (Smart & Smart, 1978). Feminists identify the institution of medicine as playing a key role in the reproduction of gender relations. Particular attention is given to the way medical knowledge is produced - the 'ideology' of medical science and how it is used

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to control women.

The ideology of medical science is an extremely important concept in a study of childbirth because obstetrical knowledge is grounded firmly within the medical science paradigm, and the medical model or perspective in turn dominates in structuring the functioning and priorities of the health care system in New Zealand (Davis, 1981).

The primary characteristic of medical ideology is the theoretical concept of the body as a machine and the doctor as a technician or mechanic. Problems of the body thus become technical problems requiring technical solutions, whether it is a mechanical repair, a chemical rebalancing or a debugging of the system (Rothman, 1982). The development of this 'engineering' approach coincided with the view dominant in the middle of last century, that progress was to be secured by the mechanical domination of nature. Powles (1973) suggests that class interest was also important in suppressing alternative approaches. For example, the prestigous 'physicians' who dominated the teaching hospitals and medical education proffered their clinical skills to the rich, while it was social and preventative medicine that was most urgently needed for the poor.

The ideology of medicine comes into sharper focus with the development of a radical critique of medicine in the 1960's. This critique challenges the traditional concept of medicine as morally neutral, essentially benign and effective in curing disease and reducing pain and suffering. It has been argued that medicine has overstated its curative claims, is often ineffective or even harmful (Dubos, 1959; McKeown, 1965; Cochrane, 1972; Waitzkin, 1983; Taylor, 1979) and through its monopoly of knowledge and technology puts increasing numbers of people into a state of dependency on white, upper class males (Zola, 1972; Illich, 1976; Ehrenreich & Ehrenreich, 1978). Radical critics have also argued that the doctor/patient relationship and the structure of medical services reproduce rather than alleviate the exploitive relations from which many social problems and illnesses derive (Waitzkin & Waterman, 1974; Navarro, 1976).

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The feminist contribution to the radical critique of medicine has been to show how medicine maintains and reproduces the exploitive realtions of gender. Feminists have identified two key areas in which medicine functions as an agent of women's oppression. The first is the major contribution medicine makes to the ideological construction of women's natures. The second is the control exercised by doctors over knowledge and technology that is of crucial importance to women. In other words, feminists claim that medicine acts both ideologically and materially as an agent of social control over women.

The development of the feminist health movement in the 1970's (see below) led to the discovery that many of the assumptions of medical science about women's natures were little more than 'a repertoire of patronising moral precepts' (Oakley, 1980: p93). Scully and Bart (1973) showed that medical textbooks put forward ideological and erroneous ideas about women's sexuality. Elston shows that this situation of androcentricity in medicine had changed only marginally by the 1980's (Elston, 1981). In psychiatry also, the medical profession has constructed an extensive body of knowledge that portrays women as more emotional, more subjective, more passive and less rational than men (Elston, 1981). Ehrenreich & English (1979) and Graham & Oakley (1981) have argued that medical science, particularly psychiatry and gynaecology, have consistently defined women as sick, as a medical problem and as people who need treatment to adjust to their social roles. Barrett & Roberts (1978), in a study of women patients in general practice, found:-

> **'women were remorselessly confirmed in traditional family and domestic roles and more than one instance of a woman's refusal to do housework resulted eventually in hospitalisation and ECT.'**
>
> (Barrett & Roberts: p43, in Smart & Smart, 1978)

The powerful position of the medical profession to define women's natures is matched by an equally powerful position to define women's needs at least for large parts of their lives. The control of

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knowledge and technology pertaining to women's reproductive processes by a predominently male medical profession forms a central issue of the feminist problematic. Wallen, Waitzkin and Stoeckle (1979) argue that information is a source of power that can be used by the medical profession to maintain women's dependence and passivity. Ehrenreich and English, in their feminist classic 'Complaints and Disorders: The Sexual Politics of Sickness', offer a succinct formulation of the issue:-

> **'The medical system is strategic for women's liberation. It is the guardian of reproductive technology, birth control, abortion and the means of safe childbirth.... When we demand control over our bodies, we are making that demand above all to the medical system. It is the keeper of the keys.'**
>
> (quoted in Elston, 1981: p189)

For radical feminists, the control of women's bodies by men constitutes the central site of women's oppression (Firestone, 1970; Millett, 1972; Rich, 1977). For Marxist feminists the central site of women's oppression lies in the material structure and ideology of the family. The medical profession, however, plays an important role in maintaining and reproducing the relations of gender (Barrett, 1980; Roberts, 1981A).

The feminist critique of medicine is part of a developing international women's health movement that seeks to divest medicine of its power to oppress women. There are several major issues and concerns with which the movement can be identified. An important one is the continuing process of redefinition of 'normalicy' for women based on women's experience and knowledge of their own bodies. Within the movement there has developed a body of literature that is readily accessible to women. The movement has promoted the development of 'self-help' groups and women's health centres which utilise traditional healing skills, orthodox medical technology and alternative health care resources. Also within the movement there have developed consumer pressure groups that challenge the structure and function of health services and particular medical

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technologies that are disadvantageous to women (Marieskind & Ehrenreich, 1975; Calvert, 1982).

Childbirth has received particular attention from the movement because of its crucial importance in women's lives. The control of knowledge and technology of pregnancy and childbirth by doctors, as suggested above, places women in passive and dependent positions in medical encounters. The 'takeover' of control of childbirth by doctors, feminists argue, allows doctors to control the amount and type of information that if 'fed' to pregnant women and define what is to be the 'legitimate' knowledge about pregnancy and childbirth (Graham & Oakley, 1981; Rothman, 1982). For example, pregnant women have been urged not to listen to 'old wives tales' or read medical textbooks (Bourne, 1975; New Zealand Department of Health, 1978). The dependent relationship between mothers and doctors increases the sense of vulnerability mothers feel during the childbirth process, which in turn increases their passivity. This is demonstrated by Danziger (1978), who showed that pregnant women consistently avoid potential conflict with obstetric care providers, which she suggests may inhibit their acquiring knowledge. Thus the inequality of the doctor/patient relationship acts to both restrict and inhibit information exchange. Support for this argument comes from Skuja et al (1982), who showed that women who are knowledgeable about childbirth are more likely to demand more personal control of the process, in the sense of wanting to exercise more options. In other words, knowledgeable women were less passive and less dependent participants.

The 'takeover' of the management of childbirth from midwives (see discussion below) allowed the predominantly male obstetricians to define the process according to the paradigms of medical science. The ideology of the medical model - the body as a machine - predicated that pregnancy and birth would be viewed almost entirely as mechanical events. Consequently, pregnancy is seen as a 'stress' on the mother and changes that occur in her physiology are frequently seen as unhealthy and thus the subject of medical treatment. The process

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of childbirth is said to have become 'medicalised' (Oakley, 1975). Rothman (1982) argues that this assumption of the 'disease-like' state of childbirth is a consequence of the androcentricity of obstetrical knowledge that takes the male body as the norm, the baseline. An implication of the medicalisation of childbirth, it is argued by feminists, is that women become alienated from their bodies even when they are not ill (Coney, 1979). Childbirth becomes a mysterious process, fraught with inherent dangers, surrounded by mystifying language, over which women have no control (Shaw, 1974; Arms, 1977; Kitzinger, 1979). A further implication of 'medicalisation' for women is that they become patients. As patients they have an obligation to be passive but cooperative participants and cede responsibility for their condition to the doctor in return for exemption from 'normal' social obligations (Parsons, 1951). Women are thus placed in a passive and dependent position in medical encounters.

There is another important assumption of the obstetric model that profoundly affects how women are 'managed' during pregnancy and birth. This is the assumption that the relationship between the mother and the fetus is one of parasite and host. The fetus is a foreign intruder in the mother's body, a 'passenger' (Rothman, 1982). Rothman argues that the ideological imperative of this assumption is that 'the fetus is child of the man', pregnancy is thus for the woman, the fulfilment of a desire to have his child. The implication of this single idea, 'the fetus is child of the man', can be seen throughout the organisation of maternity care in medicine, for the corollary of this idea is that the relationship between the mother and fetus is an adversary one, with the needs of one likely to conflict with the needs of the other. The interest of obstetrics is focussed primarily on producing a quality product (Menzies et al, 1981). A senior New Zealand obstetrician said in 1975:-

> **'The central aim of obstetrics must be concern with the quality of the babies we deliver, not simply the perinatal mortality rate (....)'**
>
> (Earl Wilson, quoted in PCB No.65, 1975: p17)

Inevitably, preoccupation with producing a 'quality product' impels doctors to give priority to the perceived needs of the fetus. Thus it becomes important for obstetricians to maintain and reproduce the ideology of 'motherhood'. For example, Bunkle argues that doctors are able to maintain control over childbirth management by the threat 'you wouldn't want to hurt your baby would you?' (Capper & Bunkle, 1978).

This phrase epitomises the ideology of motherhood. Wearing (1984) identifies the central tenets of this ideology as nurturance and self sacrifice. She argues that such an ideology circumscribes women's lives, limiting their life options, autonomy, self concepts and activities outside the home. It is an ideology that keeps women willing to give more than they receive in nurturance and sexual satisfaction (Ferguson & Folbre, 1981). In the New Zealand context, Novitz (1976) and Barrington and Gray (1981) found that mothers invariably gave their role as mothers priority over other roles, no matter what their personal circumstances.

The medical profession in New Zealand has been an important contributor to the maintainance and reproduction of the ideology of motherhood. For example, in the early part of the century medical men, such as Batchelor and Truby-King, claimed the authority of medical science to justify their pronouncements on the nature of women. Although the theory of sexual selection offered by social Darwinism had been quickly discarded by the scientific community, Truby-King and Batchelor used it to insist that women had been genetically programmed for the role of motherhood. Therefore, they claimed, academic work and the professions were not suitable for women because they interferred with their physical development and ability to bear children (Tennant, 1976; Olssen, 1981).

The influence of Truby-King in defining motherhood for New Zealand women was enormous. Not only was he and the Plunket Society that he founded instrumental in defining motherhood and homemaking as women's only legitimate activity, he was able to persuade women

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that they needed to be subject to the control of outside experts (Olssen, 1981). The effect was that New Zealand women were being socialised towards an 'ideal mother' personality that had little to do with a biological definition of motherhood.

The threat of dire consequences for the baby if mothers fail to conform can thus be a powerful weapon which women are powerless to resist. Press coverage of the childbirth management debate does suggest that some of New Zealand's senior obstetric specialists do resort to this argument when challenged (Ray, 1980; van Dongen, 1985).

In New Zealand, as in many other Western countries, the 'medicalisation' of childbirth has been so successful that the competing profession, midwifery, has become an ancillary service to medicine (Rothman, 1982; Larkin, 1983). The 'takeover' of midwifery began in the 17th century, but was not completed, at least in New Zealand, until early this century. In Europe up to the 17th century midwifery was a folk-craft firmly excluded from medical practice because it was women's work. It was seen as an extension of the woman's sex-role and was largely practiced within the confines of a female subculture. As such, this traditional lay mode of childbirth embodied the belief that birth was a normal, physiological event (Versluysen, 1981). But by the 17th century an alternative view of childbirth was being promoted, one that argued that giving birth was potentially dangerous and complicated and needed the supervision of a technically competent expert, a 'man-midwife', today's obstetrician.

The traditional midwife's 'holistic' view of childbirth as a physical, psychological and social process contrasted sharply with the 'engineering' approach of the man-midwife. Elizabeth Nehill writing in 1760, clearly distinguishes between the two. Women she said had a 'supremely tender sensibility towards one another in the case of childbirth' but men, she said, have 'an unaffectionate perfunctory air', an observation Manawatu women still make today. Elizabeth Nehill constantly reiterates that labour must not be rushed, that nature

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be allowed to take its course, that midwives can alleviate pain manually and 'through a thousand little tender attentions suggested by nature and improved by experience' (quoted in Rich, 1977). It took over 200 years for medical science to discover what midwives knew empirically. This is what one of New Zealand's most senior O&G specialists said in 1974:-

> **'While gynaecology was originally used for diseases of the pelvic reproductive organs, recent knowledge has shown a two-way interrelation between the emotional and the endocrine centres in the brain, so that the patient is now thought of as an entire women.'**
>
> (Bonham, 1974: p101)

The shift of control of childbirth management from midwifery to the medical profession has been portrayed as a triumph of scientific knowledge and logic over ignorance, superstition and filth. Accounts of the history of midwifery, however, have been mostly written by obstetricians (Versluysen, 1981). Such accounts contain portrayals of midwives as 'Sairy Gamps', hopelessly dirty, gin sodden, ignorant and incompetent (see account in the MSC Report, 1976). Recent feminist research casts serious doubts on the accuracy of this view (Ehrenreich & English, 1973; Versluysen, 1981; Willis & Willis, 1981).

Oakley (1976) argues that domicillary midwifery may have been safer than hospital delivery at least until the 1930's. She suggests that one of the three major causes of maternal mortality at the turn of the century was puerperal sepsis. In the first three decades of the new century, rates of puerperal sepsis rose. Oakley claims this rise was associated with 'hospitalised, doctor-controlled childbirth'.

In New Zealand the majority of women gave birth in their own homes until the early decades of this century (MSC Report, 1976). The transfer of control of childbirth management from female midwives to male obstetricians began in earnest with the state registration

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of midwives in 1904. State registration allowed the state to impose progressive limitations on the midwives' autonomy, culminating in the 1925 Nurses and Midwives Act. With the passing of this Act, midwifery lost its independence as a profession, for the Act incorporated midwifery into the nursing profession already subordinate to the medical profession. Hospitalised childbirth grew from virtually nil in 1900 to 82% of all confinements in 1936. In 1921 the incidence of puerperal sepsis had increased so alarmingly that it attracted adverse international attention and prompted the first of two public enquiries (MRC Report, 1976).

By the 1950's the iatrogenic effects of hospitalised childbirth were beginning to be noticed. Forceps delivery and haemorraging were increasing. Separation of mothers from their babies and heavy sedating were preventing mothers from forming good relationships with their babies (Dobbie, 1981). A group of concerned, middle class, professionals, influenced by the ideas of 'attachment' theorists such as Bevan Brown (1950) in Christchurch and later John Bowlby (1951) and the 'natural childbirth' methods of Dick-Read (1944), formed a consumer pressure group, the Parents Centre Movement (PCM) in 1951. The group's concern was primarily with the iatrogenic effects of medical management of childbirth on the child. It wasn't until the influence of feminism in the 1970's emerged in New Zealand that the effects on the mother herself were highlighted, and the medical profession began to be perceived as having inappropriate control over normal birth. The PCM gained support steadily over the next twenty years and was primarily responsible for the reform of the more inflexible routines of maternity hospitals (Swain, 1981). 'Rooming in', husband's presence at labour and delivery and 'demand' feeding are some of the successful campaigns of the PCM.

In the 1970's a more radical critique of childbirth management emerged in New Zealand. A growing number of feminists were pointing out the degree of social control exercised over women by the medical profession (McDonald, 1977; Fenwick, 1980). The strategic position

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'medicalised' childbirth played in perpertrating women's dependency was a major argument. Linda Daly-Peoples writing in 1977 claimed:-

> **'The institutionalisation of childbirth, as it is currently practised in New Zealand, is a major technique in the suppression of women, reinforcing their dependence on a male power structure. To operate efficiently this system requires women's submission. If their submission cannot be achieved through positive willingness to participate in hospital procedures, then women are coerced into accepting these procedures, usually by veiled intimidation, the threat of dire consequences for non-conformists.'**
>
> (Daly-Peoples, 1977: p14)

Associated with the radical critique of childbirth was the re-emergence of domicillary delivery in 1975, followed by the formation of the Homebirth Association in 1978 (Ray, 1980). The 'midwifery' model of childbirth management is the perspective that is associated both with the Homebirth Association and many, but by no means all, domicillary midwives.

The 'midwifery' model embodies many of the concepts of traditional midwifery; for example, that pregnancy and birth are natural processes of growth and development for women, embedded in a social and psychological context. The mother and fetus are seen as an integral unit; what is good for the mother is good for the baby. Childbirth in this model is not normally hazardous, to be viewed in terms of risk, but a process women accomplish themselves without intervention, given support and encouragement. In this model the mother is the active participant, giving birth rather than being delivered. The midwife is 'in the background guiding but not imposing'. The relationship between the mother and the midwife is one of equality with the mother being encouraged to make decisions and take responsibility. The emphasis of antenatal care is, therefore, on sharing information, and developing rapport. Physical care focusses on promoting health in the mother through good nutrition and physical fitness. Monitoring for abnormality is part of antenatal care but in this case the baselines are other pregnant women. The emphasis during labour

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is on supporting the mother to give birth herself. Strict time limits for the stages of labour are abandoned; each labour is held to be unique. Mothers may adopt any position they like during labour and birth. Rupturing membranes, episiotomy and early cord clamping and drugs are not usual practice (McLean, 1980; Donley, 1980; Rothman, 1982).

In 1979 the Maternity Services Committee issued to obstetric personnel the policy statement 'Obstetrics and the Winds of Change'. In this statement the Committee states:-

> **'We in the medical and nursing profession face a major challenge to meet the demands of a vocal minority, as well as the larger needs of the majority (....)We must be prepared to replace rigidity with flexibility, if we are to keep our patients happy. Some of the women who are demanding home deliveries may be doing so as a protest against regimented, institutional care. A few of them insist on a home delivery, even though they may be in the high-risk categories.**
>
> **How can we protect the lives and IQ's of our future citizens and counter this move away from our hospitals?'**
>
> (MSC, 1979)

The statement then proceeds to suggest ways in which hospitals can make their routines more flexible for mothers and the environment less clinical. Who is permitted these more liberal conditions for birth, however, remains a decision of the providers of the service. This response to demands for change in childbirth management (see also Parry, 1979) has been somewhat cynically termed 'interior-decorator obstetrics': the wallpaper and curtains are changed, the power relationships remain intact. The policy statement epitomised the dichotomous perceptions of the medical model - the separation of the emotional needs of the mother and the physical health of the baby. Not surprisingly, mothers who choose to give birth at home are viewed as irresponsible. Similarly, mothers who choose to go to the small 'single-handed' general practitioner hospitals put themselves and their babies at risk, albeit unwittingly (MSC Report, 1976).

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Recent evidence both overseas and in New Zealand casts doubt on this claim. Analysis of national perinatal surveys and the results of specific studies indicate that birth in general practitioner hospitals and at home are at least as safe, if not safer, than birth in specialist obstetric units (Klein et al, 1983; Tew, 1985; Rosenblatt, 1985). Such findings raise questions of the specific nature of the advantages conferred by delivery in GPU's or at home or conversely, the disadvantages of specialist units. The midwifery model offers some hypotheses, the most important being the non-dichotomising of mind and body and of mother and baby.

The next chapter discusses details of the study sample and methods that were designed to examine more closely some of the issues raised above.

CHAPTER II

THEORETICAL AND METHODOLOGICAL PROBLEMS OF RESEARCHING CONSUMER PERSPECTIVES

This chapter examines some of the methodological issues and problems encountered in the study. In the first section an appraisal of some New Zealand consumer studies of maternity services is undertaken and some of the theoretical and methodological limitations of the studies exposed. This is followed by a discussion of the methodology used in this study in an attempt to overcome some of these limitations. In the next section, attention is paid to some variables thought to be important in an analysis of women's experience of childbirth. These are socio-economic class, race, marital status and the level of exposure to medical technology and expertise. Some of the theoretical problems and practical difficulties encountered in selecting a suitable sampling frame and method of sample selection are outlined. This is followed by an explanation of the approach used in analysing the data. Finally, biographic details of the women included in the study are provided.

In the introduction it was pointed out that the 1976 MSC Report failed to take account of women's experiences of maternity care. It was argued that this led to an imcomplete evaluation of maternity services because social variables were largely ignored. This omission provided the impetus for this study.

It may be argued that since publication of the MSC Report, consumer surveys of maternity care have been carried out in Dunedin (Hood et al, 1978), West Auckland (WACHG, 1980), and Wellington (SROW, 1985), which show overall satisfaction with the services provided. This was particularly characteristic of the Dunedin and Wellington studies, which were based on the same questionnaire. The Dunedin study said, for example:-

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'A high level of satisfaction with whatever service is provided is one of the recurring themes of this report.'

These consumer surveys appear to indicate that the maternity service provided is meeting the needs of New Zealand women. Yet as indicated in the introduction, childbirth management is an area of considerable debate. Critics have described the management of childbirth in New Zealand as 'alienating', militating against the formation of healthy relationships, psychologically damaging, potentially iatrogenic and a barrier to the establishment of breastfeeding (Daly-Peoples, 1977; Capper & Bunkle, 1978; Coney, 1979; Phillips, 1983). Such conflicting assessments of maternity services are not peculiar to New Zealand. Consumer surveys of maternity services overseas have consistently found high levels of satisfaction (Riley, 1977; Sullivan & Beaman, 1982). These findings have led providers of maternity services to claim that it is only an 'unrepresentative minority' who are demanding change (Riley, 1977) (see also Bonham, 1980). This apparent contradiction is only understandable when the serious theoretical and methodological problems of consumer surveys are examined.

High levels of satisfaction are a consistent finding of medical care in general (Locker & Dunt, 1978). Some of the factors which influence this situation have been identified. Many surveys are carried out while the respondent is in hospital or still receiving medical care. Newson and Newson (1963) suggest that such studies are particularly liable to the tendancy of patients to wish to produce acceptable responses, because of the need to avoid conflict with caregivers when in such a dependent position. Danziger (1978) and Riley (1977) suggest that this is aprticularly true of obstetric patients.

A characteristic of many consumer surveys of medical care is the use of global (overall) evaluations. For example, in the Dunedin study mothers were asked to rate the general care they received on a one to five scale. Locker & Dunt (1978) claim that global evaluations of a medical service tend to mask differential criticisms

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of aspects of the service and are, therefore, biased towards the satisfaction end of the scale. Cohen (1971) has shown that there is often a reluctance to criticise a service when the caregiver is liked or when the service is perceived as a favour rather than a right.

Obstetric patients have a unique characteristic that is likely to influence satisfaction levels. This is the joy and responsibility of producing a live baby. Giving birth to a healthy baby can overshadow negative experiences, producing a 'halo' effect. Riley (1977) argues that because women are not responsible for themselves alone they will, for example, accept medical intervention if it is suggested that it is to the advantage of the baby. The baby's wellbeing has priority over personal discomfort or distress. The previous chapter has shown how feminist writers have elaborated this idea of priority for the baby and exposed the ideological components of the medical justification 'for the sake of the baby' that draws on a concept of mothering imbued with an expectation of self sacrifice.

If women do give priority to the baby over personal discomfort and distress it may explaim the preponderance of neutral 'don't mind' responses to some of the questions in the Dunedin study and in studies overseas (Riley 1977). For example, in the Dunedin study three-quarters of the women respondents 'didn't mind' a pubic shave. Over half 'didn't mind' a suppository/enema. Almost two-thirds 'didn't mind' an internal examination. As all these procedures could be expected to be, at the very least, uncomfortable and embarrassing, it is unlikely that women would feel totally indifferent to them. The same may be said for over half the women in the same study who 'didn't mind' being separated from their babies shortly after birth. The author's explanation that women accepted such procedures 'without complaint or approval' hardly helps an understanding of women's attitudes towards these procedures.

It has also been demonstrated in consumer studies that there is a link between expectations of a service or caregiver and satisfaction

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(Stimson & Webb, 1975; Tessler & Mechanic, 1975). Expectations about care are dependent to a large degree on knowledge and experience about options and alternatives. Skuja et al (1982) showed that women who were well informed about choices and alternatives in obstetric care were more likely to want changes in the service. This supports the claim of Shaw (1976) that people unclear about the range of services currently available are unlikely to be clear about what changes or different forms of provision they would like. This may account for the finding of the West Auckland study that almost half the respondents had no preferences about how labour, birth and the post partum period should be conducted. Riley (1977) and Sullivan & Beaman (1982) have also argued that pregnant women's expectations of treatment in hospital are low because they are given minimal information about obstetric options and alternatives.

This raises the wider question about what consumer surveys of maternity services are actually measuring? Questionnaires that measure consumer satisfaction with a given set of procedures, practices or services, are not consumer evaluations of quality of care, but are methods of merely identifying elements of services with which the consumer is either happy or unhappy. The standards of provision have already been set by the provider. Locker & Dunt rightly point out that:-

> **'A true study of consumer evaluation of care would need to identify and employ criterion for standards used by consumers themselves.'**
>
> (Locker & Dunt, 1978: p290)

It would appear that consumer surveys of the management of childbirth carried out in New Zealand so far have not measured women's experience of childbirth but only a partial experience, based on what is considered 'legitimate' criteria for childbirth management. The ambiguous 'no comment', and 'don't minds' found in the New Zealand studies would seem to reflect the difficulty that women have trying to respond to questions that are often tangential or inconsequential to their experience; this despite the fact that the questionnaires

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were largely designed by lay women's groups. Not only is the theoretical basis of these consumer surveys open to question, but the methodology used, the structured questionnaire, is an added constraint to the documenting of women's experience. Skuja et at (1982) in their study of Australian mothers recognise this when they say:-

> **'Questionnaire responses provide little insight into the personal meaning underlying the demands expressed by the consumers (....) the need to supplement our empirical data with a phenomenological account sensitive to the variety of motives and feelings underlying consumer demand was clearly evident.'**
>
> (Skuja et al, 1982: p210)

Although the authors were apparently concerned only with the absence of contributing psychological factors, the same can be said of the contributing social factors.

It was felt, therefore, that if this study was to examine women's perspectives of childbirth it was essential that it adopt a methodology that allowed those issues and concerns that were significant for the women to emerge. In the previous chapter it was suggested that studies of women's experience must begin with first-hand accounts from women themselves. Women themselves must be permitted to define what is relevant and significant in their lives. Support for this argument also comes from research on health care reporting. This research has shown that the importance or impact of an event for a respondent is related to the likelihood of report (Verbrugge, 1979). Events of less impact or less significance are best elicited by direct questions functioning as probes (Cartwright, 1964; Locker & Dunt, 1978).

In view of the above, a structured questionnaire would be clearly inadequate for the purposes of this study. A combination of methods was eventually decided to be most appropriate. A structured questionnaire was used to elicit the demographic details of each woman (see Appendix I). This was followed by a tape-recorded interview in which women described

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their pregnancy, birth and post-natal experiences. Where necessary, direct questions were asked to probe underlying meanings (see Appendix II), to elicit attitudes on issues and events not mentioned spontaneously and to facilitate the recall process. Because it was felt necessary to avoid as far as possible disrupting the flow of the interview, not all questions in the interview schedule were asked of all women. In other words, the researcher's efforts to get comparable data were secondary to the main task of discovering what, in each woman's experience, was of significance and value.

Interviewing strategy used in this study was influenced by Oakley's experience of interviewing women about childbirth (Oakley, 1981). She criticised traditional interviewing practices which insist on a hierarchial and often exploitive relationship between interviewer and interviewee. Such practices, she argued, were especially counter-productive when the goal is the documentation of intimate details of women's lives. Instead, she found women responded to a more reciprocal and non-hierarchial relationship in which the interviewer recognised and responded to the needs of the interviewee during the interview process, e.g. volunteering information about the research project, answering interveiwee's questions and the investment in the relationship between the interviewer and the interviewee of some of the interviewer's own personality.

This approach was employed in this study and clearly contributed to the general willingness on the part of the study women to share with the researcher intimate details and personal feelings. For some this was a new experience:-

> **Vickie: "Gosh, this is the first time I've talked to anybody like this. I've enjoyed it."**

Special effort was made to avoid exploiting the women as merely sources of data. Before the interview began, time was taken to inform the women about the project, its origins and possible uses. Personal details about the researcher's background were volunteered.

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It was speculated that the researcher's lack of personal experience of childbirth might be a handicap in achieving rapport with mothers. However, this proved not to be the case. The researcher's previous nursing experience of childbirth and early infant care in a domestic setting, may have offset her non-mother status. It was stressed, however, that the researcher had no connection with any medical institution.

It was made clear to mothers that the demands of the household had priority over the interview. Consequently interviews were often interrupted while mothers attended to babies and young children. In one case, the interview was interrupted to collect other children from kindergarten and in more than one case, the interviewer shared a meal with the mother. Such interruptions provided natural breaks in what was generally a long interview.

The use of the tape recorder undoubtedly contributed to a relaxed interview. Most interviews were conducted with the participants seated at the kitchen table drinking tea or coffee. A remote microphone sited near the interviewee, but out of her line of vision was soon forgotten in the vast majority of cases. Some women appeared to actually benefit from the interview exercise:-

Carolyn: "I enjoyed talking about it. It helps you get over it."

The assurance that only the researcher would have access to the research data may have also contributed to the willingness of women to share intimate details.

Advantages of tape-recording the interview included the retention of non-verbal responses such as tone of voice, hesitancy and, particularly, laughter. Laughter has special connotations in interviews with women. Rowbotham (1969) has pointed out that girls giggle at the moment of taboo. It is a way, she says, of making the point and avoiding the issue. Hobson (1978) has extended this observation

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to an analysis of the significance of laughter in interviews with women. When women interview women, she says, there are common understandings among women that preclude the necessity for interviewer or interviewee to discuss the matter further:-

> **'(....)the laughter occurs at points of contradiction where actual alternatives are possible, if unlikely, or when sites of contradiction are revealed. However, the laughter also establishes an area of shared understanding between the women and myself. There is no need for them to explain why they laugh, or indeed why I laugh with them at some points, because the laughter is a form of non-verbal communication which is understood by both of us. It "works" against the background of tacit (consensual) knowledge, of common sense about women, which is constantly evoked in the exchanges, on the basis of which the statements "make sense".'**
>
> (Hobson, 1978: p82)

Hobson's analysis of laughter was strongly supported by the interviewing experience of this study. For this reason, laughter is noted in the text of the study women's responses to indicate sites of contradiction and shared understanding.

It was hypothesised that there would be some variables that would influence how women experienced childbirth more than others. These were: socio-economic class, race, marital status, and the degree of 'medicalisation' of the childbirth process that the mother experienced.

The recognition that class ethnicity and marital status influenced maternal and infant mortality wasn't officially recognised in New Zealand until the late 1960's with the passing of the Maternal Mortality Research Act 1969. In the first report the following year it was found that the rate of non-European maternal deaths was three times that of European maternal deaths. Single women also had a maternal mortality rate twice that of married women (MSC Report, 1976). Maori women have twice as many exnuptial births as Pakeha women (Awatere, 1980). But the difference between the mortality rates for single and married women persists when race and age factors are controlled (MSC Report, 1976: pp31-35). It

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remains debatable to what extent class and ract act independently of each other (Spoonley, 1982). There is international agreement on the linear association between social class and perinatal mortality. On the other hand, there is some New Zealand evidence that when access to services is improved, Maori maternal and perinatal mortality can be lower than the European rate (MSC Report, 1976: p35). What is not clear is whether it is the appropriateness of the service provided for Maori and Pacific Island mothers or the availability of services that is the determining factor. Salmond's 1975 study of Wellington mothers indicates that both factors can be operating simultaneously. Some Maori women themselves argue that socio-economic status is much more important, for it determines a Maori mother's general health before and while she is pregnant (Wright, 1984), which in turn impacts on the maternal and perinatal mortality rate.

Unfortuantely, for reasons detailed below, it was not possible to examine the effects of race on women's experience of childbirth. Some women in the study did mention that Maori women do sometimes arrive at the hospital unbooked and with no previous antenatal care. Two women felt that there were elements of overt racism in their birth hospital. For example, one woman noted the relationship between nursing staff and Chinese and Maori patients:-

> **"I was very aware that it's a white, middle class system. It's easy for me to adjust....the fact that I had a name picked out for the baby, whereas this (Chinese) woman's grandmother would be choosing a name for her baby. She was ridiculed a lot because the baby didn't have a name. It was particularly emharrassing...on the other hand, the Maori women were more confident about defying the rules and regulations. They just laughed."**

It is noticeable that studies of maternal and child health invariably underrepresent Maori, Pacific Islanders, lower socio-economic groups, and non-partnered women (Salmond, 1975; Hood et al, 1978; WACHG, 1980; McGee & Silva, 1982; SROW, 1985). This study is no exception. The implications of this are serious. The most vulnerable groups are being represented least. Health services are at present likely

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to be designed chiefly to meet the needs of middle class Pakehas (Salmond, 1975). If surveys persistently overrepresent middle class Pakehas, then considerable bias is introduced, leading to an overconfidence in the relevancy and efficiency of existing services.

There are several reasons why vulnerable groups in New Zealand are likely to be underrepresented. They are often more geographically mobile and thus harder to trace (Salmond, 1975; SROW, 1985). They are likely to be overrepresented in interview refusal rates (Wright, 1980), possibly because surveys are likely to be perceived as emanating from middle class institutions and are carried out by predominantly middle class personnel. But, yet a more ominous reason concerns the medical profession itself. The medical profession is able to act as gatekeeper to data which is necessary for random sampling. This has been seen particularly in the area of consumer studies of maternity services conducted by non-medical researchers, both in New Zealand and overseas (Riley, 1977; WACHG, 1980). New Zealand studies undertaken by non-medical reseachers have incariably had to submit questionnaires for vetting by medical personnel before access to patients or data is granted (Wright, 1980; Driscoll, 1982; SROW, 1985). Refusal of access to patients by medical authorities is usually on the grounds of confidentiality (WACHG, 1980; Wright, 1980). As Wright says:-

> **'Some medical personnel credit only their own profession with a code of confidentiality.'**
>
> (Wright, 1980: p26)

Access to the names and addresses of women who had given birth in the Manawatu region was refused this researcher by the Hospital Board and the Health Department. It was, therefore, impossible to obtain a random sample. Instead, a sample of women attending Plunket was used. Excluded, therefore, from the sample were mothers receiving post-natal care from other services such as Public Health Nurses or District Nurses, and mothers receiving no post-natal care. Women most likely to fall into these excluded categories

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were Maori and Pacific Island mothers and mothers without partners (Salmond, 1975). The resultant sample reflects this bias.

Assigning women to socio-economic classes was another problem encountered in designing the study. The traditional sociological method in which the family is seen as the basic unit of stratification is criticised by a number of feminists. For example, Acker (1973), Gray (1981), and Delphy (1981) challenge the assumption that women share the class position of their fathers or husbands and only have autonomous positions in the class structure when they live in households which do not include a man. The main thrust of feminist critiques of stratification theory is that it ignores status and power inequalities between men and women. For example, feminists say having a social status conferred by one's association with a particular husband or father is not the same as having equal status with that man. It ignores the dependent relationship between men and women where the majority of women are dependent on their partners for financial support. In New Zealand, only about a third of women are in full-time employment (Novitz, 1982). Delphy (1981) argues that it is this economic dependency that constitutes for women a separate class system by virtue of their sex. Acker (1973) rejects this position, claiming that women differ from each other in the class structure, but also within each class they do not enjoy equal status with men. She considers the individual as the most appropriate unit of stratification. Gray (1978), on the other hand, argues that women do have additional resources through their association with men, but they may also occupy a class position on the basis of their own skills, assets or work situation. She, therefore, suggests that when access to resources is being considered the household is the most appropriate level for consideration and the individual the most appropriate unit of stratification in status considerations. Some support for the latter comes from Davis (1982) who shows that women's social status appears to be based more on meritocratic criteria rather than inheritance.

The Australasian evidence suggests that in their command of maternity service resources, women's educational and occupational status

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act together with status acquired through marriage. For example, Salmond (1975) found women living in the most prestigious geographical areas were also better educated and had higher occupational status. Such women received the highest standard of post-natal services regardless of need. In Dunedin, Hood et al (1978) showed that both education and husband's occupation were often positively related to perceived personal control in the sense of the ability to exercise some options. However, in other areas, negative experiences bore no relation to these variables. Skuja et al (1982) showed that it was 'knowledgeable' women - those with higher education and higher occupational status - that governed the direction and extent of consumer demand.

It was, therefore, decided that edcuation and a woman's own occupation ought to be taken into account when assigning her a class position. Barrington and Gray developed a socio-economic status classification for their study of New Zealand women (Gray 1981). The characteristics of the women in Barrington & Gray's (1981) study were similar to the characteristics of the women in the present study. For example, both samples had women who were not in paid employment and others who were in part-time or full-time employment. Barrington & Gray's classification was designed to give primacy to woman's own class position by taking her education and own employment into account, but also, where relevant, taking account of her household socio-economic status. As Barrington & Gray admit, this requires detailed knowledge of the subject's circumstances. However, as is the case in this study, research projects concerned with women's issues are increasingly utilising detailed interviews with small numbers of women. One reason for this methodology is that it more readily allows the women interviewed some control over the type of questions asked and how the answers are framed (Novitz, 1982).

In this study the Barrington-Gray socio-economic status classification was used with two slight modifications (see Appendix III for details). Because there were no women in the study financially dependent on their father, this category (father's occupation) was not used

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in ranking. In addition, Barrington-Gray's educational classification of 'school certificate' was unclear. It was decided to use passes in three school certificate subjects as an equivalent of Barrington-Gray's 'school certificate' classification. Eight of the 48 women in the study were assigned to a class position on the basis of their own occupation: three working class women, four middle class women and one upper middle class woman. Two of the three working women were non-partnered women and the third woman was the principal income earner. All five middle and upper middle class women were married and four out of five were teachers.

A third variable hypothesised as likely to influence women's experience of childbirth was the level of exposure to high technology medicine. Oakley (1980) first demonstrated a causal link between the high technology birth and post-natal depression. The Parents Centre Movement in New Zealand have been increasingly concerned about the effects of advanced medical tehcnology on the birth process (Swain, 1981). New Zealand feminists have argued that the trend towards high technology birth for increasing numbers of women, with no apparent benefit to women or their babies in terms of lower perinatal and maternal mortality rate (See Timmings & Duff, 1985) is not only alienating women from the birth process (Coney, 1979), but increases the likelihood of iatrogenesis (van Dongen, 1985) (see also previous chapter, page 23).

In view of this current debate in New Zealand and the opposition to the closure of low-technology GPU's (van Dongen, 1985), it was decided to include in the sample women undergoing birth in a high technology (base) hospital and women giving birth in GPU's. The Palmerston North Hospital Board catchment area was chosen because it contained both a relatively high technology base hospital obstetric unit and several low technology general practitioner maternity hospitals.

The base hospital obstetric unit has available specialist gynaecologists, a neonatal paediatrician, specialist anaesthetists, pathologists,

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radiologists and other medical experts. The unit has closed beds for specialist care at no cost to the patient. It has facilities for the monitoring and treatment of the 'high risk' patient, including caesarian section. In addition, there is a neonatal intensive care unit. The unit also provides open beds for general practitioners' patients, as well as antenatal, post-natal and family planning clinics. At the time of the study the unit was staffed principally by registered midwives, registered obstetric nurses, enrolled nurses and student nurses, plus 'duty' medical staff. Usually there were two midwives or registered obstetric nurses supervising each ward or unit per shift.

The four GPU's varied in size from six to 14 beds. The average bed occupancy varied from one to six. One unit was under threat of closure at the time and has since closed. The units were attended by two to six general practitioners. Staff usually consisted of one midwife and one nurse-aid per duty. At night, if the midwife lived on the premises, she was 'on call' if needed by the nurse-aid. Emergency facilities were limited to basic life support equipment, for example, suction, oxygen and intravenous equipment. In addition, an incubator was available for the transfer of babies to the base hospital. Transfer to the base hospital for a mother or baby could take from fifteen minutes to one hour.

It was hypothesised that mothers in the high technology unit would experience greater amounts of medical intervention and as a consequence would have a less satisfying experience than mothers in the GPU's. It was most important, therefore, that the characteristics of the two groups were comparable. There were some major difficulties associated with sample selection.

Sampling mothers attending Plunket introduces a bias towards white, married, middle class women as indicated above. To some extent the class bias was moderated by the method used in the study. Because no central register of women attending Plunket was available, it was decided to visit as many Plunket rooms as possible, drawing

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a small sample from each. This had the advantage of ensuring the inclusion of women from rural areas and lower socio-economic areas. To obtain two samples with different levels of exposure to medical technology, hereafter called the base hospital sample (BHS) and the local hospital sample (LHS), rural and urban Plunkets were visited and samples taken until there were equal numbers of women from each. The result was a fairly broad geographical distribution of subjects within the two samples (Figures I and II).

It was assumed that a woman's experience would be influenced by whether her pregnancy was viewed in medical terms as 'high risk' or 'low risk'. In general, only 'low risk' women are booked for birth in GPU's. Base obstetric units book both 'low risk' and 'high risk' women. It was desirable, therefore, that both samples should contain only women who were apparently healthy and expected to give birth without complication: the obstetrical 'low risk' woman. As no access to women's medical records was permitted, the selection criteria used by obstetrics, such as the guidelines for 'high risk' obstetric patients set out in the MSC Report, were not feasible. It was decided to select all women apart from those who had pre-existing disease or pathology likely to prejudice the pregnancy or birth process. Further selection would take place at the initial contact with the mother. The mother's own evaluation of the 'normalicy' of her physical state would be the sole criterion which decided whether she was included in the sample or not.

Ten Plunket Nurses representing 13 Plunket catchment areas took part in the initial drawing of the sample. They were asked to select the first five women meeting the conditions outlined above for initial inclusion in the sample and whose next Plunket visit would fall between four and five months post partum. The second condition was necessary because the researcher was not permitted access to the women's addresses. Approaches had to be made to the women in person as they arrived for their Plunket visit.

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FIGURE I

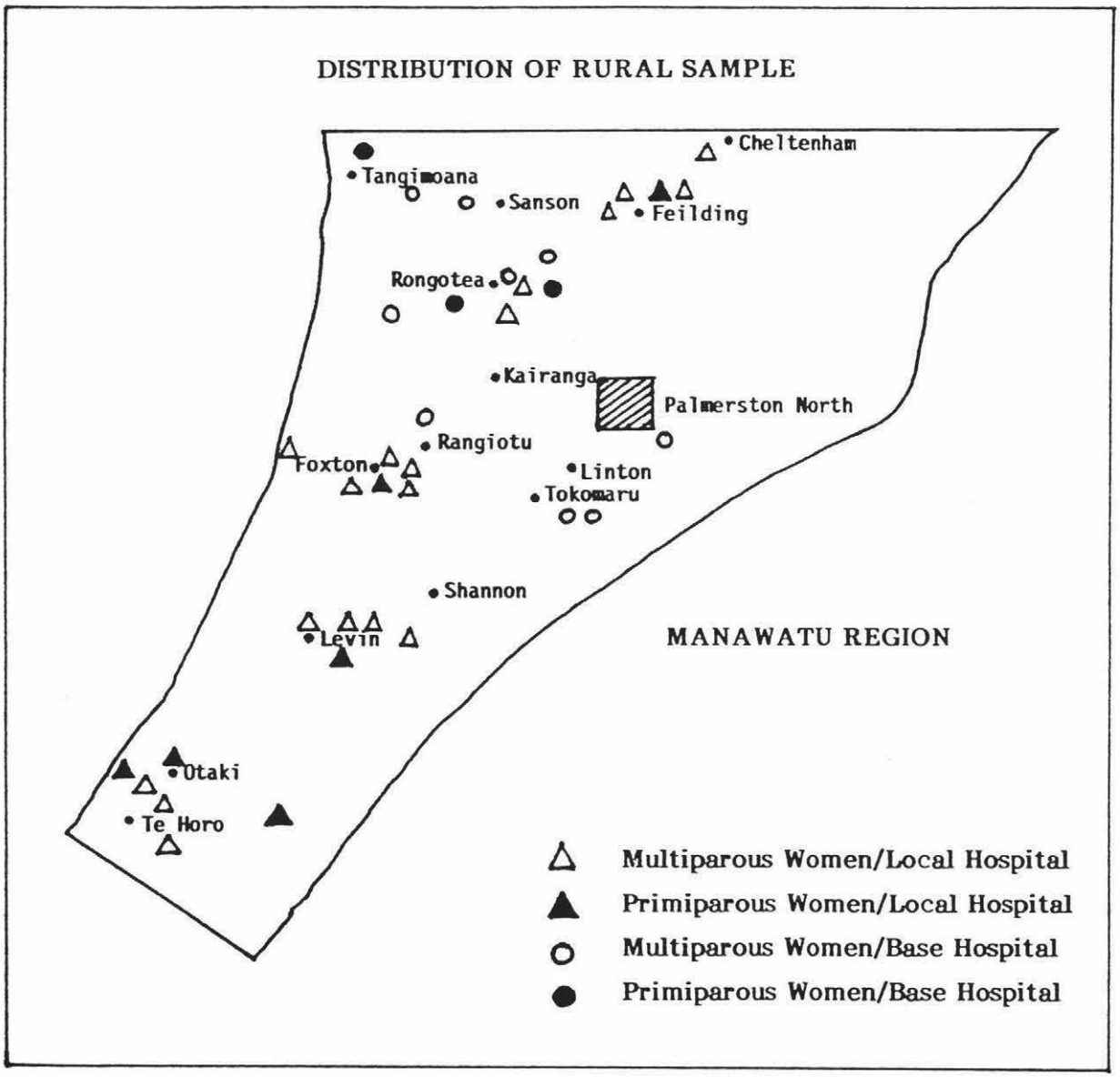
DISTRIBUTION OF RURAL SAMPLE
Cheltenham
Tangimoana
Sanson
Feilding
Rongotea
Kairanga
Palmerston North
Rangiotu
Foxton
Linton
Tokomaru
Shannon
Levin
MANAWATU REGION
Otaki
Te Horo
Multiparous Women/Local Hospital
Primiparous Women/Local Hospital
Multiparous Women/Base Hospital
Primiparous Women/Base Hospital

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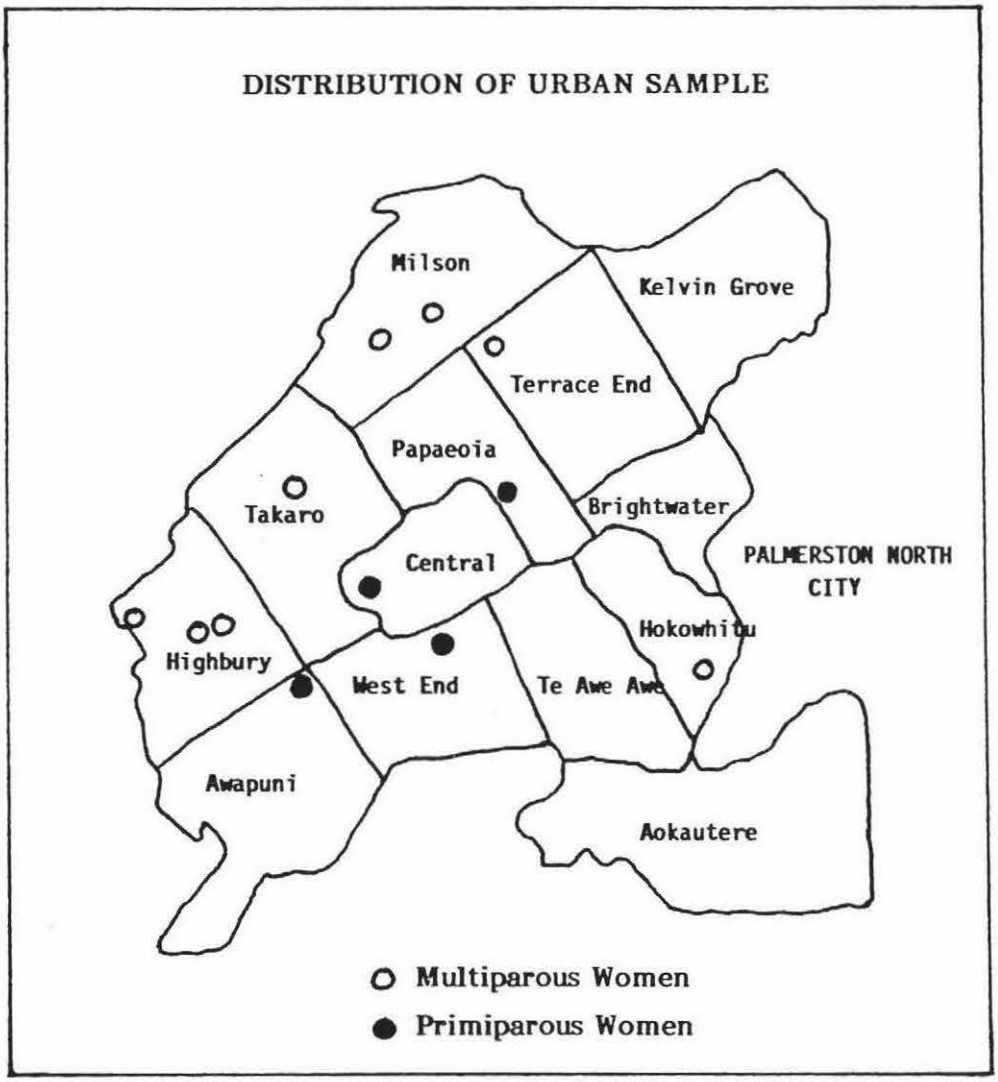
FIGURE II


DISTRIBUTION OF URBAN SAMPLE
Milson
Kelvin Grove
Terrace End
Papaeoia
Takaro
Brightwater
Central
PALMERSTON NORTH CITY
Hokowhitu
Highbury
West End
Te Awe Awe
Awapuni
Aokautere
Multiparous Women
Primiparous Women

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Five months post partum was chosen as the time for interview in an attempt to avoid the 'halo' effect of a new baby described above. It also avoided the first few months when the mother is likely to be most stressed. By five months mother and baby have usually settled into a routine. Salmond (1975) and Oakley (1980) have shown that women at five months post partum have very good recall of events surrounding the birth process.

A total of 60 women were drawn from the Plunket files. Fifty-five women felt they had a normal pregnancy and at full term were expecting to have normal labour and birth. All agreed to be interviewed. Five women repeatedly failed to turn up for their clinic appointment. No information was available on these defaulters. Two had Polynesian names. A further four women were ultimately delivered by Caesarian section. These women were eliminated from the study. Pretests of the interview schedule suggested that such women had a substantially different experience from women giving birth vaginally. Much of the difference could be reasonably attributed to the presence of an abdominal wound. It was felt unreasonable to expect these women to answer further questions if they were not taking part in the study, but an impression was gained that all four were middle or upper middle class Pakeha women.

The remaining 51 women who had agreed to being interviewed in their own homes, were given verbal and written information about the research project and the researcher. In each case a telephone number was obtained for the purpose of arranging a suitable interview time. Three women (6%) after initially agreeing to be interviewed, subsequently declined. One Pakeha woman from a farm found she was 'too busy'. The Plunket Nurse volunteered that she 'always had lots of problems'. The second woman to refuse was a young, first-time (primiparous) mother, probably under 20 years, married and Maori in appearance. She failed to keep three appointments and finally admitted she didn't want to be interviewed. She seemed shy and somewhat suspicious of being interviewed. Her housing conditions, from the outside appearance, were the worst encountered

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in the study. The house was dilapidated and situated in a run down, mixed industrial/residential area in the inner city. The third woman was also 'too busy', possibly because she appeared to be running some sort of business from her home. She cancelled three appointments and eventually fell outside the time span of five months post partum. Impressions of her and her household suggest she was Pakeha, married, in her early 20's, working - middle class.

The 48 women who were eventually interviewed for the study, were generally enthusiastic and often went to considerable lengths to rearrange their schedules to accommodate the interview. Interviewing began in May 1982 and continued to September 1982 and related to births that took place between December 1981 and April 1982.

The first part of the interview involved the recording of the women's responses to a structured questionnaire designed to develop a social profile of the respondent. This questionnaire was adapted from one used by Shipley (1982) in her study of women's unemployment in the Manawatu, and generally worked well. It was designed so that variables could be analysed using an SPSS computer programme. However, the small sample would have made significance tests, such as gamma correlations, unreliable because of the small numbers in each cell. Because of the exploratory nature of the study, it seemed more appropriate to analyse the data by hand. The remainder of the interview in which the women described their experiences was recorded on tape. The interview tapes were transcribed in their entirety. Observer variability was minimised by the researcher undertaking all the interviews and transcribing all the tapes. This allowed a high degree of familiarity with the data and sometimes for unexpected themes to emerge, for example, the general dislike of any association of the childbirth process with sickness.

The comparative method was chosen as an analytic tool to discover differences in the level of medical intervention women might be exposed to and the degree to which it influenced their satisfaction with the birth process. The inclusion in the study sample of five

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women who were transferred from one type of hospital to the other, introduced the possibility of transfer bias. It was felt of some importance, however, that the experience of these women not be excluded because of the policy trend towards relegating rural hospitals to 'after care' units (Department of Health, 1977). Transfer bias was avoided by including women who transferred in the sample which related to their booked hospital. The splitting of the sample by hospital type made comparisons between the experiences of primiparae difficult because of their small number (13 women).

The social profile of the study women that emerged from the structured questionnaire is set out below.

As indicated above, the total sample (BHS and LHS) underrepresents Maori and Pacific Island women compared with the 1981 Manawatu Region Census (Table I).

TABLE I

DISTRIBUTION ACCORDING TO ETHNIC ORIGIN OF STUDY SAMPLE AND MANAWATU REGION

ETHNIC GROUP	STUDY SAMPLE	MANAWATU REGION CENSUS 1981*
	%	%
European	95.8	90.3
New Zealand Maori	2.1	6.4
Pacific Islander	0	0.9
Other, or Not Specified	2.1	2.4
TOTAL	100.0	100.0

*** Source: 'New Zealand Census of Population and Dwellings', 1981 Bulletin 3 - Provisional Regional Statistics**

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Immigrant women from Australia and continental Europe are slightly overrepresented, while immigrant women from non-European countries are underrepresented (Table II).

TABLE II

DISTRIBUTION ACCORDING TO PLACE OF BIRTH OF STUDY SAMPLE AND MANAWATU REGION

COUNTRY	STUDY SAMPLE	MANAWATU REGION CENSUS 1981
	%	%
New Zealand	83.4	89.6
Australia	6.3	1.2
UK and Ireland	6.3	6.3
Continental Europe	4.0	0.8
Other, or Not Specified	0	2.1
TOTAL	100.0	100.0

The study women had similar personal incomes to those of the women in the Manawatu Region Census 1981. For example, 27% in both groups had no personal income. However, at the higher end of the income scale, 10% of the study women had incomes of $12,000 per annum or more. The equivalent census figure was 6%. When household incomes are examined, it is clear that the study sample underrepresents the lower household incomes compared with national figures. For example, households with an income under $10,000 make up 30% of all household incomes in the 1981 census. In the study sample, only 10% of women had household incomes of less than $10,000 per annum (Table III).

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TABLE III

HOUSEHOLD INCOMES OF STUDY SAMPLE
BY 1981 NATIONAL CENSUS FIGURES
FOR HOUSEHOLD INCOMES

HOUSEHOLD INCOME	STUDY SAMPLE	CENSUS*
$	%	%
0 - 4,000	4.0	20.0
5,000 - 9,999	6.0	10.0
10,000 - 15,999	25.0	19.0
16,000 - 19,999	17.0	10.0
20,000 - 24,999	15.0	11.0
25,000 +	33.0	30.0
TOTAL	100.0	100.0

* Source: 'New Zealand Census of Population and Dwellings', 1981 Bulletin 11

Census figures for Manawatu household incomes were not available. It would seem from the personal income figures that the study women were not particularly unrepresentative of the region in terms of income, but this was not so when compared to the national figures. The findings in the following chapters should be viewed in this context.

Using the classification for socio-economic class outlined above (page 35) shows that the study sample comprised of 31% working class women, 56% middle class women and 13% upper middle class women. There were twice as many working class primiparae as middle class primiparae (Table IV). This situation was reversed for multiparae, where middle class women outnumbered working class women by three to one. Interpretation of this finding is difficult; the numbers of primiparae were small: 27% of the total sample. However, it

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is difficult not to conclude that working class mothers drop out of Plunket care with subsequent babies.

TABLE IV

SOCIO-ECONOMIC CLASS BY BASE HOSPITAL SAMPLE AND LOCAL HOSPITAL SAMPLE BY PARITY

(Percentage in Brackets)

	BHS		LHS		TOTAL
	Primiparae	Multiparae	Primiparae	Multiparae	
Working Class	5	4	3	3	15 (31)
Middle Class	1	10	3	13	27 (56)
Upper Middle Class	1	3	0	2	6 (13)
TOTAL WOMEN	7	17	6	18	48 (100

The oldest primipara was 31 years and the youngest 18 years, with a median age of 22 years. Multiparae were aged between 23 years and 37 years, with a median age of 30 years.

Only one woman lived more than 80 kilometres from the base hospital. No woman lived more than 35 kilometres from the hospital in which she was booked. One quarter of the total sample lived within the city boundary. One third lived in small towns containing essential services, such as doctors, Plunket Rooms, chemist shops, etc. A third lived in rural areas (defined as greater than 10 kilometres from the nearest city or town containing essential services). The remainder (4 women) lived on the edge of towns (5-10 kilometres from the town centre). Of the women living in relative isolation in the rural areas, one quarter were primiparae under 25 years. Both non-partnered women fell into this category.

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The great majority (96%) belong to nuclear family households. The two non-partnered women were the only women in an alternative type of household. One lived in an extended family household and the other shared accommodation with non-relatives.

The two child family occurred most frequently in the sample (38%), followed by the three child family (27%), then the one child family (25%). Only 10% of the sample had four or more children. Parity (Number of children born to a woman) was similar in the local hospital and base hospital samples (Table 5).

TABLE V

PARITY OF WOMEN BY TYPE OF BIRTH HOSPITAL

PARITY	BASE HOSPITAL	LOCAL HOSPITAL	TOTAL
0	7	6*	13
1	10	7	17
2	5	9°	14
3	1	2°	3
4	1	0	1
TOTAL	24	24	48

* Includes three mothers transferred to the Base Hospital for delivery

° Includes one mother transferred to the Base Hospital for delivery

At the beginning of pregnancy, just under two thirds of all women were in paid work. This included a quarter of the sample who were in full-time paid work. First-time mothers and mothers with two children were unlikely not to be in paid work. On the other hand, mothers with one child were more likely not to be working (Table VI).

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TABLE VI

WOMEN IN PAID WORK AT BEGINNING OF PREGNANCY BY PARITY

PARITY	0	1	2	3	4+	TOTAL
Full-time	9	0	2	0	1	12
Part-time	1	8	9	1	0	19
Not Working	3*	10	1	2	1	17
TOTAL	13	18	12	3	2	48

* Includes two women seeking work

Going back to work for mothers with two children was not apparently an indication of the completion of childbearing for these women. Only two of the 12 women in this category said their third baby was unplanned.

Despite two thirds of mothers working, 22 women (46%) had a personal income of less than $2,000 per annum in the previous financial year. This reflected both the high degree of part-time work undertaken and the fact that many mothers seemed to move in and out of the workforce in any one year. Eleven women (23%) had no personal income other than the Family Benefit. Over three quarters of the study women felt they were totally dependent on their husband, financially. Eight women (17%) felt they were dependant on both incomes. Two women were dependent on the Domestic Purposes Benefit and one woman whose husband was a student, was principal income earner. Household incomes ranged from $2,904 per annum (a non-partnered Maori woman) to just over $66,000 per annum (a Pakeha woman married to a doctor). The median income was $18,548 per annum. Primiparae had incomes that were slightly lower on average than multiparae incomes ($17,197 per annum compared with $21,499 per annum).

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However, both groups had a median income of $18,000 per annum. The lower average income of primiparae may reflect the stage of the husband's career, although it should be remembered that working class women formed the majority of primiparae. The relatively high median income of the women in the study obscures the fact that over a third had to manage on $15,000 per annum, or less. Three quarters of these lower income mothers had more than one child.

Despite relatively low household incomes of many of the women, housing in general was of a reasonably comfortable standard (see below). Rental housing was the norm for primiparae (62%), while only 14% of multiparae lived in rental accommodation (Table VII).

TABLE VII

TYPE OF ACCOMMODATION BY PARITY
(Percentage in Brackets)

	PRIMIPARAE	MULTIPARAE	TOTAL
Own Home	3 (23)	29 (83)	32 (67)
Rental Accommodation	8 (61)	5 (14)	13 (27)
Goes With Job	1 (8)	1 (3)	2 (4)
Other	1 (8)	0 (0)	1 (2)
TOTAL WOMEN	13 (100)	35 (100)	48 (100)

Again, as with household income, this may reflect the stage of the partner's career. But Table VIIA shows that there was a strong association of rental accommodation with lower socio-economic status. For example, 53% of working class women lived in rental accommodation compared with only 15% of middle or upper middle class women. Rental accommodation was more likely to be in need of redecoration

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and repair than privately owned housing. Apart from one woman whose rented accommodation was so poorly constructed that it was damp and cold, and one woman who was living in a caravan while waiting for a house to be transported, housing seemed to be adequate, containing basic facilities, such as inside toilets, hot water, washing machines, adequate heating, etc. One woman had had her telephone disconnected because she was unable to pay the bill.

TABLE VIIA

TYPE OF ACCOMMODATION BY SOCIO-ECONOMIC CLASS
(Percentage in Brackets)

	WORKING CLASS	MIDDLE CLASS	UPPER MIDDLE CLASS
Own Home	5 (33)	22 (81)	5 (83)
Rental Accommodation	8 (53)	4 (15)	1 (17)
Goes With Job	1 (7)	1 (4)	0 (0)
Other	1 (7)	0 (0)	0 (0)
TOTAL WOMEN	15 (100)	27 (100)	6 (100)

The next three chapters are concerned with the data generated by the taped interviews. The two-hour long tapes produced a considerable volume of data. It was necessary, therefore, to omit some aspects of childbirth, particularly those that have been addressed elsewhere, for example, antenatal education (Wright, 1980, has investigated this aspect of childbirth). What is included in this study reflects the particular interests of the author.

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CHAPTER III

PREGNANCY

In this chapter, how the study women experienced pregnancy is examined. The data encompasses two broad aspects of pregnancy; the personal meaning women attach to being pregnant, and the opinions, feelings and attitudes of the women towards their obstetric care.

Becoming pregnant was a time of excitement and joy for just over half (56%) of the women in the study. "Rapt" was a common expression and aptly described the delight of a confirmed pregnancy.

> **Karen:** **"I was quite rapt. We actually planned to have two children."**
>
> **Alison:** **"Oh, I was quite excited. Yes, I enjoyed having our other one, so I was really pleased to find out I was pregnant again."**

For these mothers pregnancy was anticipated and included in the family plans. For two mothers the confirmation of pregnancy was specially welcome, for it ended a period of apparent infertility.

For 21 mothers (44%), however, becoming pregnant was unexpected and, to varying degrees, unwelcome news. For eight women in this group another baby was wanted, but the mother faced other pressures that made the pregnancy inconvenient or problematic. For example, Liz had felt sick throughout her previous pregnancy and dreaded the thought of this for another nine months. Maureen, having already had four children, although thoroughly committed to accepting each pregnancy, knew she would have to face the criticism and hurtful comments of family and friends for having such a large number of children. Bronwyn felt she should have a second baby before she was too old, but was ambivalent about 'going through the whole process again'. For the majority of this group with mixed feelings,

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however, the problem was the timing of the pregnancy. Mothers were often exhausted from coping with a toddler under a year and now there was another pregnancy to cope with. Jacqui is typical:-

> **"A surprise, I wasn't supposed to be pregnant...quite pleased really, we did plan another child. We didn't plan one quite as soon as that!"**

For the remaining 13 women (22% of all women), becoming pregnant was the cause of distress and disruption in their lives. Four of the six primiparous women in this group were under 21 and unmarried; two subsequently decided to marry during pregnancy. For example, Wendy married a man, not the baby's father, because "I couldn't bear to be a solo mother". Janice and Paula had supportive parents, who helped bear the burden. Both, however, were forced to give up jobs they liked to look after their babies and at the time of interview were dependent on the Domestic Purposes Benefit. Trudy was the breadwinner of the family and first thought of abortion, but changed her mind and continued her career, but often under considerable stress.

Seven women who already had children were on the whole ill-prepared to cope with another baby, either because emotional, physical or financial resources, or a combination of these, were already stretched:-

Kirsty: **"It was quite funny really. I thought 'not again' because I had just had the first one. She wasn't quite a year old. I didn't know really what to think. I just thought 'oh no, not again'."**

Celia: **"I was just numb with surprise and thought 'oh, how can we cope?'"**

Sally: **"It was quite a surprising feeling, because all the others had been planned. I hadn't even thought about having a baby that had never been planned before."** (Her fifth)

Stephanie: **"I laughed all the first day and cried all the next day, then I came right. It took a lot of adjusting because the other two were at school and I was going to work."**

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The reason why so many women had unanticipated pregnancies is uncertain. Contraceptive practice was not questioned in the study and few women volunteered information. The finding that 44% of women had not 'planned' the pregnancy suggests that contraceptive methods are failing many women. Hubert, in her 1974 study of working class women, showed that few women use effective forms of contraception, because of real lack of knowledge. While it is true in this study that almost twice as many (60%) of working class women as middle class women (35%) had 'unplanned' pregnancies, the corresponding rate for upper middle class women was 75%. Trlin & Perry (1981) showed that 31% of Manawatu women using contraceptive methods have 'unplanned' pregnancies. They suggest that a considerable proportion of these appear to occur because women use less effective methods or stop contracepting for reasons other than wanting to get pregnant. The findings above, and Trlin & Perry's data, indicate that it is too simplistic to argue that unplanned pregnancy is a consequence of failure to obtain or use the more 'effective' methods of contraception through ignorance or lack of family planning education and advice resources (MSC Report, 1976). Feminist research suggests that women are rejecting the 'more effective' methods, for example, the 'pill', IUD's and Depo Provera, because of their side effects and dubious safety. (Seaman, 1977; Madaras & Patterson, 1981; Pollock, 1984). Contrary to popular opinion, a safe, reliable and acceptable contraceptive method for all women does not exist. Thus, fertility control continues to be a major problem in many women's lives (Calvert, 1982; Bunkle, 1984).

Most women 'feel' pregnant before they approach the doctor. In this study, nearly half (47%) 'knew for certain' and 43% were 'fairly certain' they were pregnant before it was confirmed medically. This left only three women who didn't realise they were pregnant until it was clinically diagnosed. Most women put off going to the doctor until there was little doubt of the pregnancy in their own minds. This was apparently because they didn't want to be seen as wasting the doctor's time. Few mothers felt able to request a pregnancy test without consulting the doctor. Many women, however,

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intimated that an 'on demand' pregnancy test would have been of considerable benefit in removing the stress of uncertainty.

The average timing of the first visit to the doctor for primiparae was six weeks after missing a period. In contrast, half the multiparae did not visit the doctor until twelve weeks or more after the missed period. Such mothers had specific reasons for delaying the visit to the doctor. The most frequent reason given was waiting to be sure of the pregnancy. Several felt an earlier visit was unnecessary. At least one woman wished to avoid the vaginal examination:-

> **Heather:** **"I didn't go to her before four months because I felt well and I didn't think it was necessary."**
>
> **Lisa:** **"My doctor does the internal examination and I was trying to avoid that, I kept it so that I stayed away as long as possible, so that he could feel the fundus. When you could I went in. I really hate internals."**

Several women delayed the first visit to the doctor because it was perceived as somewhat of an ordeal by them:-

> **Kirsty:** **"I waited three months before going to the doctor. I get down to the doctor and I go all shy. The doctors here are fairly old. I would have liked a younger doctor or perhaps a lady."**

Phillipa delayed going to the doctor because during her previous pregnancy she had been told she wasn't pregnant when she was sure she was, and didn't want the same hassle. The false negative pregnancy was mentioned by several women as a source of distress. The distress arose because women were told they 'couldn't possibly be pregnant' because the test was negative. Yet the women were very sure they were pregnant. It was not always clear whether it was the doctor or other practice personnel who were making this kind of statement, but doctors did so on several occasions. For at least two women where a clinical diagnosis of pregnancy proved difficult, the resulting distress suffered by the women was diagnosed as 'neurosis':-

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Jane: "What happened was that I had a miscarriage when I was on holiday and didn't see the doctor until quite a few weeks later. I didn't know for sure whether I had had a miscarriage and went to the doctor to find out. He decided I hadn't had enough bleeding and must still be pregnant. The following month I still didn't feel right. I just felt funny. He decided then that I hadn't ever been pregnant and said I was imagining things, and that I desperately wanted to be pregnant and that's what the whole problem was. He told me to go away and relax and everything would go back to normal again. I knew everything wasn't normal but I tried not to think about it for a month."

Researcher: "This was now the third month?"

Jane: "Yes, and we decided to see another doctor."

Jane and her husband had to insist on a second opinion. She saw a specialist who was "kind" and confirmed the pregnancy with a scan. But the whole experience was very traumatic for Jane:-

"I was really upset. It really shook me for a while there. I really had problems facing a doctor. If the specialist hadn't been so kind and gentle and confirmed what we had worked out, what must have happened, I don't know whether I would have gone to a doctor again. I had never had that kind of message before from anyone, that really shook me....I was so mixed up emotionally. It really was a bad experience. It was good the specialist sent me off for a scan because I could see this little grey blur for myself. You can see why I was so relieved. I wasn't cracking up after all."

Linda, pregnant for the first time, also found that her worries about her pregnancy were seen by the doctor as neurotic in origin. In the circumstances, Linda's worries were not unjustified. She had had two negative pregnancy tests. Thinking she was not pregnant she had taken travel sickness pills. The pack contained a warning that they were contraindicated in pregnancy. On return from holiday she was diagnosed as pregnant. During the first 28 weeks she was plagued with doubts about the existence of her pregnancy. When she finally heard the heartbeat she began to worry about fetal abnormality because of the pills she had taken. Her pleas for

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a scan were dismissed as irrational:-

> **"I wanted a scan in case he was abnormal. I thought I could prepare myself for abnormality. Instead I worried myself sick about it (....) One time he said 'thousands of people go through this.' To him I was just one of thousands."**

At the time of interview Linda said she still had moments when she worried that her baby was abnormal. Uncertainty about whether one is pregnant or not appears to be particularly stressful, suggesting that the psychological preparation for birth begins early. Shields (1974) argues that two essential psychological 'tasks' women must accomplish during pregnancy are the acceptance of the pregnancy as real, and the existence of the baby as real. Acceptance of the pregnancy as real can be difficult for some women. Two single primiparae and one married multiparous woman delayed seeking confirmation of the pregnancy because of the difficult social consequences. Wendy, single, 20 years old, and unemployed, put off facing the inevitable:-

> **"I was three months....oh God....after three months I thought, 'jeez, I better do something about it'. It takes you ages to realise you are pregnant. You just don't believe it for a while, and then you gotta realise that you gotta get all your things together(....) I had to think quick because you see the guy that I married...it wasn't his baby and, oh jeez, what a mess.... I got married at five months."**

Going to the doctor for a pregnancy test appears to start off the medical management of the pregnancy. Many women seem to wish to delay this 'take over', yet, as already suggested, uncertainty about pregnancy is stressful. This is compounded if clinical tests conflict with messages women are receiving from their own bodies. Many of the study women had considerable knowledge about their menstrual cycles. Several practiced 'natural family planning' and felt confident they could pinpoint when they ovulated. There was evidence that sometimes this knowledge was disregarded by doctors. The more confident or more experienced women were able to cope

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with false negative preganncy tests that conflicted with their subjective knowledge of their body signals. For example, Yvonne, told she couldn't possibly be pregnant by her doctor following a negative test, being rather more assertive than most of the women in the study, continued to submit samples every two weeks until she had a positive result. Less confident women, cowed by the authority of medical science, can become quite disturbed. As Linda said:-

> **"I was three months pregnant by this stage and I finally thought there was something drastically wrong with me because of the negative tests. So I was quite shocked really when this one was positive."**

The more recent pregnancy test using a blood sample is considerably more accurate, though more expensive, and avoids this problem of false negative results, but only doctors decide who may have this test.

There would appear to be a case for allowing women unfettered access to accurate pregnancy testing that is independent of the antenatal system. This would avoid the stressful period of uncertainty and allow women to begin early the psycho-social preparation for birth in advance of submission to obstetrical management.

The issue of the less than straightforward diagnosis of pregnancy deserves one further comment. There is a tendency by doctors to attribute unexplainable systoms to psychological origins in women. This had been documented by Lennane and Lennane (1973). In the past, dysmonorrohea, nausea of pregnancy and labour pain, have all been labelled psychogenic in origin. As Ehrenreich & English (1976) say:-

> **'How many times do we go to the doctor feeling sick and leave, after a diagnosis of psychosomatic, feeling <u>crazy</u>?'**
>
> (Ehrenreich & English, 1976: p83)

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Medical students in New Zealand today are taught that the theory of the psychogenic condition has been abandoned, that there is no mind-body dichotomy (personal communication). Nevertheless, the above data suggests that this theory persists with some doctors.

All women in the study had medical supervision of their pregnancy. Of the 26 women living within 25 kilometres of the city centre where a range of options for medical care were available, 19 (73%) chose general practitioner care, five (19%) chose a private specialist gynaecologist, and two (8%) chose care from the base hospital antenatal clinic. No working class mothers chose specialist care, nor any primiparous mother. Choosing specialist care usually followed the mother's exposure to emergency specialist referral at a previous birth. For 87% of those choosing general practitioner care, the doctor was already the family doctor. The major factor in the choice of caregivers was that the doctor was known to the mother:-

> **Judy:** **"I wouldn't like to start a pregnancy and a new doctor."**
>
> **Michelle:** **"After I had the first baby I thought about changing GP's generally, but never got round to it. When I got pregnant again I went to who I knew. (Laughs)."** [1]

When mothers were asked whether it mattered if pregnant women had a choice of doctor the majority said it did, although a number said it was more important to have the same doctor than a choice. Three women felt the availability of a competent doctor was more important than choice. Two mothers were indifferent as long as there was a doctor. The idea of 'shopping round' for a doctor

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1. The importance of laughter is explained in Chapter II. In this case Michelle acknowledges the contradiction (by her laughter) between the need for a better doctor and her need for established relationships with caregivers when pregnant.

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was clearly foreign to many women. All women did have 'options' in doctors, although this was sometimes only a choice between two. Changing doctors was generally perceived as a 'hassle' few women were prepared to undertake. Not a few were 'handed over' to partners in the practice when the original doctor died or retired.

Most mothers (90%) felt it was important to have a good realtionship with the doctor during pregnancy. Seventy per cent said this was the case with their doctor. However, this high rate may be misleading on closer examination of the interaction between mothers and their doctors. For example, using women's descriptions of their encounters with their doctors, the relationship between the mother and her doctor was classified into one of three categories identified by Szasz & Hollender (1956) and Danziger (1978). The three categories were:-

1. **'active-passive'** - in which the doctor assumed the role of 'expert'; interaction was perfunctory with little information exchanged.

2. **'guidance-cooperation'** - in which the doctor acted as a 'counsellor'; dispensing advice and selected information.

3. **'mutual participation'** - which involved both the doctor and the mother acting as co-participants in decision making and information sharing.

Thirty-two per cent of mother/doctor relationships in this study were classified as 'active-passive', 57% as 'guidance-cooperation', and 11% as 'mutual participation'. Discussion with the women about their attitudes towards the type of role played by their doctor,

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revealed that only 52% were satisfied, with middle class women being most likely to be satisfied. All women in 'active-passive' relationships were unhappy with this situation, complaining that they found the doctor intimidating or dismissive of their concerns:-

> **Karen:** **"I felt that I was just a patient the Government was paying him money to do his routine services on. You were in and out and that was it. There was no taking time to explain. You felt you were a nuisance. He was always in such a hurry to get out of the room."**
>
> **Lynn:** **"He would just come in, feel the baby, 'oh yeah, right, see you in a fortnight's time' and that was it."**

The majority of women in this type of relationship were working class primiparae. Upper middle class women were more likely to complain of being in a 'guidance-cooperation' relationship. Criticisms voiced were that the doctor was patronising or reluctant to impart information on implications or alternatives of treatment or procedures, effectively preventing women from partaking in decision making:-

> **Claire:** **"He knew I was a registered nurse. He should have been a little more explicit with me, not treating you as if you weren't the full quid and that there's some things you shouldn't know. Basically, what I think he was trying to say was 'you are in my hands, do as I say, it doesn't matter what's going on'. A lot of people are quite happy with that. I wasn't."**
>
> **Lorraine:** **"I think they don't want to share the information. It's not going to hurt them at all to tell you these things. People may not have the knowledge the doctor has and he's spent many years getting it. Fine, but we do want to know what goes on."**

The degree of passivity of mothers in the doctor/patient relationship appeared to depend, to a large degree, on the role adopted by the doctor. Mothers unhappy with the doctor's mode of interaction did not feel they could challenge it. There are several factors

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that are thought to contribute to this unequality in the relationship. The doctor is in a position of professional dominance in which s/he is able to determine what is relevant information and, therefore, to continually control and structure the interaction (Freidson, 1970).

The obstetric encounter is most often a male-female one. Consequently, the male doctor brings to the encounter the assumptions of his social milieu, those of white upper middle class males (see Chapter I). As has already been pointed out, much of the treatment of women by male doctors is contingent on their assumptions of appropriate 'feminine' characteristics and behaviour. It may follow that women adopt particular patient roles that they feel will meet the doctor's expectations of them in order to obtain the information they need. This, coupled with the increased vulnerability women feel during pregnancy (see Chapter I), must tend to increase the passivity of women in obstetric encounters, thus confirming the assumed link between passivity and femininity. Another aspect that may increase the asymmetry between women and their doctors is the physical environment of the encounter. The action takes place on the doctor's 'turf'. Women often find they are forced to converse from a position where they are flat on their backs, semi-clothed or with various parts of the anatomy exposed.

The study women didn't themselves always isolate these contributing factors to their feelings of dependence. They were more likely to see their passivity as a personal characteristic. For example, Maureen's conversations with her doctor were always conducted when she was lying flat with her tummy exposed. She frequently had questions she wanted answered but said:-

> **"I found the nurses were better to ask really....they didn't seem so busy. I suppose it's my fault. I just have a scare of the doctor really."**

Many mothers felt they were in no position to question the doctor. It was not uncommon for women to refer to their doctors in religious

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terms:-

> **Rosemary: "I regarded him as an expert. His answers were gospel. I wouldn't question his judgement."**

Although Celia attributed her failure to get all the information she needed to not wanting to 'cause any trouble', she nevertheless described how the doctor's professional status and his status as a male can inhibit women from voicing their needs:-

> **"You become very aware of this male-female thing that goes on when you are pregnant. In a way they are sort of gods the way they come into the clinic. They sweep into this all female setup. It is somehow more apparent in a little place like X. Everyone is waiting for this person who is going to arrive. It's a bit awesome in a way. You have to tell yourself you are being ridiculous. It's just this chap. And he is not really a formal person when all is said and done. He tries to relax you as best he can."**

Michelle was able to pinpoint what inhibited her:-

> **"I suppose I was scared of a knockback. I felt I was the patient. I was lying on my back with my bra and pants on. I sort of felt....vulnerable."**

Few women thought of themselves as patients when pregnant and many women felt uncomfortable having their antenatal care as part of the doctor's routine surgery. The reason for this seemed to be that because they saw themselves as well, rather than ill, their presence among a waiting room of 'sick' people was somehow fraudulent. Conversely, 60% of the study women felt their doctors viewed them primarily as patients. These conflicting views inhibited many women from bringing up for discussion social or emotional subjects with their doctor for fear of 'wasting his time'. Seventeen per cent of women were able to attend antenatal clinics that were held separately from routine surgery. Such women seemed to display more confidence in the encounter with the doctor (see Brenda below). These women were no less likely to be treated as patients by the

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doctor, but there appeared to be some advantage to women in this disassociation from illness. Those attending separate antenatal clinics at the base hospital, or provided by specialists, however, did not feel more confident. The environment of specialist medicine outweighed any advantage gained from disassociation with other sick patients.

The ability to promote the exchange of information, to be 'easy to talk to' or to listen, was rated by the study women as the most desirable characteristic of a doctor twice as often as was medical competence. Brenda is typical of the women who were happy with the doctor-patient relationship:-

> **"He was easy to talk to, he never let me worry. I don't know what is is, I think I was more relaxed because in his waiting room there were a lot of pregnant women. I didn't think I was run of the mill...you know, 'here comes another cow'. You were an individual."**

Brenda and her doctor, like the majority of satisfied mothers, were in a 'guidance-cooperation' relationship. However, 19% of mothers preferred 'mutual participation' in their antenatal care. Just over half of this group felt their doctors cooperated with their wish to take some responsibility. Trudy and her husband describe their doctor:-

> **"We tried to participate more actively. We may have thought about it more than maybe other people do and asked more questions, rather than just have things done to us. He was very friendly, quite like a friend talking. (Although) he is the one with the knowledge, he regarded me as intelligent. You are not afraid to ask him anything. He has the modern approach of being very explicit and taking a lot of time with you and trying to allow for all of your wishes. He takes your worries seriously and explains everything. He was throwing up options even while I was in labour which was a bit harder at the time, but it is very much better than an overbearing doctor sho says 'we want this and that'. We were not used to it but it's good."**

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Taking responsibility in decision making requires considerable knowledge about childbirth. Mothers in this group preferring mutual participation, were either members of Parents Centre, nurses or upper middle class women. This would suggest that unless women are aware of choices and options and the implications of various courses of action in the childbirth process, they are unlikely to question their medical treatment or demand participation in decision making.

Women in the study, whatever their level of knowledge or number of previous pregnancies, had information needs that were not always adequately met by their doctors. The major problem appeared to be intimidation. Frequently, mothers said, 'I never got round to asking', or, 'I forgot to ask', but there were strong indications that the doctor's behaviour or manner discouraged asking. For example, 28% of the study women said that the worst characteristic of their doctor was his/her unapproachability. Conversely, doctors who facilitated information sharing were highly appreciated. Diane found asking for information very difficult, usually, but describes what happened when a locum doctor took over the practice for a month:-

> **"He was really great. He told me a lot of things - what he was writing on the card. I asked him a lot of things that month. He used to say 'what do you want to know?'. The first time I said 'I don't think I want to know anything', he said, 'Oh come on, you are eight months pregnant, there must be something you want to know'....He said, 'Oh well, I won't let you go until you have asked me a question'. I found him really good. I wish he could have stayed."**

Debbie also benefited from help in articulating her need for information:-

> **"We had good talks. He always asked me just before I left, 'Is there anything you want to ask me?'."**

A third of the study women said they received some socio-emotional support from their doctors. Most women did not expect it. For

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example, only a sixth specifically mentioned lack of emotional support as a defect of the antenatal care they received. Yet for those mothers who did receive this kind of support it was considered by them to be the best thing about their doctor's care. A factor mentioned frequently was the need for emphasising positive feelings about the pregnancy. All the mothers, once they had accepted the fact of their pregnancy, had strongly positive feelings towards the coming baby. Mothers felt a need to have this acknowledged and discussed:-

> **Phillipa:** **"I think they should treat you as if there is something good that is happening to you and not just something that has to be treated as an illness."**
>
> **Carolyn:** **"He never asked me anything personal like 'how does it feel to be a mother?'. I would have liked him to ask me that."**

Only one doctor recognised this need in mothers:-

> **Clare:** **"One of the things I did like about him was that he did try to help you enjoy your pregnancy. He used to get you to daydream about how nice it was going to be to breastfeed, how nice it was going to be to get the baby at the end. He always used to tell you how good you looked."**

A rather surprising finding was that for several mothers the study interview was the first time they had discussed personal feelings about the pregnancy and birth <u>with anyone</u>. Perhaps even more surprising was the finding that two thirds of the study women did not discuss at all with their doctor their coming labour and delivery, including 11 of the 13 primiparae. Doctors appeared to believe that this was the province of the antenatal education class. Where the subject was discussed with the doctor, it was usually the mother who brought up the subject. In view of the above findings, it is perhaps not unexpected that the majority of mothers felt that antenatal care offered no personal benefit, other than 'reassurance that the baby was all right'.

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Mothers who attended antenatal classes run by Parent's Centre or the local yoga group, appeared to have opportunities to discuss the emotional aspects of pregnancy. These women often formed friendships among one another that lasted beyond the post partum period. Such women were, however, unlikely to be working class. Women who attended the base hospital antenatal classes not only appeared to have no opportunity to discuss personal feelings, they were frequently too embarrassed in front of other women, to ask any questions at all. Those attending the smaller, local GPU antenatal classes seemed to have more opportunity to speak personally with a midwife.

The experience of the four women who were single at the beginning of pregnancy deserves some mention, because young, single mothers are designated 'high risk' in obstetrical terms (see Chapter II). The risk attached to this category of pregnant women appears to be related to 'fragmentation of care' rather than age, according to the MSC Report (1976). Wendy and Janice received antenatal care from the base hospital antenatal clinic. Paula and Julie received GPU-based antenatal care from their general practitioner. The social circumstances of the two pairs of women were remarkably similar. Wendy and Janice saw a different doctor at each visit. Both women described such visits in perfunctory and impersonal terms. Wendy felt she was 'just another fat sheila'. Both did say that on one occasion there was a 'nice' doctor. A doctor who 'treated me as a person', as Janice said. Wendy said she was depressed throughout her pregnancy but apparently received no professional help. Both women attended antenatal classes at the hospital which included a tour of the obstetric unit. On admission to the unit when in labour, however, hoth women were terrified about what was going to happen to them. Wendy described her admission as 'like walking into a horror movie'. Neither woman seemed to expect or want to play any part in the birth process. In contrast, Paula and Julie appeared to approach labour with much more confidence. Several factors may have contributed towards the less passive approach of these two women. For Paula and Julie, having their antenatal care and education classes situated in the more intimate atmosphere

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of the small hospital apparently allowed them to become familiar with the staff and the environment. Continuity of care from a familiar doctor may have contributed, although both said the doctor offered little in the way of emotional support. Support was forthcoming from the midwives, however, and it would seem that this more sensitive response to individual needs flowed from the high level of cooperation and information exchange between the doctor, midwife and the mother. The need for continuity, and non-fragmentation, of care from childbirth professionals seems particularly relevant in the antenatal care of the young, single mother.

Thirty-eight women commented on the sex of the doctor. Just over half (53%) felt the doctor's sex made no difference to the kind of care they received:-

> Joanne: **"No difference. I had a female at college. I can't say I noticed any difference in the care I received. I could have chosen a woman at this practice."**

Just under a third of this group had actually experienced care from a female doctor. Thirty-nine per cent felt they were, or might be, more comfortable with a female doctor. Two women qualified this by saying that the medical expertise of the doctor would be more important. Three women in this group preferring female doctors had deliberately sought out female doctors for their antenatal care. One subsequently changed to a male doctor because she felt the woman doctor was 'unsympathetic'. The major reason for preferring a female doctor was that she would be easier to talk to because of her common experience of being female and/or a mother. Two mothers felt vaginal examinations, particularly the one done at 6 weeks post partum, which many women disliked, would be less disturbing if done by a female doctor. Eight per cent preferred to have a male doctor because he was perceived as being less judgemental.

Apart from getting the baby at the end, pregnancy itself was, for three quarters of the study women, not a particularly pleasant

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experience. A fairly general opinion was that pregnancy was, like menstruation, something you accepted as part of being a woman. It was something you put up with because of the baby at the end. It was not something to be relished as intrinsically rewarding. Most women would rather not be pregnant. There were a few exceptions. Primiparae found the process an exciting new experience, especially the outward signs of the baby's presence - kicks, heartbeats, hiccoughs. However, the excitement was often overshadowed by apprehension about the implication of being solely responsible for a new baby, particularly among those who received little socio-emotional support.

Multiparae who had predominantly positive feelings about the state of pregnancy, fell into three distinct groups. First, those who actually felt more healthy pregnant than non-pregnant. The three women in this group attributed this to a hormone response:-

> **Trudy:** **"It was a good experience. Hormone changes make me feel great. I'm a person who has mood changes. I was on a good, even level. Because my husband was happy about the pregnancy I didn't get feelings about my size. No, I just loved it."**
>
> **Clare:** **"I thoroughly enjoyed it. If I could actually stay in that state without having a baby I would. I feel marvellous, keen, energetic, blossoming, blooming."**

The Health Department's antenatal booklet 'Your New Baby', given to pregnant women at the time of this study [1], suggests that this is a common experience for pregnant women:-

> **'After the first three months most women say they never felt so well before.'**
>
> (Your New Baby: p33)

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1. This antenatal booklet 'Your New Baby' was replaced in 1985 by the booklet 'Your Pregnancy'. The observations in this study relating to the former publication, are not applicable to the latter.

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The second group of two mothers who were predominantly positive about pregnancy were particularly knowledgeable about the birth process. They appeared to have high self-esteem and felt good about their own bodies. They perceived the process of pregnancy as a creative act in which they were actively involved. They welcomed the changes in their bodies as manifestations of this creative process, regardless of the attitudes of others towards their changing shape:-

> **Donna:** **"I like being pregnant and nuturing a baby. There are some who feel sorry for you. The pregnant body is repulsive to them. I was not bothered. I knew I would lose weight after I stopped feeding."**

There was another, larger group of seven women who were positive about pregnancy, but for very different reasons. This group of mothers believed very strongly that motherhood was woman's most important and rewarding role. They were generally committed to the idea of larger than average families. It was in these women that the idea of self-sacrifice was strongest. They had characteristics that contrasted strongly with the other women who felt positive about pregnancy. For example, their commitment to self-sacrifice meant they adopted an extremely passive role in the birth process. It was to these women that the appeal 'for the sake of the baby' was strongest and most effective. Their self-esteem rested on their ability to produce and rear their children well. This commitment to their ideals overrode their personal feelings, sometimes even to the point of denying the legitimacy of personal feelings at all:-

> **Lorna:** **"What's best for the baby is more important than what I feel like (....)I'm on for anything if it means a healthy baby. That's it. I'll put up with anything."**

Breen (1975) and Oakley (1980) have suggested that such mothers are particularly vulnerable to the conflicts between the actual experience of pregnancy, birth and childcare and the cultural idealisation

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of femininity/motherhood. It was the most 'feminine' women in Breen's and Oakley's studies, those most passive and dependent, who experienced the worst problems of loss of self-esteem/depression when childbirth and mothering turned out not to be the all-fulfilling processes that the ideology of motherhood had led them to believe would be the reward for perfect selflessness. In this study, these 'feminine' mothers were likely to be middle or upper class and Catholic. The Catholic Church has promoted very strongly the ideal of the virtuous perfectly selfless mother. These idealised images of motherhood are also reflected in the antenatal literature. Graham (1977) has shown that specific photographic techniques are used in antenatal literature that construct an image in which the pregnant woman is portrayed as being 'at one' with nature: serene, content, and somehow pure and non-sexual. 'Your New Baby' used the same techniques of soft lighting, pastel shades and dreamy mother-figure on its cover. There was evidence that some primiparae were quite strongly influenced by this highly romanticised view of motherhood, as the next chapter will show.

For three quarters of the study women, the state of pregnancy bore little relation to the romantic images of the literature. It was noticeable that the majority of the women were startled by the question, "What do you like about being pregnant?". The instinctive reply was almost always "nothing", followed by a laugh which appeared to act as a device to check, contain, and half deny the admission that had slipped out. The ideology of motherhood says women are supposed to like being pregnant. Symptoms in pregnancy (e.g. nausea) have been viewed in the psychological literature as a rejection of femininity (Lennane & Lennane, 1973). Mothers in this study were not given an opportunity to offer a neutral answer and thus avoid this area of contradiction. What became clear was that whenever these sites of contradiction arose, as in this instance, women assumed that their ambivalent or negative feelings were not only inappropriate, but were unique to them as individuals. Bronwyn's answer is typical:-

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> **"I guess I must be different from other people. I didn't leap over the fence. I can't think of anything good about it....the end result is."**

A common attitude was that the 'baby at the end' compensated for the predominantly awful things you had to put up with during pregnancy. For example, pregnancy was primarily seen as a time of losses: loss of a job, loss of figure and sexual attractiveness, loss of ability to play sport, loss of mobility, loss of attractive clothes, loss of emotional equanimity. The culmination was loss of self-esteem. For many women, self-esteem depended on looking slim and attractive, being able to maintain efficiency and high standards in childcare and housework and often maintaining a part-time job as well. The most important loss appeared to be the loss of sexual attractiveness. Women used surprisingly harsh language to describe their own pregnant bodies. "Gross" was used more than once. "Repulsive" and "grotesque" were words also used by the women to describe themselves:-

> **Sally: "I don't enjoy it. I would rather not be pregnant. Getting gross is what I dislike most."**
>
> **Lisa: "It's a drag. The worst part is being huge. I don't like being large."**

Evidence in this study suggests that women internalise male attitudes towards their changed shape in pregnancy. When her partner approves of the woman's new shape, then so does she. Debbie is typical:-

> **"I suppose it depends on your state of mind. I don't mind getting fat. Even the awful clothes, they're so old fashioned. You kind of blossom when you are pregnant. My husband says I look good, so as long as he says so, I don't mind what I look like."**

Antenatal literature may reinforce the idea that the pregnant body is unattractive. For example, 'Your New Baby' said:-

> **'Every woman likes to look attractive. Don't let yourself go during pregnancy, when your morale can be strongly affected by your altered appearance. Fashion designers**

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> **have produced styles which expertly camouflage the altered physical shape and are functional, comfortable and attractive (....)with a little ingenuity and small outlay, no woman need feel embarrassed or look unattractive."** (emphasis added)
>
> (Your New Baby: pp23-24)

Giving up work affected over two thirds of the study women. The majority of primiparae were glad to give up work because their jobs were boring. Several, however, were having second thoughts now they had a five month old baby to look after:-

> **Wendy: "I hated work. When I was younger I thought it would be nice to have a baby and not work. Now it's different!"**

But for many women, giving up paid work meant giving up a source of stimulation or personal satisfaction:-

> **Linda: "I was sad about leaving work. I wouldn't like to go back now, but I sort of felt as if I was cutting myself off a bit."**

Some women spoke of losing their independence once more. This usually meant giving up a job but could also mean not being able to pursue leisure interests or voluntary activities. However, like the New Zealand women in Barrington & Gray's study, mothers in this study were never prepared to compromise their motherhood role, however satisfying they found activities and roles outside the family. Clare echoed the feelings of many multiparae:-

> **"The biggest change was the prospect of being tied down to the house more. The reins were back on again. This was one of those things. I wanted two children and this was part of the penalty you have to pay for having children."**

How long into their pregnancies women remained in paid or voluntary work is not known, but those in family businesses or working from home tended to work right up to the onset of labour. One woman even continued her paid job during the first stage of labour.

Nineteen per cent of women regretted having to give up a regular sport. Netball, running and swimming were most commonly mentioned. Most gave up between five and seven months. Many women, including those who did not swim regularly, would have welcomed the opportunity to do so. Few felt able to swim in public, however. The summer heat was a problem for almost all women. The base hospital physiotherapy pool was available to some of the women, but most did not use it because it was felt to be too hot.

Most women said they did not feel as well physically when pregnant as when non-pregnant. When the nausea subsides after the first three months, most women complained of increasing tiredness and irritability. Three women had paid help in the house. Most just coped on their own with or without support from partners. There was little evidence that partners took any significant burden of housework or childcare off the women in the study. Some mothers admitted that they were exhausted at the end of pregnancy. Virtually all women reported a much greater propensity to burst into tears or to snap at the children or partner; being on a 'short fuse' was a common expression. Being more sensitive to criticism was widely reported, as was the tendency to weep uncontrollably when death or maltreatment, especially that of infants, was depicted in the media or elsewhere. Young working class primiparae, particularly if they had unplanned pregnancies, were likely to feel lonely and depressed. One of the reasons seems to be that friends are often single and working and, therefore, not available during the day.

Women tended not to spend much time thinking about labour and birth until about two weeks before the due date. This was true for primiparous as well as multiparous women. A dominant concern, however, was the fear of producing an abnormal baby. Like emotional lability, women seem to accept this fear as part of being pregnant. Nor is this fear surprising when 'obstetric' antenatal care comprises of largely the detection of the abnormal in pregnancy. A new worry that became apparent amongst pregnant women was the fear of 'cot death'. Many mothers had had some personal contact with this through friends or relatives who had been affected. There did seem to

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be a tendency for doctors to offer reassurance when what was needed was factual information, but women often tended not to voice their worries, because they perceived the doctor as 'not having the time to waste' or 'having a surgery full of patients' as Lorraine said:-

> **"There is nowhere you can sit down and chat about these things."**

These findings suggest that pregnancy is a difficult time for most women. But it seems that the baby creates a 'halo' effect that gets women through those difficult times. Lorraine captures the general feeling of the study women:-

> **"I don't think there is anything I particularly like. It's like a chapter in a book. It has its exhilarating times and it has its hard times. It's a pleasurable think I think. But no woman likes changing shape particularly."**

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CHAPTER IV

LABOUR AND BIRTH

Going into hospital marked the next phase of the birth process for the study women. Much of the current debate on the management of childbirth centres on the place of birth (Coney, 1984; van Dongen, 1985). Consequently, the opinions and attitudes of the women in the study about the place of birth were of some importance. In particular, it was felt that women's feelings on this matter may indicate how they perceive birth and what factors constitute a quality service from the consumer perspective. The women were encouraged to discuss how they came to give birth at that particular hospital and then to describe a place of birth that would best suit their needs. The rest of the chapter examines women's actual experiences of the labour and birth process.

The responses of the study women, when asked about their choice of birth hospital, varied according to whether they belonged to the base hospital sample or the local hospital sample (see Table VIII). LHS women were much more likely to see their birth hospital as a positive choice. Over half (54%) said they liked the hospital because it was 'familiar', 'friendly', 'more personal', or 'super'. In contrast, BHS women were much more likely to cite negative reasons for giving birth at the base hospital. Thirty-seven per cent said they had 'no choice' and 25% said they went to the base hospital because their general practitioner 'only delivered there'. Four women only from the BHS (17%) gave reasons that referred to the qualities of the base hospital. All four felt that a specialist obstetric unit was 'safer'. One quarter of all women said they went to the hospital that was most convenient. These findings remained constant when the data was controlled for social class. However, social class did influence the reasons given for choice of a birth hospital (see Table IX). For example, working class women were more likely to give convenience as a reason for their choice than any other reason. Three quarters of all women giving

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this reason were working class. Conversely, no working class woman chose a hospital because of its qualities.

TABLE VIII

REASONS FOR CHOOSING BIRTH HOSPITAL, BY BASE HOSPITAL SAMPLE AND LOCAL HOSPITAL SAMPLE

(Percentage in brackets)

	BHS	LHS	TOTAL
Preferred Type of Hospital	4 (17)	13 (54)	17 (35)
No Choice	9 (37)	0 (0)	9 (19)
Convenience	5 (21)	7 (29)	12 (25)
Doctor Delivered There	6 (25)	1 (4)	7 (15)
Never Thought About It	0 (0)	3 (13)	3 (6)
TOTAL WOMEN	24 (100)	24 (100)	38 (100)

TABLE IX

REASONS FOR CHOOSING BIRTH HOSPITAL, BY SOCIAL CLASS

(Percentage in brackets)

	WORKING CLASS	MIDDLE CLASS	UPPER MIDDLE CLASS
Preferred Type of Hospital	0 (0)	13 (48)	4 (67)
No Choice	4 (27)	4 (15)	1 (16½)
Convenience	8 (53)	4 (15)	0 (0)
Doctor Delivered There	1 (7)	5 (18)	1 (16½)
Never Thought About It	2 (13)	1 (4)	0 (0)
TOTAL WOMEN	15 (100)	27 (100)	6 (100)

Forty-five women described what they felt were the best conditions in which to give birth. Ten women, all from the BHS, opted for specialist medical facilities, such as those provided by the base hospital obstetric unit. Five of this group didn't think they would change anything about the base hospital. The remaining five would prefer some modifications, such as single rooms (three women), a permanent staff autonomous of the general hospital (one woman), and one room for both labour and birth (one woman). Five of the 10 women, when talking subsequently about discharge from hospital, said they 'couldn't get home quick enough'. Three were women who said they wouldn't 'change anything'. This may reflect a reluctance to criticise existing services or it may indicate a low expectation that maternity services could, or should, meet their needs.

The remaining 35 women (78%) described a place of birth that had little in common with a specialist obstetric unit. Three women favoured home birth. The rest favoured characteristics of the birth environment that closely approximated the small, local, maternity hospital but which also might apply to a 'birth centre' (see Goodlin, 1980, for description of a birth centre). Table X indicates the degree of preference for each characteristic. Over two-thirds of the 35 women felt the place of birth should be small and separated, physically, from the general hospital. Over half felt that the unit should have its own autonomous staff. Nineteen women thought the surroundings should be 'homelike', and the same number (42%) felt the place of birth should be situated locally. The general desire for the place of birth to be autonomous of the general hospital reflects the women's common dislike of any association of birth with illness. Bronwyn's view was typical:-

> **"I still see it being attached to a hospital, but it should be a completely separate unit. If not, I think you get a lot of very regimented staff. It's quite different having a baby than being ill. Home birth has problems. You would need a lot of help and support. In this day, that might be hard to arrange. A separate place is more practical, as long as it is not run on hospital lines. They (staff) have to be flexible and understanding."**

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TABLE X

DESIRED CHARACTERISTICS OF BIRTH PLACE BY BASE HOSPITAL SAMPLE AND LOCAL HOSPITAL SAMPLE

(Percentage in brackets)

	BHS	LHS	TOTAL*
Small Unit	9 (43)	22 (92)	31 (69)
Separate Unit	9 (43)	18 (75)	27 (60)
Own Staff	8 (38)	15 (63)	23 (51)
Homelike	8 (38)	11 (46)	19 (42)
Local	3 (14)	16 (67)	19 (42)
Specialist Unit	10 (48)	0 (0)	10 (22)
Home Birth	2 (10)	1 (4)	3 (7)
NUMBER OF WOMEN	21	24	

*** Percentage sums to greater than 100 because women offered more than one characteristic**

The issue of separate staff deserves comment. The study women tended to associate student nurses, and sometimes even general trained obstetric nurses, with the general hospital. They often believed that these nurses adopted a more clinical approach, and were generally more interested in the pathological than the normal birth. Many women said the permanent staff were there because they 'loved babies' or because they 'loved their work'. In fact, it was particularly noticeable how often women used the word 'love' in describing approved attitudes of staff. Women who had experience of the specialist obstetric unit felt the needs of the normal mother and baby were often secondary. Donna's feelings were echoed by others:-

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"I wouldn't go to the base hospital if it was close. It's the structure of the place. I'd always wanted my babies in a small place. It (the local GPU) had a lovely feeling about it. It's like a big old home. It is geared to mothers and babies. It wasn't as if there were nurses there who might yesterday have been in the surgical unit or something."

The majority of women stressed the need for emergency medical equipment, but they wanted it 'out of sight' or 'in cupboards'. Other factors that reminded mothers that they were in hospital were also mentioned unfavourably: such things as long corridors, high beds, stainless steel, and lack of privacy.

The need for a local unit was not unnaturally of greater concern to rural women and those in small towns. The majority of women depended on partners to care for other children during the hospital stay. The thought of the possibility of having to be transferred to the base hospital was a common dread amongst LHS women, for it usually meant isolation from family and friends.

A strong opposition to homebirth as an alternative service emerged spontaneously from women's responses. Two reasons appeared to predominate. The first and most common was the belief that homebirth was unsafe. This belief was held by BHS and LHS women alike. Yet, the local GPU's held no more emergency facilities than those carried by domicillary midwives, except perhaps a transport incubator (personal communication). Mothers are not generally aware of this. It would appear that a hospital is safer because it is a hospital rather than because of any objective level of clinical facilities it might have. The second reason, almost as frequently mentioned as the safety factor, was the opposition to the idea that birth was a 'family affair'. While most mothers want their partner with them during labour and delivery, the idea that other members of the family, particularly children, might be present was generally repugnant to them. Diane is typical:-

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"I certainly wouldn't like to have him at home. The hospital is geared to having a baby, whereas the home is not. I don't think it's any place for the kids. They wouldn't want to be part of it."

Many women felt that with a home birth they would be worrying about their family's needs rather than their own. It would appear that many women's only knowledge, or experience, of home birth was based on a television programme about a rather public birth in an alternative community. The idea that home birth was synonomous with a public spectacle was quite common. But perhaps more importantly, women could not envisage their own homes providing the privacy they needed. As Jannine says:-

"It would be the last thing I wanted, having my family see me in pain."

Above all, women wanted privacy, calm and peaceful conditions in which to labour. A base hospital is less able to provide those conditions because it must cater for crisis and emergency. The local hospital is in a much better position to provide such conditions. Liz and Celia feel that these are the major advantages of the local GPU:-

Liz: **"I do like having a bit of peace and quiet. Going into hospital is the only time I'm on my own. It's lovely. I would never go on holiday without my kids."**

Celia: **"I like having that time away from home. I wouldn't have it at home for that reason. I enjoy that private space. I was thinking all the time I was pregnant, 'I will have a week all to myself'. It's the same reason I wouldn't have the kids in for the birth, I would be making emotional adjustments for them. But the closer they make it to the home situation the better. The less they make the medical considerations get in the way of the human considerations the better."**

The idea of 'a home away from home' was a constant theme, the phrase being repeated by numerous women. There are, however, exceptions.

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A few mothers felt that separation from toddlers was harmful. Such mothers were more likely to see merit in home birth, seeing worry sbout a fretting child as equally distracting. Maori women may also have a different perspective. The one Maori women in the study particularly appreciated having several members of her family with her in labour.

While it was expected that LHS women would endorse the conditions they experienced in the low technology GPU, what was unexpected were the numbers of BHS women who opted for similar conditions. Few, if any, had experience of a small maternity hospital. Working class women were just as likely as middle or upper middle class women to want a small, separate unit, a 'home away from home'.

Most mothers began labour spontaneously, apart from four women who were induced, and three women who were admitted following spontaneous rupture of membranes without contractions. The timing of admission to hospital once labour had started depended on the mother's confidence in assessing how far she had progressed. Multiparae, on average, stayed at home much longer than primiparae, frequently continuing with household routines or trying to sleep. Primiparae were much more likely to want emotional support at the onset of labour and tended to go to hospital very early in labour; for example, with a cervix dilatation of two centimetres. One source of anxiety and confusion that several women reported, was the labour pain associated with occipito posterior position of the baby in utero. With occipito posterior positions, labour pain is typically experienced as back pain. Labour is often longer and more painful. Adopting an 'all fours' or kneeling position in labour will usually be more comfortable (Kitzinger, 1972). The several women who experienced this type of labour, at least five of whom were primiparae, were unaware of the possibility of this type of labour or how to help relieve it. Some women were not told their baby was in this position until after it was born. The general opinion was 'if only I had known I could have coped'.

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The early admission of primiparae has implications for their subsequent labours, for admission to hospital tended to mean that women spent more time in bed with nothing to do but 'think about the pain'. It is generally accepted that remaining upright and mobile is more physiologically efficient in early labour.

For multiparae, the major concern relating to admission to hospital was childcare. The majority of women depended on partners for this. But partners are also expected to be the mother's support person during labour. The result was often complicated arrangements with friends or neighbours. Donna found this could be awkward at 3.00 a.m.:-

> **"That was the reason I stayed at home so long, because I knew I had to wake my neighbour."**

Multiparae, because of their previous experience of hospital, are better able to circumvent some of the less aceptable aspects of institutionalised care. For example, Barbara delayed going into hospital because she didn't want to be cared for in labour by two shifts of nurses:-

> **"It's horrible when you've got someone who takes care of you, then all of a sudden says 'well, I'm off duty now' and you think oh you have to start all afresh. So I waited until 7.00 a.m. then went in."**

Only one woman had no access to a car and had to ask a neighbour to drive her to the hospital.

All women said they were received cordially when they arrived at the hospital. Most women were given some form of surgical preparation (prep) as part of the admission procedure. The exceptions were two women whose labours were too far advanced and one woman who said 'preps' were not part of the hospital routine. This seems unlikely, however, as at the time all the hospitals in the Board's area were giving routine 'preps'. There was some evidence that individual midwives didn't always fully implement the routine of

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pubic shaving, enema/suppository and shower/bath. For example, while all 45 women were shaved, only 33 were given an enema or suppositories. Forty-six women were asked about their attitudes to these 'prep' procedures (see Table XI). All but two women were given a 'mini' shave, confined to the perineal area only. Two midwives, however, insisted on a complete pubic shave. Thirty-two women disliked or disapproved of shaving. Nevertheless, eight women said they would still have it because they believed it lowered the risk of infection to the baby, or was more 'hygienic'.

> **Sally: "I would have it if I had a choice. The safety of the baby is very important. I would go through anything to ensure that, but I don't like it. It's just an unpleasant thing you have and you accept it as such."**

Given the choice, the remaining 24 women (52%) would refuse being shaved. None, however, refused at the time. The reason appeared to be that pointed out by Danziger (1978): to avoid potential conflict with obstetrical caregivers. Trudy explains why she didn't refuse a shave:-

> **"You felt that by going along with it, they would be most happy. You seem to be gathering your energies together and you don't want to be bothered arguing."**

For one woman, the shave was the worst thing about the birth process:-

> **Maureen: "I dread having the shave. That's the worst thing to my mind."**

Seven women said they preferred to have the shave for hygienic or safety reasons. These women didn't appear to suffer any distress from the procedure. Another seven women also did not appear to be too concerned about the procedure. Yet when their individual circumstances were examined, shaving was acceptable only because some other procedure, usually the enema, was even more humilating or embarrassing:-

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Linda: "The enema is the worst. I think that was the worst bit of the whole pregnancy, that enema. That was the pits. The shaving didn't worry me much because it was only between my legs."

Barbara: "That was something they never told me about. That was the worst thing about having a baby, the enema. It was awful. The shave didn't worry me at all. It was small. The nurse explained it was to stop infection."

TABLE XI

WOMEN'S ATTITUDES TO THE 'PREP' PROCEDURES OF SHAVING AND ENEMAS

(Percentage in brackets)

	SHAVE	ENEMA
Approve of for Safety/Hygienic Reasons	7 (15)	14 (42.5)
Indifferent	7 (15)	0 (0)
Dislike, But Would Have For Safety/ Hygienic Reasons	8 (18)	4 (12)
Dislike, Wouldn't Have If a Choice	24 (52)	15 (45.5)
TOTAL WOMAN	46 (100)	33 (100)

There is no evidence that shaving has any effect on infection rates (Kantor et al, 1965). A current medical justification for the perineal shave is that it makes it easier for the doctor when performing an episiotomy (practicing midwife, personal communication). Such a justification for the procedure, however, might be less acceptable to mothers, for it does not carry the moral weight of the invocation 'for the sake of the baby' that the infection argument does.

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Thirty-three women were given enemas or suppositories, which suggests for some women there was an element of choice. Fifteen women found the enema unacceptable as Linda and Barbara have illustrated. A further four women intensely disliked the procedure, but given the choice, would have an enema because the humiliation of 'going on the table' was perceived as even worse.

> **Eve: "I hated that. That's horrible, but there again I guess it's necessary rather than going on the table. The enema is the worst."**

For the same reason (fear of defeacating during birth), 14 women found the procedure acceptable.

The overall effect of these two procedures performed on admission to hospital was to strip women of their dignity:-

> **Liz: "I tell you, your dignity is left at the door when you go into hospital."**
>
> **Eve: "When you walk in you leave your pride at the door and you pick it up when you go out."**

Most multiparae expect this but it was a shock to primiparae, many of whom had not anticipated such procedures. Liz also points out the apparent illogicality of these procedures:-

> **"Shaving. I reckon that's stupid, ridiculous. It's pretty humiliating. You shouldn't have that. They 'prep' you, there is disinfectant everywhere. You are showered and shaved. But you can be in labour 12 HOURS! you have gone to the toilet umpteen dozen times and then you have your baby. So how ridiculous can you get?"**

Initially, when asked for their attitudes about such procedures, over a third of the women in this study did give neutral answers, similar to women in the Dunedin Study (Hood et al, 1978), such as 'I didn't mind', 'it didn't worry me'. However, with probing, it became clear that 13 of the 17 women giving neutral answers

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were quite disturbed by these procedures, but were not prepared to put their own feelings before what they felt was the safety of the baby.

Showering and bathing was generally welcomed if the labour was not too advanced. A few mothers said they found sitting in the bath for a long period helpful. This was only possible in the local hospitals.

A vaginal examination, to assess the progress of labour, was also a routine admission procedure. All the 31 women who commented on this procedure, disliked it. Some said such examinations were humiliating:-

Bronwyn: **"I didn't think much of them. They hurt your pride more than anything."**

Barbara: **"Pretty foul. I think when you get to hospital you leave your modesty at the door."**

The majority found the procedure uncomfortable, often painful:-

Sally: **"I don't like them at all. They hurt when done in labour."**

Wendy: **"Oh that hurt. She said 'you've only just started' as if I shouldn't have said 'ow'."**

All women, no matter how much they disliked them, believed they were a necessary part of being in labour:-

Diane: **"I hate them, but they have to be done."**

A few women said they liked to know how dilated the cervix was, so found them useful:-

Alison: **"I hate them, because they are so uncomfortable. Then again, they want to know what stage you are at and you do too."**

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For some, knowledge of progress was a pleasant surprise:-

> Donna: **"I don't like them but I was more than happy for her to do it because then I knew at what stage I was. It was blissful to know I was almost there."**

But for primiparae, such knowledge can be, if given without a supportive explanation, a severe blow to the mother's confidence:-

> Lisa: **"The nurse came in and did a PV (vaginal examination). She said I had hardly dilated at all. 'Oh', I thought, 'what's ahead of me?' That was the worst moment of my life."**

> Yvonne: **"They didn't worry me at all. It was uncomfortable. She said, 'You could be there for hours'. That frightened me. I thought 'oh dear'."**

Several women did not like being touched when in labour. Vaginal examinations were another distraction and disturbance:-

> Liz: **"It doesn't worry me. I don't like them as labour gets on. I don't like being rolled on my back. I didn't want to be touched but they made me push over. They have got a job to do and are not worried about you being uncomfortable. I just like to be left alone to get on with it."**

It was during the admission procedure that many women experienced their first medical intervention, e.g. artificial rupture of the membranes (ARM). All but three women remembered when their membranes ruptured. Just under a quarter (24.5%) experienced spontaneous rupture of the membranes at home, leaving just over three quarters of the study women who were admitted to hospital with intact membranes (See Table XII). In 10 (29%) of this group of 34 women, the membranes were left to rupture spontaneously. The remaining 24 (71%) had their membranes artificially ruptured. For 15%, ARM was part of an induction procedure. For another 23%, ARM was part of the admission procedure. ARM was performed during the first stage of labour in another 18% and during the second stage in 15% Although there

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appeared to be little difference on the overall rate of ARM between women in the BHS and LHS, base hospital staff were much more likely to perform ARM on admission or during the first stage of labour; 32% compared with 5% in the latter. Base hospital doctors and midwives performed ARM during the first stage of labour. In local hospitals, midwives did not elect to rupture membranes during the first stage. Any ARM carried out during the first stage of labour on LHS women was done by doctors. There was some evidence that ARM on admission was offered to mothers as a procedure to shorten labour, and in a way that it would seem foolish to refuse:-

Karen: **"She asked me if I wanted to persevere normally or she could break my waters and I could have it within a couple of hours."**

Janine: **"She said, 'do you want to have your baby quick or slow?'. I said, 'quick please', so she broke my waters."**

TABLE XII

SPONTANEOUS AND ARTIFICIAL RUPTURE OF MEMBRANES, POST ADMISSION, BY BASE HOSPITAL SAMPLE AND LOCAL HOSPITAL SAMPLE

(Percentage in brackets)

	BHS	LHS	TOTAL
ARM on Admission	7	1	8 (23)
ARM During First Stage	2	4*	6 (18)
ARM During Second Stage	0	5	5 (15)
ARM as Part of Induction	4	1	5 (15)
Spontaneous Rupture	7	3	10 (29)
TOTAL WOMEN	20	14	34 (100)

*** Includes three women who were transferred to the base hospital during the first stage of labour with intact membranes. Two had ARM to enable a fetal monitor to be attached to the baby's scalp.**

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In this study, those who had ARM experienced slightly longer labours than those whose membranes were left to rupture spontaneously; 6 hours and 5.6 hours respectively. What mothers were not told was that ARM usually results in a sudden increase in the intensity and frequency of contractions, making it more difficult for the mother to suddenly adjust to the increased level of pain (J. & P. Johnson, 1980). In only two non-induced women experiencing ARM was this procedure associated with fetal monitoring via a scalp electrode.

In order to assess whether the level of medical intervention influenced women's experience, as has been suggested by Oakley (1980), medical intervention (including narcotic drugs and anaesthetics) was classified into four categories:-

NIL	**No medical intervention**
MINIMAL	**Not more than two interventions**
MODERATE	**Three interventions**
HIGH	**Four or more interventions**

(See Appendix IV for medical procedures classified as 'interventions' and overall rates reported).

Narcotic drugs and anaesthetics were classified in the following way:-

ONE INTERVENTION:	**One injection of pethidine or 'gas and air' (Entonox) via mask**
TWO INTERVENTIONS:	**Two injections, or one injection plus 'gas and air'**
THREE INTERVENTIONS:	**Three or more injections, or two injections plus 'gas and air', or an epidural anaesthetic**

Women who were transferred from the local hospitals to the base hospital during labour were included in the local hospital sample to avoid transfer bias (see Klein et al, 1983: p118).

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TABLE XIII

LEVEL OF MEDICAL INTERVENTION BY BASE HOSPITAL SAMPLE AND LOCAL HOSPITAL SAMPLE

(Percentage in brackets)

	BHS	LHS	TOTAL
Nil	2 (9)	5 (22)	7 (15)
Minimal	9 (39)	12 (52)	21 (46)
Moderate	5 (22)	2 (9)	7 (15)
High	7 (30)	4 (17)	11 (24)
TOTAL WOMEN	23 (100)	23 (100)	46 (100)

Table XIII shows that women in the LHS experienced considerably less intervention than women in the BHS. Almost three quarters received little or no medical intervention, compared with less than half of BHS women. The use of drugs and anaesthetics was also examined separately to indicate the extent to which their use influenced the pattern of intervention. Table XIV shows that the level of drugs and anaesthetics administered was similar in both types of hospital.

When intervention was examined in relation to parity, it was evident that first births accounted for 61.5% of all moderate to high intervention. However, parity does not alter the difference found in levels of intervention between the two types of hospitals. Table XV shows that 82% of LHS multiparae received minimal or no intervention, whereas the corresponding figure for BHS multiparae was 56%. These differences in medical intervention between high and low technology hospitals were also found by Klein et al (1983), who showed that morbidity in the baby was associated with greater medical intervention. This may suggest why Rosenblatt (1985) found lower morbidity in

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in babies in New Zealand's low technology hospitals. It was not possible to measure neonatal outcomes in this study, for the focus of this study was on maternal morbidity.

TABLE XIV

LEVEL OF DRUGS ADMINISTERED BY BASE HOSPITAL SAMPLE AND LOCAL HOSPITAL SAMPLE

(Percentage in brackets)

	BHS	LHS	TOTAL
Nil	8 (35)	10 (42)	18 (38)
1 Intervention	11 (48)	9 (37.5)	20 (43)
2 Interventions	1 (4)	2 (8)	3 (6)
3 or more Interventions	3 (13)	3 (12.5)	6 (13)
TOTAL WOMEN	23 (100)	24 (100)	47 (100)

TABLE XV

LEVEL OF MEDICAL INTERVENTION BY PARITY (46 WOMEN)

(Percentage in brackets)

LEVEL OF INTERVENTION	PRIMIPARAE	MULTIPARAE
Nil	1 (7.5)	6 (18)
Minimal	4 (31)	17 (52)
Moderate	1 (7.5)	6 (18)
High	7 (54)	4 (12)
TOTAL WOMEN	13 (100)	33 (100)

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To examine the level of satisfaction mothers felt with their labour and birth, women were grouped into four categories:-

VERY SATISFIED: Such women used expressions like 'enjoyed', 'pleased with myself', 'a breeze':-

Jane: "I enjoyed it right from the start."

Debbie: "I liked it because I was in control."

Brenda: "I was chuffed."

FAIRLY SATISFIED: Women in this category said 'better than the last', 'pleased', 'more aware', 'coped well':-

Joanne: "Quite pleased, I thought I coped well. I felt good about it, except for the episiotomy."

Donna: "Better because of no drugs, although more intense pain."

Diane: "Not as bad as the first two because I was prepared for the worst. I felt very much on top of it."

FAIRLY DISSATISFIED: These who were 'fairly dissatisfied', felt 'disappointed', or it was 'not so good', or it was 'spoilt':-

Sally: "I was disappointed. I didn't do it on my own."

Lorraine: "It wasn't a very good labour due to the indifference of the doctor."

Katrina: "It was more painful because it was posterior."

VERY DISSATISFIED: 'Very dissatisfied' mothers spoke of the experience as 'a nightmare', 'far worse than expected', 'nothing good about it':-

Janice: "It was a bad experience, far worse than expected. The best thing was that it was all over."

Wendy: **"Never again. I shall never forget it."**

TABLE XVI

SATISFACTION WITH LABOUR AND DELIVERY
BY LEVEL OF MEDICAL INTERVENTION
(46 WOMEN)

LEVEL OF INTERVENTION	NIL	MINIMAL	MODERATE	HIGH
Very Satisfied	2	8	2	2
Fairly Satisfied	3	8	3	5
Fairly Dissatisfied	2	3	2	0
Very Dissatisfied	0	2	0	4
TOTAL WOMEN	7	21	7	11

Table XVI suggests that there is little relationship between satisfaction with labour and birth and the level of medical intervention. This finding was rather surprising in view of the concern expressed over the increasing use of obstetric technology (Coney, 1979; Swain, 1981). This posed the question 'what were the variables associated with satisfaction or dissatisfaction with the birth process?'. Obstetricians have, at times, suggested that the degree of physical difficulty of labour and birth will best predict how a woman will feel about the process (Riley, 1977). Women's experiences of pain and length of labour were examined in this study. Pain was categorised using four headings:-

NIL OR MINIMAL: **Women in this category said they had no pain or almost no pain:-**

Raewyn: **"I had one painful contraction."**

Michelle: **"I was only having 10 second contractions."**

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MILD: In this category women said the pain was 'mild', 'bearable', 'bad for only a short period', 'not as bad as expected':-

Karen: "I was bad only in the last half hour. In fact, I was walking around laughing and joking until they brought me into theatre."

Diane: "I didn't feel there was nearly so much pain as there was with the others, probably because I was better prepared. I felt very much on top of it."

FAIRLY BAD: Women in this category described their pain as 'very bad' but they generally felt in control"-

Katrina: "I wouldn't like to go through that again. It was quick but a posterior birth is more painful. I was in control most of the time. Sometimes you want to scream, but I didn't."

Barbara: "I think it was worse than expected, the pain. I don't think you can ever describe labour pain. It was a straight-forward labour and there were no complications, but it was by no means a breeze."

VERY BAD: Women with very bad pain felt out of control, describing their pain as 'unbearable' or 'terrifying', and were clearly very frightened and distressed:-

Lorraine: "The pain was so bad I just lost control and cried and screamed."

Paula: "I was in agony. I was surprised I could stand so much pain. I thought it was the end for me, it was that bad. I thought, 'I'll be surprised if I see the morning'."

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TABLE XVII

SATISFACTION WITH LABOUR AND BIRTH BY DEGREE OF LABOUR PAIN (48 WOMEN)

PAIN	NIL/ MINIMAL	MILD	FAIRLY BAD	VERY BAD
Very Satisfied	3	8	3	0
Fairly Satisfied	1	12	5	2
Fairly Dissatisfied	1	3	3	1
Very Dissatisfied	0	0	2	4
TOTAL WOMEN	5	23	13	7

Table XVII shows that while only four out of 28 women with minimal or mild pain were dissatisfied, women with fairly bad pain were also more likely to be satisfied than dissatisfied. This situation was reversed for women experiencing very bad pain, with five out of seven women being dissatisfied with labour and birth. When length of labour was examined (Table XVIII) no association was found between an unhappy birth experience and the length of labour, with six out of 11 women with labours lasting more than 9 hours feeling satisfied. There would appear to be a slightly stronger association of dissatisfaction with the use of drugs and anaesthetics than with the level of pain experienced (Table XIX). Interpretation of this finding should be cautious, however, as the numbers were small. What can be fairly confidently suggested is that the use of drugs and anaesthetics does not appear to improve the outcome for mothers in terms of their satisfaction with the birth experience.

No association was found between dissatisfaction with labour and birth and the type of hospital. Nor did social class apparently play any role in how mothers felt (Tables XX and XXI).

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TABLE XVIII

SATISFACTION WITH LABOUR AND BIRTH
BY LENGTH OF LABOUR
(47 WOMEN)

HOURS OF LABOUR	<5	5-8	9-15	>15
Very Satisfied	8	3	0	3
Fairly Satisfied	8	9	1	2
Fairly Dissatisfied	3	3	1	0
Very Dissatisfied	0	2	1	3
TOTAL WOMEN	19	17	3	8

TABLE XIX

SATISFACTION WITH LABOUR AND BIRTH
BY LEVEL OF DRUGS AND ANAESTHETICS
(47 WOMEN)

NUMBER OF DRUG AND ANAESTHETIC INTERVENTIONS	NIL	1	2	3+
Very Satisfied	6	8	0	0
Fairly Satisfied	8	9	1	2
Fairly Dissatisfied	5	2	0	0
Very Dissatisfied	0	1	1	4
TOTAL WOMEN	19	20	2	6

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TABLE XX

SATISFACTION WITH LABOUR AND BIRTH
BY BASE HOSPITAL SAMPLE AND LOCAL HOSPITAL SAMPLE
(48 WOMEN)

	BHS	LHS
Very Satisfied	9	5
Fairly Satisfied	8	12
Fairly Dissatisfied	5	3
Very Dissatisfied	2	4
TOTAL WOMEN	24	24

TABLE XXI

SATISFACTION WITH LABOUR AND BIRTH
BY SOCIAL CLASS
(48 WOMEN)

	WORKING CLASS	MIDDLE CLASS	UPPER MIDDLE CLASS
Very Satisfied	6	6	2
Fairly Satisfied	4	13	3
Fairly Dissatisfied	1	6	1
Very Dissatisfied	4	2	0
TOTAL WOMEN	15	27	6

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TABLE XXII

LEVEL OF SATISFACTION WITH LABOUR AND BIRTH BY PARITY (48 WOMEN)

	0	1	2	3+
Very Satisfied	3	7	3	1
Fairly Satisfied	4	8	7	1
Fairly Dissatisfied	0	2	2	4
Very Dissatisfied	6	0	0	0
TOTAL WOMEN	13	17	12	6

The strongest association with dissatisfaction was found to be with the factor of parity. Table XXII suggests that primiparae are most likely to be very dissatisfied with their birth experience. Mothers having a fourth or fifth baby are most likely to be fairly dissatisfied, and mothers having a second baby were likely to be satisfied with the experience. This disturbing finding, that nearly half of all primiparae (46%) were very unhappy about their labour and birth experience, compared with 14% of women having a second or third baby, merits closer examination.

When primiparae were divided into satisfied and unsatisfied groups, the only major differences in experience between the two was that the dissatisfied group complained of more pain and were given more drugs and anaesthetics. The difference in the amounts of drugs and anaesthetics used by the two groups was a consequence of the dissatisfied group receiving three times as many epidural anaethetics as the satisfied group. There was no difference in difficult fetal presentations between the two groups.

There was, however, a marked difference in the two groups' psycho-social responses to labour and birth. Those who were satisfied

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with the experience almost always said their experience was as, or better than, expected. This included three women who found the pain worse than expected, but at the same time found there were unexpected compensations; for example, the sheer intensity of the experience. Trudy and Barbara were typical:-

> **Trudy:** **"I didn't think it would be such a total experience emotionally and physically. To learn about yourself and what you can endure. It was very nice."**
>
> **Barbara:** **"Everything happened as I expected but the real feeling of joy when your baby is born took me by surprise."**

Taking an active part in labour seemed to be an important factor:-

> **Brenda:** **"I could feel it was getting better, getting lower, as I was walking around."**

Trudy and Barbara also pointed out the importance of emotional support:-

> **Trudy:** **"I think I was lucky with the people around me; my doctor, the reassuring presence of my husband, and the midwife always praising you and creating a positive atmosphere. I was aware they could make or break the situation."**
>
> **Barbara:** **"Nobody had that businesslike 'nursey' effect, especially the one (midwife) I knew. She was terrific. Beforehand I dreaded having her there, but I found at the time it was marvellous. Just a familiar face."**

The dissatisfied group were much more likely to have been passive participants in the process. Things were done to them. Unlike the satisfied group, they generally had very unrealistic expectations or had not thought much about it:-

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Carolyn: **"I remember being so dreamy. That was my one big regret. I was so sleepy. I couldn't remember what things looked like, how I'd got there. Everything was just so vague. I felt like I was having a major operation. I always imagined that after I'd had her I would end up crying and thinking 'oh it was lovely' and looking up at my husband and smiling. I had a real fairytale idea, because it was so different."**

Tracey: **"I was just doing what they said. When they said 'push' I pushed."**

Lack of emotional preparation for the realities of the birth process left such women shocked and without coping mechanisms to deal with the pain. Consequently they felt out of control and alienated from the experience. Such women were no less likely to have support from partners or family than the satisfied group, but they appeared in the main not to have either the emotional support from, or any rapport with, skilled midwives that the satisfied group experienced:-

Tracey: **"When you go into hospital it all comes as a big shock. You have all these nurses around but you don't sort of know any. I didn't even know who was going to deliver my baby until he came into the labour room."**

Women having a second or subsequent baby can compare births and are thus better able to isolate variables that contribute towards a satisfactory experience. The 27 multiparae who were happy with this birth experience mentioned two factors more consistently than any others. Eleven women (41%) mentioned factors that indicated the mother's active participation in the birth process. For example, they used expressions such as 'did it on my own', 'being on top of it', 'playing an active part', 'not being drugged', 'being more assertive'. Six of the 11 women used the words 'being in control'. Clare and Debbie were typical:-

Clare: **"This time the labour was much better because I was prepared to be more assertive. I was asking questions and getting the answers I wanted. I asked all the way through so I knew exactly where I was. I didn't have a change of staff. I was more effective because I was**

Debbie: "I liked it. I was in control. They let me do everything I wanted, not like last time. The staff were more relaxed."

This change in interrelationships between staff and patients mentioned by Debbie, and the generally more flexible attitudes and routines of maternity care, was perceived by 10 women (37%) as a key variable in a satisfactory experience. 'More relaxed' was the most common expression used. Seven of the 10 women in this group were from the LHS. Other factors contributing to a happy birth experience were: 'being more experienced', mentioned by four women (15%). Alison was typical of some of the more unassertive mothers who gain confidence from their own experience when supported by familiar surroundings:-

"I had an easy time. I felt on top. The pain was the same as last time (but) this time I knew more about what to expect. I was possibly more relaxed. I knew the staff already."

Having an earier, shorter labour was mentioned by a further four women as a contributing factor, but this was always mentioned in conjunction with other factors, such as a relaxed atmosphere, never as the sole contributing factor. Three women said their labours were actually longer than previous labours but were better this time because of the relaxed atmosphere of the hospital. Two women said their labours were better this time because they were not induced.

The finding that physical factors were much less important than psycho-social factors in a happy birth experience, supports the claims of advocates of the 'midwifery model's' more holistic approach. The importance of active participation in the birth process by the mother contradicts the 'medical model's' requirement for passivity in patients. These contradictory needs of the mother and doctor are highlighted by the issue of the administration of drugs in labour.

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In this study, pethidine, a narcotic drug, was disliked by most women because it produced drowsyness and disorientation. These effects interfere with the woman's ability to stay in control of the labour process. Three quarters of the multiparae managed without pethidine during this labour and perceived this as a satisfying accomplishment, sometimes even when the pain was worse than last time (see Donna, page 92). Two thirds of the primiparae were given pethidine. Three volunteered that they would not have it again because it restricted their participation in labour. Women also found the amnesia-producing effect of pethidine disturbing. For Carolyn, a first-time mother, this was the major factor in her disappointing birth experience (see page 100). Susan's comment suggests that it is important for women to stay in touch with the birth process, rather than have gaps in their experience:-

> **"The first time I was drugged and you don't get any pain. Although (this time) it was worse pain you know what it's like. You know what it's like. I don't think I would have drugs again."** (Emphasis added)

Of the eight multiparae who were not so happy, all felt a past birth had been better. Two had posterior births with longer and more painful labours than with previous anterior babies. Two women had labours that were too rapid, leaving them in a state of shock:-

> **Liz: "It was more trying than the others because it was quicker. I was shocked. It took me days to talk about it."**

Mothers appear to feel dazed if they are cheated of the gradual progress of labour to the climax of birth in which they are able to accommodate and adjust to the increasing tension and excitement. Six of the 10 women who had labours of under three hours, felt they were too quick.

Not having one's own doctor for delivery was a source of distress for a few mothers. This applied only to doctors who were on holiday rather than those arriving too late for delivery. The latter didn't

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usually disturb mothers. Maureen had considerable rapport with her own doctor, who allowed women to participate in delivery:-

> **"It was not as good as the last....(then) the staff shared in our experience and could see my joy at having the baby the way I did. This time it was just another delivery."**

A major theme of women's comments about relationships with staff during labour centres around the need for a calm, supportive environment. Joanne, talking about her own experience, gives a good summary of the comments of other women:-

> **"The nurse-aid was particularly helpful, probably because I know her and she has an enthusiastic, outgoing personality. The midwife was so calm and gave an aura of being very competent. I had all the trust in the world in her. One of the best aspects of the birth was the supportive care I received. Nobody can do anything really; it's just a matter of helping you go with it. It's the calm, caring, positive attitude that the staff have that helps you."**

There was one particular time during labour when mothers' need for calm and non-distracting surroundings appeared to be paramount. This is the period sometimes known as 'transition'. It marks the end of the first stage and the beginning of the very active second stage when pushing begins. It is at this stage, according to the Parents Centre medical adviser, that mothers tend to loose confidence and become, for a short period, frustrated and apprehensive. This is the time when the mother needs support, encouragement and praise (Henderson, 1981). In this study, it was usually at this stage that mothers were moved from the labour room to the delivery theatre. Mothers said this upheaval was disturbing and distracting, an added burden just when it was not needed. The practice was condemned by many mothers, who would have preferred to remain in the same room for labour and birth.

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Maureen: **"The thing they do, when you say you are going to push, they get into a panic that gets you all uptight. It was really hard to relax knowing I had to go to theatre so I stopped pushing. I always hate going from the labour room to the theatre. I would have been calm if I could have stayed in one place."**

Once in the theatre, women are then expected to climb on to the higher, narrower delivery table. All but a few women commented critically on this practice. The general feeling was that it was not unreasonable to expect that at the very least one of the beds should have adjustable heights:-

Liz: **"They don't move you until you are bearing down, which is terrible - having to move you at that moment. I would rather be on the bed and left there. You have to move from one bed to another, which is a different height, while you are pushing down. It's really terrible. Honestly, in this day and age it appalls me to think what a woman in labour has to go through. You are in enough pain as it is. That's what ruins my back. I often wonder if I would have been better off squatting."**

Liz was one of two women who felt the delivery table was responsible for physical injuries sustained during labour. Some women were even frightened that the baby would be injured during the transfer. The Dunedin maternity study reported, as long ago as 1978, that moving from the labour bed to the delivery table was a source of dissatisfaction to women (Hood et al, 1978: p2). In this study, Lorna suggests that dissatisfaction was not just restricted to the women interviewed:-

"This is something everyone comments about. Why the heck don't they have beds in the labour room that are the same height as the theatre bed? One of the most crazy things they say is 'get on the delivery bed' when you are in a contraction. I look at the delivery bed and think 'how am I ever going to get on that?'."

Base hospital multiparae were delighted with what the majority felt were vastly improved mother/nursing staff interactions.

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LHS women were unlikely to make this historical comparison, suggesting that staff/patient relationships have traditionally been more relaxed in smaller hospitals (see also page 101). Only one professional group, the 'duty' specialists, were the subject of almost universal criticism for their insensitive manner towards mothers. More often this would be a specialist gynaecologist, but women also complained that paediatric and orthopaedic specialists could also demonstrate disregard for mothers' feelings:-

> **Julie:** **"The specialist was abrupt and rude. He made all the patients feel upset."**
>
> **Debbie:** **"The bigger doctors get you all worried and upset and then walk off."**

Caution is necessary in interpreting this finding, however, for the women experiencing specialist attention comprised approximately 10% of the total sample. Debbie phoned her own doctor, who was able to calm her near-hysterical state. Several women bypassed base hospital staff to phone their own doctors if they were worried, suggesting the high value mothers place on professionals who are known and trusted.

The presence of a support person of the mother's choice during labour and birth was generally appreciated. The experienced father, who had been involved in antenatal preparations for birth, was a source of practical support to his partner. But most women said partners were useful only for 'moral support'. A few felt that it was important that partners should understand the birth experience firsthand:-

> **Diane:** **"I could never have explained to him what I felt about it, what it was like, if he hadn't been there."**

The first-time father and the 'less involved' father were not substitutes for skilled and experienced professional attendants. Such men appeared to need a good deal of support and reassurance themselves,

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a need that was generally overlooked by maternity staff. Ten per cent of the study women said their partner did not cope well with the experience. Twenty per cent of partners refused or were ambivalent about being present during labour and/or birth. There was some evidence that some of these men were pressured by staff to be present. Driscoll, in her 1982 study of Waikato women, found that 10% of fathers gave neutral or negative responses when asked if they were happy about being present at birth. These findings cast doubt on the assumption that the father/partner is automatically the best support person. A minority of women would have benefitted from the presence of a female relative or friend. The assumption that the support person will actually give the necessary support for a labouring woman is also doubtful. While no woman was ever left alone in labour, there was a tendency, particularly in the base hospital, where one midwife was responsible for several labouring women, to leave much of the emotional support to the partner or a student nurse. Neither, because of their lack of experience and knowledge, were particularly useful, except as companions, many mothers felt.

The physical environment of labour was of less importance to mothers than the quality of the interrelationships of mother and her attendants:-

> **Donna:** **"It was quite sparse. You don't expect music and candles. You don't give a hoot. All you want to do is get on with it. I really don't think curtains and carpets would make any difference."**

When pressed women said lack of space and boredom were the main problems, at least in the base hospital. Trying to keep mobile and active is almost impossible in a room that barely accommodates a bed and a chair:-

> **Barbara:** **"The room was pretty clinical. You get sick of looking at the same walls. There was only one chair, which was inconvenient. No magazines. Pretty boring. We were pacing the floor. I remember when I was up there wishing I was home. I could have done something, baked a cake or vacuumed, just to keep busy. You had nothing to do but think about the pain."**

Very few women were visited by their doctors during labour unless there was some medical concern. Mothers didn't seem to expect it, seeing labour supervision as more the concern of the nursing staff. The majority of women saw the doctor for the first time in labour when they were on the delivery table.

Once women were in the delivery theatre their scope for active participation in the birth process became even more curtailed. For example, not only was the delivery table high and narrow, offering little scope for acquiring comfortable positions, but only a minority of women were permitted a position of their own choice in which to give birth. Of the 33 women who discussed their delivery position, 12 were permitted to choose their own position. Of the remaining 21 women (64%), seven were delivered by forceps and one had an internal fetal monitor insitu. The remaining 13 women had no apparent medical indication for what are now considered physiologically inefficient positions, the semi-recumbant and lateral positions (Moore, 1977). Seven of the 13 women felt they would have been more comfortable upright or in a squatting position:-

Lynn: **"I was on my back. I'd rather be squatting. K had to hold pillows behind me. Next time I want to be pushed up higher."**

Clare: **"The whole experience of having a baby seems to preclude you being in a comfortable position. I definitely feel you would be better off in a crouched position. It's easier on your back when you pull in your legs. On your side is ridiculous."**

Mothers with posterior babies were unaware of the more comfortable 'all fours' or kneeling position (see page 81). LHS women were more likely to have been able to adopt a birth position of their choice than BHS women. Most of this difference may be accounted for by BHS women who had specialist doctors. Such women were not permitted to choose their birth position. Middle class and upper middle class women were most likely to complain about the birth position.

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A mirror to enable the mother to watch the progress of the baby's head emerging was available to BHS mothers. Women who were delivered on their back or side found this useful:-

> **Eve: "I would recommend it. At first I thought 'oh how ghastly and revolting'. I didn't really want to watch. But I turned my head and I could see and it was the most fantastic feeling. It takes your mind off the pain and you can relate it to how much you push."**

The absence of the mirror in the GPU's did not appear to be regretted. The probable explanation for this was that such mothers were likely to choose their birth position, inevitably choosing a more upright position where they could see what was happening anyway.

Seven women (15%) had forceps assisted births; five were BHS women. Information on episiotomy was available on 40 women who had unassisted deliveries. The episiotomy rate was 38% (15 women). The BHS rate was 44% and the LHS rate was 32%. Both these rates were considerably below the 60% rate for unassisted deliveries reported for some Wellington hospitals (SROW, 1985). Thirteen women, a third of all women who had unassisted deliveries, had intact perineums. Nine women who had had previous episiotomies, did not have an episiotomy with this baby. Six of the nine women had intact perineums. Twelve women (30%) had perineal tears ranging from slight nicks to second degree tears. Eleven of these 12 women had their tears sutured. An unexpected finding was that those who had episiotomy repairs were five times more likely to complain of painful stitches as those who had tear repairs. Mothers who had perineal tears this time, but had had episiotomies with an earlier baby, said they felt more comfortable and healed better this time. This finding was consistent even for second degree tears and when episiotomies for forceps deliveries were excluded:-

> **Alison: "My stitches gave me no trouble at all, not like last time (episiotomy). I was expecting all that discomfort and it never happened."**

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Phillipa: **"It was quite a long tear to the anus. It healed much better than my previous episiotomy. It made a worse scar at the time, but that's gone now. It healed much quicker with much less pain. I didn't want an episiotomy. You still go over it months afterwards. This time I was pushing too hard because they were telling me to. If I hadn't, maybe I wouldn't have torn and also if I hadn't had my waters ruptured it would have been slower and perhaps better."**

In New Zealand the major medical rationale for elective episiotomy is that it heals better, protects the mother from future prolapse of the pelvic organs and prevents diminution of sexual satisfaction (Wilson, 1975; Bonham, 1980). There is, however, no published evidence to support these claims (Arms, 1977, Kitzinger, 1984). Kitzinger, in her study of UK women, suggests that, not only does research show no advantages from episiotomy for either the mother or the baby, but episiotomy pain is likely to be much greater than laceration pain. Her finding is supported by this study of NZ women. Women in this study found episiotomy physically traumatising, e.g.:-

Yvonne: **"They killed me for about two weeks, especially when I went to the toilet. It used to take me an hour to walk along the corridor to the other end."**

Paula: **"He did the episiotomy. I think I could have well done without it. It still bothers me."**

as well as the source of psychological trauma, as Phillipa (above) has indicated. For one mother it was her greatest disappointment (see Joanne, page 92). Many multiparae said they didn't want an episiotomy but felt they couldn't insist:-

Katrina: **"I didn't want it. He said the other doctor had done it and he had to do the same. Once it was done it always had to be done."**

Lynn: **"I didn't want it but it had been done before, so she said I needed it because of that. It's a shame."**

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Trudy: **"He said it would take another hour if he didn't do it."**

Lisa: **"He said, 'I will give you a little cut' because I was going to tear."**

Allowing the perineum to stretch slowly may take longer. However, it is not consistent with the medical model for doctors to sit waiting and 'watching a hole'. For in medicine, even action with very little chance of success is preferable to no action at all on the assumption that doing something is better than doing nothing (Friedson, 1970: p168; Bates, 1979). There are also constraints on the doctor's professional time. Medicine, in addition, imposes time limits on the obstetrically normal labour. For example, second stage labour becomes pathological when it exceeds one hour (Rothman, 1982).

The surgical repair of the episiotomy appeared also to be associated with greater discomfort to mothers than did the repair of tears. Six of those who had episiotomies complained that suturing was painful, compared with one mother from the tear group:-

Linda: **"I remember when he was sewing me up, I could feel every prick. I was too busy thinking of these stitches to think of the baby."**

Sally: **"The suturing was done without local (anaesthesia). I remember feeling 'golly, that hurt a lot'."**

Joanne: **"I wondered why an episiotomy hurt so much. It was because there was no anaesthesia. I felt them going in."**

Kirsty: **"I felt him stitch me up. He nicked me. I felt that. He said 'you didn't feel that'."**

For a few women, the act of pushing the baby out was a source of pleasure:-

Lorna: **"That's the incredible part. That's why you go back two, three and four times. That's the best part. It's worth all the pain, which you don't forget. Just to feel the baby coming out. That's worth every minute. I wouldn't have an epidural."**

Liz: **"I like the feeling of relief, just feeling it come away."**

Jenny: **"The greatest feeling was the squelsh."**

For the three women who were permitted to take an active role at the moment of birth, it was a rewarding experience:-

Eve: **"Then when the shoulders were born I put out my arms and pulled him up and laid him on me with the cord intact. I was so wrapped up in the baby and the fact that he was a boy, I don't remember the placenta coming out."**

Clare: **"As soon as the head came through and there was one arm he got me to hold on and then when the second arm came out he actually got me to deliver her up on to my chest. It was absolutely terrific. I really enjoyed it."**

But for other women who wanted to have contact with the baby as it was being born, their efforts were frustrated:-

Debbie: **"I put my hand down by the baby's head. He gave me a good growling because of that."**

Susan: **"I was annoying them. I was putting my hand down to touch her. She was getting wild with me because it was in the road."**

Kitzinger (1976) argues that seeing and touching the baby in those first few minutes of birth is a need that the majority of women have. Thirteen women (27%) in this study had their babies delivered directly on to their bodies before the cord was cut. All but one felt this was a special experience:-

Brenda: **"I was sitting up when the head came out. They pulled him up on my tummy and I cuddled him before they cut the cord. I cried. I was chuffed. It was all emotion."**

Jill felt this early contact with the baby by both parents had long term effects on their relationship with him:-

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> **"He put him straight up against me before the cord was cut. I really liked that. My husband thought it was fantastic. After I fed him he held him, still all covered with muck. He thought that was marvellous. He seemed much closer (to this baby) than the last baby, who was just shown and taken away."**

Several mothers not given the baby immediately, felt it was important to see the baby uncovered:-

> **Katrina: "As soon as the paediatrician had finished with her they gave her to me. She wasn't that wrapped up. That's important, that you see all of her."**

But for Maureen, her efforts to examine the baby were frustrated:-

> **"I tried to unwrap him, but they wouldn't let me. They said he was blue and had to be kept warm."**

But not all women wanted early contact with their babies. Ten women (21%) could not 'be bothered' with the baby at first:-

> **Carolyn: "I never thought 'how marvellous' until later on. Before I was taken out (of the theatre) they tried to put her on my breast. I remember thinking 'just take her away'. I couldn't have cared less. I could have thrown her at them."**
>
> **Yvonne: "I didn't want to see him. I couldn't give a stuff. They said, 'come on, hold the baby'. I said, 'No. Give it to W'. But I held him for a few minutes."**

Compared with 10 mothers randomly selected from the group that did enjoy early contact with their babies, disinterested mothers had longer labours, more pain and more drugs, and they were more dissatisfied with their labours and births. There was no difference in the level of medical intervention. Primiparae, however, were disproportionately represented in the disinterested group. Forty-six per cent of primiparae were disinterested in their babies at first, compared with 12% of multiparae. The association of disinterest

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with a distressing labour is strong for primiparae, but there was no such association amongst multiparae. Three of the four disinterested multipatae could be described as having relatively 'easy' labours. For such women, initial disinterest was normal for them:-

> **Sally:** **"Everybody seems to think you have to get the mother/baby bond established straight away. I don't agree with that at all. As far as I'm concerned....whether it's selfish or not I don't know, and it hasn't made any difference in my love for the kiddies....I'm not interested in my babies, apart from having a good look to see if they are all right."**
>
> **Lisa:** **"The baby's something to get out. You are not terribly interested. You don't really want to cuddle them. That's not until a wee while after that."**

It was expected that giving birth to a live, healthy infant would be a source of personal esteem and satisfaction to most mothers. Mothers were asked how they felt about themselves when the baby was born. It soon became obvious that the question was irrelevant to most women's experience:-

> **Lorna:** **"You are not feeling about yourself. You are just thankful it's normal."**
>
> **Trudy:** **"I didn't really give it much thought."**

For over half the women in the study, the primary feeling straight aftr birth was one of relief: relief that 'it was all over' and relief that 'it was normal':-

> **Joanne:** **"The immediate reaction is 'it's out and that's it, all over!"**
>
> **Bronwyn:** **"I think I was pleased with myself as long as she was normal."**

Only six women felt a sense of achievement. A possible explanation may be that women view birth as something the doctor does. The

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active part many women feel they play in labour does not generally extend to the birth itself. Even those who helped to pull out their own babies were no more able to make choices or decisions in the conduct of the second stage than those taking a less active part. Given the operating room environment, it was hardly surprising that women's first thoughts are similar to those of anyone undergoing a surgical operation: thankfulness that the ordeal is over and relief at surviving it. Mothers have to be told they have done well:-

Katrina: "I felt pleased it was all over. I felt good when the doctor praised me."

The conduct of the third stage of labour, the expulsion of the placenta, appeared to be similar in all hospitals. An oxytoxic agent was given, apparently routinely. This necessitates early clamping of the cord and accelerates the third stage. No mother experienced the practice of allowing the cord to stop pulsating before clamping. Only one woman was aware of this alternative practice:-

Phillipa: "I wanted to leave the cord to stop pulsating but I never got round to asking the doctor."

While the majority of women had no difficulty expelling the placenta, nine women (19%) said that the placenta needed manual expression, which was a painful and distressing exercise:-

Kirsty: "The doctors pushed on my stomach and hurt me. It was just as bad as having the baby."

Judy: "Another thing which I didn't really approve of; they banged an injection into my thigh to get rid of the placenta. They didn't give it time to come away naturally. They could have given it a bit longer. As it was, it seemed to pull away too quickly. It was the most awful tearing feeling. He seemed to push down on my tummy and pushed and pulled cord. I went into shock and had the most awful after pains."

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All multiparae and nine of the 13 primiparae were encouraged to put the baby to the breast before leaving the theatre. Almost all multiparae reported this initial feed as successful. There was no difference in success between those feeding immediately after birth and those feeding after they had showered. Women who were not particularly interested in their babies at that stage were no less successful. Primiparae, in contrast, felt that this first feed was generally unsuccessful. This could be worrying for a new mother:-

> Barbara: **"I failed to put him to the breast straight away. I had to discover that breastfeeding had to be learnt. It wasn't a natural thing. He didn't know what to do and I didn't know what to do. I thought 'what the hell am I going to do?'. But I knew I could ask them later on."**

There was no association between unsuccessful, initial feeding and the rate of medical intervention, level of pain, drugs given, or length of labour. Multiparae may be more successful because they are more experienced or confident and may not have high expectations of the first feeds.

The practice of leaving parents and baby alone after completion of the third stage, to phone relatives, have a cup of tea and just be together, appeared to be universal and appreciated by all.

Before proceeding to the post-natal ward, mother and baby were washed. Several women would have preferred to defer the shower until later. Others would rather the baby was not washed immediately, but the majority of women didn't think about these practices, accepting them as part of the hospital routine.

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CHAPTER V

POST PARTUM EXPERIENCE

In this chapter, women's post partum experiences in hospital are examined. As in previous chapters, the needs of the mother are the primary focus. A brief outline of some of the factors that concerned women once they arrived home with a new baby is also included.

Extreme mood elevation was fairly common in the first days after birth. Thirty-eight per cent, unprompted, said they were 'too excited' or 'too high' to sleep for the first two or three days:-

> **Alison:** **"All I wanted to do was think about what had happened. I didn't want to sleep."**
>
> **Joanne:** **"My mind was going round and round. It's crazy - you go from one thing to another. You go over everything in your mind. It's like watching a video. The whole thing plays before your eyes. You are on such an emotional and hormonal high. I couldn't sleep."**

For a small number, this 'high' lasted until they went home, but the more usual pattern was a drop in mood on the third or fourth day. This was described as having the 'blues' by 46% of the study women. Primiparae were twice as likely as multiparae to report suffering from the 'blues'. Social class did not influence primiparous rates, but working class and upper middle class multiparae were considerably more likely to report the 'blues' than middle class multiparae. Women make clear distinctions between post-natal 'blues' and post-natal depression. Five women (10%) said they suffered from 'post-natal depression' (their term) lasting from six to twleve weeks. This depression was predominantly characterised by a feeling of being unable to cope. Three of the five women were working class primiparae. Other factors associated with depression included geographic and social isolation, no partner or a non-supportive

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partner, a household income of $15,000 or less per annum and unplanned pregnancy. The five women had either a high level of medical intervention during the birth process (primiparae) or experienced post-natal complications in themselves or the baby (multiparae). These factors are similar to those isolated by Oakley (1980) as likely to contribute to an outcome of post-natal depression. Women who said they were depressed in this study also said they felt reluctant to ask for help because this would have reinforced their sense of failure.

While it was apparently official policy in all the study hospitals to allow mothers to 'do their own thing' during the post partum period, the design of most hospitals makes this policy difficult to implement in practice. Under half (43%) of the study women had a single room post partum, whereas 70% would have preferred a single room. Sixty-four per cent of primiparae said they would prefer to share, usually with one other. Primiparae felt lonely and shy about asking staff for advice. Sharing a room with an experienced mother was an important source of information for the first-time mother. Multibedded rooms of four or more were least appreciated by the study women; mainly because rooming in with the baby at night was made virtually impossible in this environment:-

Raewyn: **"A couple of the girls didn't want to room in. We two that wanted to didn't feel we could have our babies there because they would disturb the other two. We felt obliged to (put the baby in the nursery at night) rather than anything."**

Jane: **"She would scream at night so I thought it wasn't fair, especially as one of the other women had a baby in the neonatal ward."**

There was general acceptance by mothers and staff that women should have their babies with them during the day. Attitudes towards rooming in at night by staff and mothers was more complicated. In one local hospital where all mothers had single rooms, night-time rooming in was accepted practice by both mothers and staff. In all other hospitals, putting the baby in the nursery at night tended to be the norm. In the base hospital, lack of single rooms seemed

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to be the main obstacle to rooming in at night. In the local hospitals where lower bed occupancy made rooming in at night more feasible, there appeared to be some covert discouragement from staff:-

> **Lisa:** **"They didn't like you rooming in at night. They didn't say anything. It was just their little attitudes."**
>
> **Celia:** **"They hadn't had a baby for three weeks. I think they wanted something to do."**

Some mothers were told they needed 'more rest' at night. The majority of women found having the baby in the nursery at night quite acceptable. However, a considerable number, at least a third, were not happy with this arrangement and would have preferred to have their babies with them at night. Some worried whether the babies were sufficiently supervised at night in the base hospital:-

> **Sandra:** **"There was a night nurse who brassed quite a lot of us off. She would wake us when the baby was crying, then she would go back and sit in the office. When you walked back she would be asleep. She was supposed to be keeping an eye on the babies."**

Others, from both types of hospital, felt they couldn't control what was being fed to the baby at night:-

> **Jenny:** **"I didn't trust them not to 'comp'[1] her. I pinned a note on the bassinette."**
>
> **Clare:** **"I said I would rather have her with me. I was dead against 'comping' the baby. I didn't want glucose or anything, I wanted to demand feed."**

Demand feeding was also apparently official policy in all the hospitals. In practice, this policy was more apparent than real. It would seem that if a baby woke for a feed at three to four-hourly intervals,

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1. 'Comp' - To give the baby a complementary bottle feed.

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all was well. But mothers with babies not conforming to this regime often faced considerable pressure to wake the baby or attempt to resettle it with boiled water or glucose solution, rather than the breast. This attitude on the part of the staff seemed to reflect a reluctance to abandon schedule feeding and was more prevalent in GPU's:-

> Lisa: **"They're still very schedule minded. They would come round with their little pieces of paper and ask you 'when did your baby last feed?'. They would tell you they were demand feeding. It was better than the old days, but they would say 'That baby's not due for a feed until 6.00 p.m. What's it doing awake now? Give it boiled water'."**

In the base hospital, mothers found pressure to conform to hospital routines in feeding matters was rather more subtle:-

> Barbara: **"I sort of felt under pressure everytime he was up and awake in the hospital. It seemed like an awful long time. All the other babies were sleeping. They all say up there 'try and get him into a four-hourly sleep pattern, he shouldn't be up so long'. I was a wee bit worried, but I think it was just officials watching and saying this baby is not very good, he's not doing properly. When I got home things seemed to straighten out."**

Some experienced mothers, less than 5%, still preferred to schedule feed their babies. Other experienced mothers, or mothers exposed to La Leche breastfeeding teaching, often went to considerable lengths to circumvent what they regarded as inappropriate hospital feeding routines. The most popular practice was to falsify feeding charts:-

> Lisa: **"I used to fib so that if the baby woke in two hours they would not try and settle it but allow it to be fed."**

Detailed information about breastfeeding outcomes was available on 41 women. A further two chose to bottle feed. Of the 41 women, 38 (88%) were still breastfeeding at three months. This rate dropped to 29 (69%) at five months. Nevertheless, this is nearly three

times the rate of breastfeeding found by the Dunedin Multidisciplinary Child Development Study. In that study, only 26% of mothers were still breastfeeding at 13-24 weeks (Hood & Faed et al, 1978). Primiparae account for most of the dropout rate between three and five months, with only 42% breastfeeding at five months, compared with 83% of multiparae. BHS primiparae were slightly more likely to be still breastfeeding at five months than LHS primiparae. Confidence and experience would appear to be the most important factors associated with longer breastfeeding. Multiparae were successful regardless of whether they 'roomed in', complemented, demand, or schedule fed their babies. One possibility that may contribute to this success was the unlikelihood of receiving conflicting messages from staff. Multiparae, in the main, received much less attention from staff. They were also more likely to resist hospital practices that didn't suit (see Lisa above), or see them as a temporary inconvenience:-

Kirsty: **"They schedule fed in hospital if she went over four hours. Once I got home I fed her when I thought she wanted it. It's a bit of a nuisance feeding that way in hospital but you can console yourself that you can do it your way when you get home."**

Primiparae are more vulnerable. Primiparae most likely to give up breastfeeding were those still feeling tense and lacking in confidence on discharge from hospital. Such women were often those whose babies needed frequent small feeds or those whose babies were a bit more difficult to get established on the breast. A few of these mothers felt the staff increased their tension:-

Yvonne: **"There was one sister sho used to get quite short with me when I was breastfeeding. She used to say 'well try!'. I'd say 'I am trying' and she used to grab my boob. I used to think 'well, that's a bit on the nose'."**

Trudy: **"There were some of the staff who were very rough and gruff, who would shove the breast in its mouth and say 'drink baby'. Some weren't very patient."**

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Half the primiparae abandoning breastfeeding before five months did so because they felt the quantity or quality of their breastmilk was not satisfying the baby:-

> **Brenda:** **"I stopped at three months. He vomited terribly one day and I thought there must be something wrong with my milk. He took a whole bottle without womiting."**

Hood & Faed et al (1978) found that 41% gave this reason for abandoning breastfeeding. Others just didn't like breastfeeding:-

> **Angela:** **"All along I didn't really fancy it. I was prepared to have a go. They say it's best. I often think I was tense when I was feeding her and that's why my milk wasn't coming. I came home breastfeeding and complementing. But after a week I thought 'oh it's no good'. I didn't know how much she was getting. She was awake every two hours."**

Yet others, including some multiparae, found breastfeeding inconvenient. Inconvenience had two aspects. Some mothers said babies needed lsss frequent feeding if they were bottlefed. But a more common reason given was that breastfeeding made demands on the mother that were incompatible with the demands of other members of the family, either the other children or the husband:-

> **Lorna:** **"As soon as I got home I went off and bought Enfamol. I knew she was hungry even in hospital. I did actually feed her for a good part of four months, complementing all the time. It was the answer. I could have fed her every one or two hours only on breast. Even though the baby comes first you still have a duty to the other children. If the house gets too untidy you get yourself emotionally in a muddle."**

It was particularly in reference to breastfeeding that the study women said they preferred nurses who were mothers themselves. Discussion with the women about the qualities of a good nurse revealed a general consensus that it was her experience as a mother, rather

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than her clinical skills, that were most valued (see also previous chapter, page 78). Women said that such nurses brought to their caregiving attitudes and qualities that were markedly superior to their single colleagues. It would seem that such nurses adopted a more holistic approach which incorporated a knowledge and understanding of the emotional and social impact of childbirth gained from personal experience:-

> Clare: **"I do actually feel that the person in charge should have had a child. It's very hard to relate to someone who is single. The women (nurses) who have had babies, their whole attitude is different. They are more supportive and understanding. Their total handling of you as a person and of your body is more coherent and more natural."**
>
> Bronwyn: **"The main midwife must be about 60. She's good, she's not an old battleaxe, she's adapted quite well to the new thinking. Being older and a married woman she knows what she is doing. She's had children of her own."**

Mothers felt that nurses who were not mothers (many mentioned student nurses doing their general/obstetrical training in this context), generally adopted a more clinical 'medical model' perspective, or as many women described it, a 'sticking to the rulebook' attitude:-

> Karen: **"One staff nurse was single with no children and young. She gave me the impression she had read the rule book from cover to cover and nothing would bend the rules."**
>
> Lorna: **"I found the young nurses hard to cope with. I try to see their point of view, but when you have four babies I think they should respect that a little. You kind of swallow your pride. They are only young, about 17 or 18. They're new to it. They're doing exactly what the book says."**

Holistic care in the sense of taking into account social and emotional needs, was much more likely in GPU's for two reasons. First a much greater proportion of staff were likely to be mothers themselves.

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Second, the intimate atmosphere and minimal hierarchy promoted more sensitive and flexible responses to individual needs:-

> **Lynn:** **"It was one big happy family up there compared with the other two hospitals I had been in. There was only one nurse who was more like she had been in a big public hospital. All the rest made you feel very at home. They went out of their way to make things pleasant for you. It was like a holiday somewhere - all friends."**

The third reason that made holistic care more likely in GPU's was the divorce of the unit from the disease environment of general medicine. The focus was on the needs of the healthy mother and baby. In the base hospital, women were exposed to the disadvantages of large institutions:-

> **Carolyn:** **"There are so many nurses you get a new one all the time. They've all got different ideas. This nurse said 'your baby's very jaundiced isn't she?'. I could have burst into tears at that stage. I felt so alone. I was up there and I didn't have anybody. M wasn't there and I had the baby to myself, and this nurse wasn't giving me any encouragement. I was just another mother and baby."**

But a more crucial difference between the base hospital obstetric unit and the GPU is the hierarchial structure of the former. The power structure of the specialist unit is dominated by the specialist gynacologist. Bunkle (1979) suggests that it is illogical for the specialist to spend time on the 'ordinary' case since his competitive effectiveness is maintained by his skill with the 'interesting' case. In the specialist unit, therefore, the aim of the routine will be to minimise the demands on the doctor, rather than maximise the support of the patient, since his perceptions of what is trivial and what is important and his time are seen as more valuable (Capper & Bunkle, 1978; Bunkle, 1979). Because nurses are not the decision makers, they are powerless to respond to women's needs. Women also felt that they themselves were in no position to assert their needs. Three factors made birthing women particularly dependent:

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being a patient, inexperience of the birth process, and the need to avoid conflict:-

> **Donna:** **"When you are a new mother you are very vulnerable and the minute you get into a nightie you are even more vulnerable."**
>
> **Phillipa:** **"It's all very well knowing everything and knowing what you want to do. If you are confronted with regimented attitudes and things you are in no state to demand. You can't cope with fronting up to someone. If you are told to do something you tend to do it no matter how much you disagree with it."**

One issue that mothers did confront staff over, was circumcision. All but one mother who wanted a son circumcised, reported resistance from both medical and nursing staff. Mothers were generally skeptical of this change in attitude of the medical profession:-

> **Stephanie:** **"The doctor said 'it's his and it's for him to make up his mind when he's old enough', which I thought was a pretty stupid statement in view of all the other things they do. When I was last there it was circumcision and breastfeeding or else. Now it's no circumcisions and do what you like about breastfeeding. It seems to run in cycles (laughs). They seem to run round in circles deciding what they will do next."**

Tiredness/lack of sleep were the commonest physical complaints experienced by mothers. No mother said her baby was responsible for her tiredness. Being disturbed by lights, noise or other people were the reasons given by 12 of the 15 women (31%) who complained. BHS mothers were three times more likely than LHS mothers to report this problem. Twenty-nine per cent complained of 'afterpains' caused by the uterus contracting and returning to its non-pregnant state. Afterpains came as an unexpected shock to several primiparae:-

> **Trudy:** **"I was getting afterpains that I didn't expect. I didn't know anything about them."**

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Painful stitches were experienced by 19% of the study women. This is a much lower rate than was found in Hood's Dunedin study (Hood et al, 1978) and probably reflects the lower episiotomy rate in the Manawatu.

Women generally agreed that doctors were not really necessary during the post partum period. Nevertheless, they appreciated their doctor's regular visits. Of the 26 women commenting on this aspect of care, just over two thirds were happy with their doctor's care. The remainder were less happy. The most frequent complaint was that the doctor visited once or not at all. Several felt that s/he lost interest once the baby was born.

> Barbara: **"I didn't see him, quite honestly. He came in once, the day I went home. I was a wee bit disappointed really. I sort of got the impression 'well, she's delivered, she's out of the way'. I didn't need him but everybody else's doctor came."**

Information on the length of stay in hospital was available for 42 women. To a certain extent mothers had some choice about when they left hospital, but there were strong pressures to stay at least four days. BHS women were also not expected to stay longer than eight days unless there was a medical reason for doing so. The length of hospital stay ranged from three to twelve days. Twenty-nine per cent stayed eight days, 17% stayed five days and 14% stayed seven days, with the remainder spread across the range. Closer examination of women's reasons for leaving hospital was revealing in that it was often a good indicator of feelings about hospital care. BHS women were three times as likely to leave hospital under a week as LHS women (Table XXIII). This did not reflect a greater pressure on beds in the base hospital, as there was no evidence that mothers were discharged from hospital against their wishes. Almost three quarters of base hospital mothers said they 'couldn't get out of hospital quick enough'. Only 10% of LHS mothers gave this reason for leaving hospital. The major reason for wanting to leave hospital at the earliest opportunity was not being able

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TABLE XXIII

LENGTH OF HOSPITAL STAY BY BASE HOSPITAL SAMPLE AND LOCAL HOSPITAL SAMPLE

(Percentage in brackets)

DAYS	BHS	LHS	TOTAL
3 - 4	7 (32)	0 (0)	7 (17)
5 - 6	7 (32)	4 (20)	11 (26)
7 - 8	7 (32)	11 (55)	18 (43)
9 - 10	1 (4)	4 (20)	5 (12)
> 10	0 (0)	1 (5)	1 (2)
TOTAL WOMEN	22 (100)	20 (100)	42 (100)

to relax in the hospital environment. Lack of privacy and constantly being under scrutiny by a variety of strangers were the major contributors to tension amongst base hospital mothers:-

> Karen: **"I don't enjoy hospital. I hate it. It's too sterile for me. The waiting to come home is the tiring part, almost depressing. You are eager to get the baby home and dress it the way you want. They have their way of doing things. I prefer to fold the naps in a certain way."**

But women wanting to get out of hospital quickly did not often feel going home was a great improvement. Susan was typical of such women:-

> **"I got bored and sick of it. It drove me nuts, probably because I was on my own. I was lonely. I wanted to go home but I was dreading to come home to housework and lots of things to do."**

LHS women, conversely, were likely to complain that they were forced to leave hospital before they felt ready because the family was

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not coping at home:-

> **Donna:** **"I came home after a week. One reason was that the family wasn't coping all that well and I suppose I thought 'well I had that delicious week in hospital' that had to come to an end at some stage."**

Mothers said their main requirement was for privacy, peace and quiet and relief from other social roles (see previous chapter, page 80):-

> **Jacqui:** **"I would have stayed longer. They said 'go home when you want to'. I only came home because I felt sorry for my husband. I would have liked to have stayed longer for that little bit of extra rest and that break."**

> **Liz:** **"It's the only time you are something special. For a change people are thinking about you. Nothing is expected of you. It's lovely, beautiful."**

Despite efforts of the staff to reduce tension, the base hospital obstetric unit was seldom the place of rest and relaxation that most mothers said they needed and LHS mothers said they experienced. BHS women said the physical structure, the long corridors, the busy hospital atmosphere, the constantly changing staff, made it difficult to feel relaxed.

Going home generally meant the end of any recuperation, at least for most multiparae. It became very evident that stepping over the threshold was accompanied by the assumption that the mother would resume all her former domestic roles, even if she had given birth three or four days earlier. More than one indignant mother found on arrival home that she was expected to provide the very next meal:-

> **Raewyn:** **"Well I remember getting home and I felt flat. My husband and daughter had been staying with my mother-in-law and they hadn't even been home. I just burst into tears because my husband hadn't even got any groceries in and then he wanted tea!"**

Donna **"I came in the door and the house was extremely untidy. The children's beds hadn't been made and there were clothes everywhere. I knew that if I started crying I would just cry and cry and that was no good for the baby. So I didn't. I don't know how I didn't. I got home about 11 a.m. and there was absolutely no mention of lunch. So I had to turn round and cook lunch in my first hour at home."**

Primiparae were not always exempt either:-

Brenda: **"Oh yeah, it takes a while, the excitement.... till you get home you never really believe it. You come back to reality when it's time to get the meals. The first couple of days it was a real disaster. Tea was late. I kept thinking 'there's got to be an easier way. Mum did it. Everybody does it'. So I just did most things in the morning."**

There was a feeling of resentment from many women about this lack of temporary relief from the demands of the family. Only three women had paid help in the home. 'In-laws' attempting to help out were more likely to be a source of tension. The few women who had their own mother to take over household tasks appeared to be happy with this arrangement:-

Trudy: **"My mother was here when I needed her. It was a wonderful time for me. I just had to care for the baby."**

However, for the majority of mothers the only source of domestic help on arrival home was their partner. But it appeared that only a minority of women had partners who were able to cook meals or take over other household tasks:-

Michelle: **"I wasn't worried about coming home but I didn't want to. Everything went flat. My husband was really good for the week (but) I still had to cook meals, do the dishes and the nappies."**

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Lorna: "The first day my husband took over. But after that you are into the routine quickly."

For a minority of women, including some primiparae, even this source of help was denied them if the partner was unable to get leave from work.

Family members, mothers, sisters, sisters-in-law, were the usual first source of advice about child care for new mothers. In lieu of family, Plunket Nurses were the most valuable source of advice. As with hospital nurses, Plunket Nurses with children of their own were most acceptable. Mothers were high in praise of most of the Plunket Nurses; even very experienced mothers valued a second opinion at times. Two primiparae said access to the Plunket Nurse 'after hours' prevented them from harming the baby:-

Yvonne: "The Plunket Nurse was marvellous. I rang her up at 9 p.m. I knew if I didn't I could have killed him. She came. I felt horrible. She was the best out of anyone. She would pop over in five minutes."

Three urban women used the Karitane Family Centre to get a break from a crying baby. Several women living outside the urban area would have benefitted from such a service. But for a few women, particularly those who were depressed, even asking the Plunket Nurse for help is too difficult. Such women may need to be identified and offered practical support by support services:-

Susan: "I just broke down. I couldn't get into a routine. I couldn't handle it. I thought I'd manage somehow on my own. I didn't tell my husband how bad I was feeling."

Researcher: "Would a homehelp have helped?"

Susan: "Yes it would, it would have helped a lot. If I had had someone to come and help me, talk to me or do something I would have been on top of the world. The Plunket Nurse said 'if it gets too much just give me a call'. But I didn't....I didn't feel like hassling her. She has enough on her hands, never mind my problems."

TABLE XXIV

BIRTH HOSPITAL INFLUENCE ON CHILDBIRTH EXPERIENCE BY BASE HOSPITAL SAMPLE AND LOCAL HOSPITAL SAMPLE

	BHS	LHS	TOTAL
Positive	3	19	22
Negative	4	2	6
Nil	14	0	14
Other	3	2	5
TOTAL WOMEN	24	23	47

Finally, 47 women commented on the degree of influence they thought their birth hospital had on the overall experience of childbirth. Seventy per cent felt the type of hospital did influence their experience of childbirth. The remainder felt their experience would be the same in any hospital (Table XXIV). The latter were all BHS women. Of those who felt the hospital played a role in their experience, two thirds felt the hospital made a positive contribution. Nineteen of these 22 women were from the LHS:-

Bronwyn: **"Gosh yes, it plays an important part. You can ring up and they know who you are. If you rang the public hospital they would say 'who?'. They call you by your first name here. It's really friendly."**

Dianne: **"I think this one gives you more personal attention and you are known. I think in the public hospital you are more of a number. When they get a birth here they are all excited about it. You get the full treatment and that's really nice. I think that's part of it."**

LHS women like Bronwyn and Dianne stressed that it was the psycho-social relationships of the GPU that were most valued. For example,

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knowing and being known by the staff, not feeling intimidated, feeling 'relaxed'. Most LHS women were able to isolate these values because most had experienced base hospital maternity care. BHS women in the main had not experienced GPU care and this may be why the majority felt the hospital did not affect the experience, as there was no other model of maternity care with which to make comparisons. Nevertheless, when a 'birth centre' model of maternity care was explained, half these BHS women felt it would be preferable to the existing obstetric unit. There were six women who felt the hospital had a negative influence on their experience, four from the BHS and two from the LHS. Clashes with staff and lack of privacy were the main criticisms. Five women felt the hospital had both negative and positive influences or was less important than personal knowledge and preparation or was possibly an influence:-

> Jill: **"Possibly, because if you have him in a relaxed atmosphere you are relaxed to start with. If you come home and you are on edge you start off from a different base altogether."**

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CHAPTER VI

'MIDWIFERY' OR 'OBSTETRIC' MODEL?

This chapter discusses some of the main findings of the study. Women's perceptions of their maternity care and the meanings they attach to pregnancy and birth are compared with the 'obstetric' and 'midwifery' models outlined in the Introduction and Chapter I. Some areas for further research and implications for future policy are suggested.

Using a methodology that focussed on women's personal experiences allowed a version of the reality of childbirth to emerge that often differed from, and at times contradicted, the prevailing obstetrical definition of the childbirth process. It also permitted a distinction to be made between practices and procedures of the medical management of childbirth that were tolerated or even approved of by women for 'the baby's sake', and those that were approved of because they were of benefit to the women themselves.

Women in the study were able to identify many areas where their needs were not met by current maternity services. Only a small minority, however, felt able to define the needs of the baby in utero. Priority was given to the medically defined needs of the baby by most medical personnel and most mothers. Once the baby was born, multiparae, at least, felt more confident about deciding what was best for themselves and the baby.

The majority of women felt the antenatal services provided excellent physical care but largely ignored the socio-emotional aspects of childbirth. Women in the study, once they accepted the pregnancy, viewed childbirth in positive terms. The coming baby was something to be celebrated and pregnancy was seen as a healthy process. But the antenatal services constantly presented women with negative images of childbirth. Sixty per cent of doctors appeared to treat

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pregnant women no differently than other 'ill' patients. All but a handful of doctors appeared to perceive decision-making in childbirth as an exclusively medical responsibility and two thirds of doctors seemed to view childbirth predominantly as a physical event. The majority of women had low expectations that their doctors would cater for their emotional needs, for example, by structuring the antenatal doctor/patient encounter so that the mother felt able to actively contribute. When doctors did make efforts to reduce the inequality of the relationship, this was regarded by women as high quality care. Only a sixth of the women in the study identified the doctor's failure to acknowledge the social and emotional aspects of pregnancy and childbirth as a deficiency of antenatal care, but the finding that the majority of women didn't derive any personal benefit from the antenatal visit other than reassurance that the baby was 'all right' does suggest that antenatal care is largely irrelevant for women themselves.

The finding that the majority of doctors are solely concerned with the physical health of the mother tends to confirm the idea that mothers are viewed in obstetrical terms as 'vessels' for the fetus.

The finding that upper class and working class women were less likely to be happy with their relationship with their antenatal doctor than middle class women deserves comment. Upper middle class women were on the whole more knowledgeable about childbirth. Being more aware of alternatives and options in childbirth management makes it likely that such women would be more critical about current provision than those unaware of alternatives. The association of working class women with dissatisfaction with the doctor may be spurious. Sixty-one per cent of working class women in this study were primiparae, compared with 31% of middle class and 8% of upper middle class. A characteristic of primiparae was their much greater passivity in medical encounters compared with multiparae. Passivity in the childbirth process was strongly associated with dissatisfaction (see below). It would seem likely that parity, rather than class, would be the more relevant factor.

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Few women saw childbirth as entirely the province of the layperson or were willing to take over the major responsibility for decision making. However, one sixth did want to share responsibility and decision making. All women wished to be kept well informed, particularly when some medical concern arose. Reassurance was never an acceptable substitute for explanation and justification of medical actions.

Most women felt safer and more comfortable giving birth in a purpose built maternity unit. The safety factor, it would seem, resides in the social power of the institution as a place set aside for births, for the most popular place, the local GPU, provided no greater emergency facilities than those available to the domicillary midwife. In wishing to give birth away from home, women are apparently denying that childbirth is a domestic event, a central tenet of the midwifery model. But it may be that women are saying something different. Women may be saying that birth is not 'a family affair', or at least not a nuclear family affair. In other words, because of lack of supporting services for childcare and for the relief from other domestic roles, and because of the inevitable lack of privacy and opportunity to concentrate solely on getting the baby born and establishing breastfeeding, childbirth at home becomes untenable. Few women felt that children themselves would benefit from being present during labour and birth and few would welcome family members other than the support person, usually the husband, being involved. The one Maori woman in the study did prefer to have several members of the family with her during labour.

Because most mothers saw no alternative, they accepted that admission to hospital and the surrender of autonomy was the price to be paid for being relieved of domestic roles and giving birth in safety. The assumption of an essentially passive and dependent position that follows the adoption of the patient role and submission to medical expertise and authority, seriously conflicts with the need expressed by most women in the study to be active participants in the birth process. Passivity and dependence on the mother's part was likely to result in disappointment and dissatisfaction with

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the birth experience. The institutional structures of the obstetric service, particularly the requirement that the mother adopt the patient role, thus promote conditions that are least likely to benefit the birthing woman.

Multiparae, because of their knowledge and experience, learn to avoid or circumvent medical practices that increase passivity; for example, by delaying admission, by staying out of bed and by refusing drugs and anaesthetics. The generally unhappy experiences of primiparae seem not so much to reflect a generally more physiologically difficult birth experience that that of multiparae, but a greater vulnerability to being rendered helpless and passive participants in the process. More critical for the outcome of the birth experience for the mother was not the degree of difficulty of the labour or the level of medical intervention required, but the quality of the mother's relationship with her caregivers. This means, in essence, that women who received strong emotional support and encouragement from an experienced professional caregiver whom they knew and trusted were likely to find the experience rewarding, regardless of the physiological difficulties.

The structure of the local GPU, both social and physical, appeared to modify, but not entirely negate, the passivity and dependency effects of the medical management of childbirth. The less impersonal, less intimidating atmosphere gave mothers confidence. It was noticeable that LHS women did not talk about 'leaving your pride at the door' as BHS women did. This loss if dignity, this feeling of helplessness and vulnerability reported by many BHS women may well flow from an inability to control the access of strangers to one's body (Shaw, 1974). Both the size of the base hospital obstetric unit and its level of tehcnology and expertise will inevitably increase fragmentation of care and the number of strangers involved in the patient's care. In addition, BHS women clearly found it difficult to relax in surroundings that closely resembled a busy surgical ward.

It was a somewhat surprising finding that few women felt any sense of personal satisfaction at the moment of birth. This is presumed

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to be woman's 'moment of triumph' according to policy advisors (MSC, 1979). It would seem likely that this absence of personal satisfaction reflects the extreme passivity of virtually all women during the second stage of labour. It is difficult to see how any woman could perceive of herself 'giving' birth in the clinical environment of a theatre where gowned and gloved individuals preside over shiny metal instruments, trolleys and technical gadgetry normally associated with operating theatres and surgical procedures. The study women did not refer to themselves as 'giving' birth but rather as being 'delivered' by the doctor or the midwife.

This alienation of women from their labour was not mitigated by being permitted to 'watch' the progress of the second stage through a mirror or by being permitted to 'help' the doctor help the baby out. Women permitted these activities were not more likely to experience personal satisfaction at the moment of birth. Indeed, it may be argued that viewing the process through a mirror is increasing the alienation from one's body. Participation in helping the baby out gives an opportunity for early contact with the baby, which women appreciated, but it cannot be claimed to be allowing women greated autonomy in the birth process. The power relations in the birth process remain intact as long as obstetricians decide who will be offered options and who will not. This was well illustrated by Maureen's experience (Chapter IV, page 103). Maureen was permitted to help in getting the baby out at a previous birth, which she enjoyed very much. However, this time her own doctor was on holiday and she was not permitted to do the same at this delivery. She was understandably very unhappy as a result, but felt in no position to insist.

The local GPU was clearly superior in meeting the needs of mothers in the puerperium. LHS mothers felt more relaxed and slept better than BHS mothers. The autonomy of both the building and the staff from general medicine distanced women from the illness environment and contributed to a low tension atmosphere. The minimal level of hierarchial staff structure enabled staff members to be more flexible and responsive to individual needs.

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The local GPU was not superior to the base hospital in meeting the needs of women during labour. This is not particularly surprising. Evidence from the study suggests both types of hospital managed labour largely according to the tenets of the obstetrical model outlined in Chapter I.

In essence, this implies that both types of institution managed the process as a surgical speciality of medicine with women in labour viewed as patients requring medical expertise and skill to get them through the perceived hazards. In addition, it implies that, as patients, women in labour were expected to be predominantly passive participants in the process, ceding control and responsibility to the professional experts. A further inplication is that the management of pain in both institutions accorded closely with medical ideology; pain was to be relieved with drugs and anaesthetics whenever possible.

The findings of the study confirm that this was the approach to labour and birth adopted by both types of hospital. LHS women and BHS women were equally likely to undergo preparation and procedures normally associated with impending surgery. Similar amounts of drugs and anaesthetics were administered to women in both samples. Neither LHS women or BHS women were likely to be encouraged to make decisions or share responsibility for their own labour management, such as where the birth was to take place or whether to have an episiotomy or an oxytoxic agent in the third stage. LHS women were able to choose a birth position but this is hardly a significant concession. There are limited possibilities for choosing a satisfactory position for birth when one is on a high, narrow and flat delivery table.

There were, however, differences in the level of medical intervention in labour between the base hospital and the GPU. LHS women experienced considerably less intervention. What cannot be ascertained from this study is whether this reflects the lower level of technology and expertise available to the GPU or a more medically conservative

...138

approach to obstetric intervention. There was some evidence that some GPU midwives did exhibit a greater reluctance to rupture membranes than their medical colleagues or base hospital midwives, but there was little evidence to suggest that the perspective of local hospital midwives over the management of labour differed to any marked degree from their base hospital colleagues.

The finding that women left hospital before they felt ready to resume their domestic roles is disturbing. While early discharge greatly increases the economic efficiency of hospitals by increasing bed occupancy rates, failure to recognise the social costs of such a policy may, in the longer term, be a greater burden on vote health. Morbidity in the post partum mother at home is likely to impact on the whole family's health. It may, in the end, be a more efficient policy to provide post-natal services in the domestic setting for women who don't feel able to relax in a hospital setting and for those forced to leave hospital because the family is not coping at home. These findings suggest that women hold a version of the reality of childbirth that differs from, and frequently contradicts, the obstetric version. This supports Graham & Oakley's (1981) claim that conflict is a fundamental feature of the relationship between providers and users of maternity services.

The social construction of childbirth is seen in this study to be dominated by the obstetric medical model. There are several factors that would seem crucial for the maintenance of this domination. First, the monopoly of medical knowledge and technology by obstetricians. Second, the androcentric nature of this knowledge in which the pregnant woman is seen as a vessel for the fetus. Third, the role played by obstetrics in maintaining and reproducing the ideology of motherhood in which women are expected to sacrifice their own priorities for the 'sake of the baby'. The dependent position of pregnant women as a result of this obstetric domination makes it largely impossible for them to challenge the medical version of the reality of childbirth.

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Midwives, too, because the obstetric model dominates their training and because of their subordinate status in the health service hierarchy, appear to have all but abandoned their traditional perspective of birth as a positive, healthy process in favour of the largely negative, obstetric perspective of birth as a hazardous procedure.

The 'midwifery' model of childbirth would appear to offer certain advantages to mothers. The assumption that healthy women should be active participants in the birth process and the greater emphasis placed on socio-emotional aspects of childbirth accord with the qualities valued by women in this study. The 'midwifery' model, however, embodies an assumption that birth is a domestic event. This aspect would pose some difficulty for women because homebirth is perceived to be less safe than hospital birth and because of the non-availability of domestic support services.

In view of the general acceptability of the low technology GPU by the study women, and its safety record in terms of low perinatal mortality rates, a combination of this type of unit with an approach to childbirth management more closely aligned with the 'midwifery' rather than the 'medical' model would seem a reasonable direction for future policy planning. There was some evidence from the study that a small minority of individual medical and nursing staff are already moving away from a strictly medical model approach to childbirth management. There has also recently been some action on the part of Hospital Boards to halt further closure of peripheral low technology units (Auckland) and offer low technology 'birth centre' units to urban women (Dunedin). However, it must be stressed that it is unlikely that physical changes in the birthplace alone will benefit women unless they are accompanied by a commitment on the part of caregivers to alter the inequitable social structure between providers and consumers that currently exists, so that women are enabled to become the active participants in the birth process.

A system of care that would appear to encourage women to do this is currently practiced in the UK and might be adaptable to New Zealand circumstances and has been described by Parry (1980). Healthy

...140

women are cared for by a general practitioner/midwife team. The key figure is the community based midwife. She provides the bulk of the pregnancy and perinatal care, bringing the mother into the GPU for the birth and returning home with her. This system has the advantage of relieving the general practitioner of much of the routine antenatal care and allows the pregnant woman and the midwife to establish a relationship in which the socio-emotional aspects of childbirth receive greater emphasis.

Some midwives in New Zealand are at present questioning their role within the current maternity services and advocating the return of healthy childbirth to the midwife. The provision of a more 'holistic' service by midwives would necessitate considerable reorientation of midwifery education from its present highly technical approach to an approach more closely aligned to that of traditional midwifery.

As indicated in the Introduction, this study has largely been an exploratory exercise and the findings should be viewed in that light. Some sites of apparent contradition between consumers and providers of maternity care have been revealed and some insights into why closures of small locally based maternity hospitals have been vigorously opposed by many New Zealand women, have emerged. The associations found between variables need further empirical testing before causal connections can be established. It is hoped that the hypotheses presented in this study will act to encourage further research. Some of the findings would seem to warrant more urgent investigation. For example, the association of unhappy birth experiences with passivity and primiparity, the apparent failure of drugs and anaesthetics to benefit women in labour, and on a positive note, the beneficial effects of establishing, early in the pregnancy, a trust and rapport between the pregnant woman and those who will attend her when she gives birth. Some of these questions could be investigated by comparing women's experiences of different styles of birth management, for example, homebirth, hospital or birth centre management.

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It is hoped that this study has demonstrated the inadvisability of making health policy for women that is based on research that ignores the experience of women.

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APPENDIX I

QUESTIONNAIRE
SECTION I

INTRODUCTORY REMARKS

HELLO, my name is Anne McSherry. I'm from Massey University.

I'm doing a study of MOTHERS' EXPERIENCES OF HAVING A BABY. I need to talk to a lot of mothers who have had a baby recently TO FIND OUT HOW THEY FELT ABOUT THE EXPERIENCE.

I WONDER IF YOU WOULD BE WILLING TO TAKE PART IN THE STUDY ? It would involve me coming to talk to you IN YOUR HOME at some time that is convenient for you.

IF AGREES *refusers go to page 2*

UNFORTUNATELY I HAVE TO EXCLUDE THOSE MOTHERS WHO HAD HEALTH COMPLICATIONS THAT REQUIRED EXTRA SPECIAL MEDICAL TREATMENT, DO YOU THINK YOU WERE ONE OF THOSE ?

PROBE During your pregnancy did your doctor say anything to you that made you think your pregnancy, labour or delivery might not be straight forward ?
(Caesarian section ? Ante natal admission to hospital ?)

IF STILL APPROPRIATE FOR STUDY *Fill in admin details on page 3*

IF UNSUITABLE FOR STUDY BECAUSE HIGH RISK *record name and reason for exclusion*

_____

_____

TO BE COMPLETED IN CASE OF REFUSAL

REASON FOR REFUSAL *circle*

1. Illness / disability

2. Too busy

3. Objected to focus of survey *explain* _____

_____

4. Would not co-operate with any survey on principle *explain* _____

_____

5. Other reason *explain* _____

6. No reason given

CHARACTERISTICS OF REFUSERS *Interviewer's description - age, race, appearance etc.*

_____

_____

SURVEY ADMIN DETAILS

NAME _____ ADDRESS _____

TELEPHONE _____

BABY'S NAME _____ HOSPITAL _____

SEX _____ DATE OF BIRTH _____

APPOINTMENT FOR INTERVIEW : DATE _____

TIME _____

.....

CONTACT RECORD

DATE AND TYPE

I. _____

2. _____

3. _____

4. _____

.....

INTERVIEW

TIME STARTED _____

DATE _____

TIME FINISHED _____

TOTAL _____

MILAGE _____

CHILDBIRTH EXPERIENCE STUDY 1982

SHEDULE FOR INTERVIEWS

Serial number [ ][ ] 1-2 [ ] 3

FIRST, I WOULD LIKE TO ASK YOU A FEW PERSONAL DETAILS, THEN I'LL MOVE ON TO SOME QUESTIONS ABOUT YOUR EXPERIENCES OF HAVING THE BABY.

I. HOW MANY YEARS HAVE YOU LIVED IN THE PALMERSTON NORTH HOSPITAL BOARD AREA ? *Enter number of years*

Less than one year code 99

[ ][ ] 4-5

---

2. WHICH OF THESE APPLIES TO YOU IN YOUR PRESENT LIVING ARRANGEMENTS ? *Show Card A*

Married 0I
De facto - living together 02
Separated 03
Divorced 04
Widowed 05
Never married - single 06

[ ][ ] 6-7

---

3. WHICH OF THESE GROUPS DO YOU FEEL YOU BELONG TO ?

Show Card B

European - *Pakeha* 0I
New Zealand Maori 02
Cook Island Maori 03
Niuean 04
Tokelauan 05
Samoan 06
Chinese 07
Indian 08
OTHER 09 *Specify* _____

[ ][ ] 8-9

estion

4. WHERE WERE YOU BORN ? *PROBE if necessary*
Which country was that in ?

New Zealand 0I
Pacific Islands 02
Australia 03
Asia 04
United Kingdom 05
Republic of Ireland 06
Continental Europe 07
North America 08
OTHER 09 *Specify* _____

10-11

5. AND WHAT YEAR WAS THAT ? *Enter actual year*

12-15

6. AND HOW MANY YEARS HAVE YOU LIVED IN NEW ZEALAND ?

Enter number of years to nearest year
Less than one year code 99

16,17

7. DO LIVE WITHIN PALMERSTON NORTH CITY BOUNDARY ? *Yes 1*
No 2

18

(if no) HOW MANY KILOMETERS ARE YOU FROM THE NEAREST TOWN ? *Enter number of kilometers*

19,20

8. HOW FAR DO YOU LIVE FROM PALMERSTON NORTH HOSPITAL ?

Enter number of kilometers

[ ][ ] 21-22

---

9. HOW FAR DO YOU LIVE FROM THE HOSPITAL WHERE YOU HAD THE BABY ? *Enter number of kilometers*

[ ][ ] 23-24

IO. WHICH OF THE FOLLOWING TYPES OF TRANSPORT DID YOU USUALLY USE TO VISIT THE DOCTOR WHEN YOU WERE PREGNANT ?

Drove own vehicle 0I
Public transport 02
Walked 03
Bicycle 04
Relative's vehicle 05
Friend's vehicle 06
Taxi 07
OTHER 08 *Specify* _____

[ ][ ] 25-26

uestion

I. COULD YOU TELL ME WHO USUALLY LIVES IN THIS HOUSEHOLD ?

I MEAN ANYONE LIVING HERE FOR MORE THAN A MONTH,

OR ANYONE LIVING HERE FOR LESS THAN A MONTH BUT EXPECTED TO STAY LONGER THAN A MONTH ?

With the respondent, check through the relationships as stated and code the appropiate household type.

Nuclear Family 01 *Husband, wife & child/ren (including de facto)*

Extended Family 02 *Husband, wife & child/ren with other relatives*

Solo Mother & child/ren 03

Solo Mother & child/ren with other relatives 04

Two nuclear families Related 05 *Defined as above*

Family + Non relatives 06 *Husband, wife, child/ren, other relatives and non relatives*

Husband, wife child/ren & non relatives 07

Solo mother, child/ren & non relatives 08

Solo mother, child/ren, other relatives and non relatives 09

Two Nuclear familiies not related 10

OTHER 11 *Explain* _____

_____

21-22

2. IF I COULD JUST CHECK NOW - HOW MANY PEOPLE ALTOGETHER LIVE HERE ?

Enter number

29-30

Question

I3. TYPE OF DWELLING *Ask if necessary*

HOUSE 01 FLAT 02 OTHER 03 *Specify* _____

_____

_____

31-32

I4. WOULD YOU MIND TELLING ME IF YOU OWN OR RENT THIS HOUSE / FLAT ?

OWN 01 RENT 02 Other 03 *Specify* _____

_____

_____

33-34

Question

I5. COULD YOU GIVE ME A FAIRLY ACCURATE ESTIMATE OF YOUR GROSS PERSONAL INCOME - THAT IS, BEFORE TAX AND OTHER DEDUCTIONS - FROM ALL SOURCES FOR THE YEAR Ist APRIL I98I TO 3Ist MARCH I982, THAT IS THE LAST TAX YEAR ?

All the following elements should be included, use the list as a prompt, or to sum up elements.

Salary or wages	$_____
Student Bursary or Scholarship	$_____
War Disablement Pension	$_____
Social Security Benefits :-	
Family Benefit	$_____
Unemployment Benefit	$_____
Domestic Purposes Benefit (DPB)	$_____
Emergency Maintainance Allowance (EMA)	$_____
Sickness or Invalids Benefit	$_____
Widows Benefit	$_____
Orphans Benefit	$_____
Dividens and Interest *(incl. profit from rental income)*	$_____
Accident Compensation weekly payements	$_____
Income-in-kind *(value of company car, free housing etc.)*	$_____
TOTAL	$_____

Enter here

35-39

Question

I6. COULD YOU GIVE ME A FAIRLY ACCURATE ESTIMATE OF YOUR HUSBAND'S *(PARTNER'S)* GROSS PERSONAL INCOME - THAT IS BEFORE TAX AND OTHER DEDUCTIONS - FROM ALL SOURCES FOR THE TAX YEAR Ist APRIL I98I TO 3Ist MARCH I982, THAT IS THE LAST TAX YEAR ?

All the following elements should be included, use the list as a prompt, or to sum up elements.

Salary or wages	$_____
Student Bursary or Scholarship	$_____
National Superannuation	$_____
War Disablement Pension	$_____
Social Security Benefits :-	
Family Benefit	$_____
Unemployment Benefit	$_____
Domestic Purposes Benefit (DPB)	$_____
Emergency Maintainance allowance (EMA)	$_____
Sickness or Invalids Benefit	$_____
Widows Benefit	$_____
Orphans Benefit	$_____
Dividens and Interest *(incl. profit from rental income)*	$_____
Accident Compensation weekly payments	$_____
Income-in-kind *(value of company car, free housing etc.)*	$_____
TOTAL	$_____

Enter here

40-44

estion

17. *To those Married or Living Together only.*

HOW MANY OF THOSE PEOPLE YOU HAVE MENTIONED AS LIVING IN YOUR HOUSEHOLD ARE FINANCIALLY DEPENDENT ON YOUR HUSBAND *(PARTNER)* ALONE ?

Enter number [ ][ ] 45-46

I8. AND HOW MANY ARE PARTIALLY DEPENDENT ON YOUR HUSBAND *(PARTNER) ?*

Enter number [ ][ ] 47-48

GO TO Q.21

I9. *To Those Separated or Divorced only.*

HOW MANY OF THOSE PEOPLE YOU HAVE MENTIONED AS LIVING IN YOUR HOUSEHOLD ARE FINANCIALLY DEPENDENT ON YOUR HUSBAND / EX-HUSBAND EVEN THOUGH HE NO LONGER LIVES WITH YOU ? *Enter number* [ ][ ] 49-50

20. AND HOW MANY ARE PARTIALLY DEPENDENT ON YOUR HUSBAND / EX-HUSBAND ?

Enter number [ ][ ] 51-52

2I. HOW MANY OF THE PEOPLE LIVING IN YOUR HOUSEHOLD ARE FINANCIALLY DEPENDENT ON YOU ALONE ? *Enter number* [ ][ ] 53-54

2. AND HOW MANY ARE PARTIALLY DEPENDENT ON YOU ? *Enter number* [ ][ ] 55-56

Question

23. WHAT IS OR WAS YOUR USUAL PAID OCCUPATION ? COULD YOU DESCRIBE IT AS FULLY AS POSSIBLE _____ 57-58

24. AND ARE YOU DOING ANY PAID WORK AT PRESENT ? *YES 1* / *NO 2* 59

(if yes) HOW MANY PAID HOURS PER WEEK DO YOU WORK ?

Enter number 60-61

25. WHEN YOU BECAME PREGNANT WITH THIS BABY, WERE YOU DOING ANY PAID WORK ? *YES 1* / *NO 2* 62

(if yes) HOW MANY HOURS PER WEEK DID YOU WORK ? *Enter number* 63-64

SOLO MOTHERS ONLY GO TO Q.27

26. AND WHAT IS YOUR HUSBAND'S *(PARTNER'S)* OCCUPATION ? COULD YOU DESCRIBE IT AS FULLY AS POSSIBLE ? _____ 65-68

uestion

27. DID YOU GET ANY QUALIFICATIONS AT SCHOOL ? *YES 1* *NO 2*

69

(IF NO GO TO Q.28)

IF YES WHAT WAS YOUR HIGHEST QUALIFICATION ?

UNIVERSITY SCHOLARSHIP 01
UNIVERSITY 'A' OR 'B' BURSARY 02
HIGHER SCHOOL CERTIFICATE 03
HIGHER LEAVING CERTIFICATE 04
UNIVERSITY ENTRANCE 05
MATRICULATION 06
ENDORSED SCHOOL CERTIFICATE 07
SIXTH FORM CERTIFICATE IN 4 OR MORE SUBJECTS 08
SIXTH FORM CERTIFICATE IN 1, 2 OR 3 SUBJECTS 09
SCHOOL CERTIFICATE 10
3 OR MORE SUBJECT PASSES IN SCHOOL CERTIFICATE 11
1 OR 2 SUBJECT PASSES IN SCHOOL CERTIFICATE 12
OTHER QUALIFICATION 13 Specify _____

70-71

_____

28. HAVE YOU OBTAINED ANY ACADEMIC, PROFESSIONAL OR TRADE QUALIFICATIONS SINCE LEAVING SCHOOL ? *YES 1* *NO 2*

72

IF YES, WHICH ? *Enter details below*

	Full name of Qualification	*Field or Subject*	*Year Gained (if known)*
Qual.1	_____	_____	_____
Qual.2	_____	_____	_____
Qual.3	_____	_____	_____

73-76

77-80

81-84

Question 29. WHILE YOU WERE PREGNANT, WHICH OF THE FOLLOWING MEDICAL PEOPLE DID YOU RECEIVE CARE OR ADVICE FROM ? :-

Enter Yes 1
No 2
for each item

Private specialist Gynaecologist	85
Hospital Specialist Gynaecologist	86
G.P. practising Obstetrics	87
G.P. not practising Obstetrics	88
Hospital Registrar	89
Hosptial House Surgeon	90
Hospital doctor, designation unknown	91
Hospital Midwife	92
Hospital General Nurse	93
Hospital Enrolled nurse	94
Hospital Nurse, designation unknown	95
Practice Nurse	96
Hospital Physiotherapist	97
Hospital Dietition	98
OTHER specify _____	100

stion

30. DURING YOUR PREGNANCY, DID YOU RECEIVE INFORMATION / ADVICE FROM ANY OF THE FOLLOWING ORGANIZATIONS ? :-

Enter Yes 1
No 2
for each item

Parents Center .. .. [ ] 101

LA LECHE League .. .. [ ] 102

Homebirth Association of New Zealand .. .. [ ] 103

Pregnancy Help Inc. .. .. [ ] 104

Society for the Protection of the Unborn Child .. .. [ ] 105

OTHER specify _____ .. .. [ ] 106

APPENDIX II

QUESTIONNAIRE
SECTIONS 2 - 5

SECTION II - PREGNANCY EXPERIENCE

THANK YOU - THAT COMPLETES THE QUESTIONS ABOUT YOUR PERSONAL DETAILS. NOW I'D LIKE TO ASK YOU ABOUT YOUR EXPERIENCES WHILE YOU WERE PREGNANT WITH .....*(name of baby)*

WHEN YOU FIRST KNEW YOU WERE PREGNANT, HOW DID YOU FEEL ABOUT THE IDEA ?
Did getting the pregnancy confirmed make any difference ?

Changes Envisaged

Personal
Were there changes in your life that happened straight away ? - did you expect future changes ?
Can you remember how you felt about that ?
(giving up work)

Family
What about changes in the family's way of life ?
Did you have any particular concern about the effects of a baby on the family or any member of the family ?
If yes and what happened about that ?

Practical Problems
Did you have any worries about practical matters ?

Housing ?
Money ?
Transport ?
What happened about that ?
Would you have liked help advice about that ?

Question

4. Medical Concerns — Did you have any worries or concerns about the medical aspects of your pregnancy ?

Personal health ?
Type of Care
Labour or Delivery ? — What happened about that ?
Would you have liked help or advice about that ?

5. Choice of Hospital — Did you choose the hospital where you had ..... ? *name of baby.*

Chose hospital — Can you tell me why you chose this particular hospital ?
Would you choose it again ?
Go to Q. 6

Didn't choose hospital — Can you tell me why this was ?

No other hospital ?
Dr delivered there ?
other reason ?
How did you feel about that at the time ?
and now ?
If you had a choice in the future would you choose that hospital ? *if no* Where would you have another baby ?

stion

6. Choice of Doctor — Did you choose the doctor you had ?

Chose doctor — Could you say why you chose this particular doctor ? - was there any special reason ?
Did you consider any other doctor ?
Would it have mattered to you if you had not been able to choose your doctor ?
Go to Q. 7

Didn't choose doctor — Why weren't you able to choose your doctor ?
Did it matter to you that you had no choice ?
Would you have liked to have had another doctor at the time ? *if yes details.*
Go to Q. 7

No doctor care — Can you tell me how you came to have no doctor care while you were pregnant ?
What are your feelings about that ?
If you had another baby what would you do about medical supervision ?

Question

7. Attitude towards doctor and Doctor's Care

Now I'd like to ask you a bit about your doctor and the medical care you had while you were pregnant.

Those who had care from hospital only go to Q. 8

Sex of doctor ?

Was you doctor male or female ?
How did you feel about that ? - did you have any preference ?

Interaction ?

How did you get on with him / her ?
Was there anything you particularly liked about your doctor ? - anything you disliked or put you off ?

Attitude to doctor's Role ?

For you, what were the main advantages of your visits to the doctor ?
Were there some things about your pregnancy that only the doctor could help with ?
Did you feel that all your visits to the doctor were helpful to you ?
How do you think the doctor regarded you as a person - what impression did you get from the way he / she treated you ?

Attitude to role of self as patient ?

Can you remember whether you ever felt you would have liked to ask the doctor about something but didn't ?
On your visits, what did you talk to your doctor about ? - and what did he talk to you about ?
Did you talk about the labour and delivery ?
If no why was that ?

stion

7. continued *Summary* Can you sum up by saying what is the most important thing you expect from your doctor, when you are pregnant ?
Would you recommend your doctor to a friend who was pregnant ? - Can you say why?
Go to Q. 9

8. *THOSE WHO RECEIVED PREGNANCY CARE FROM HOSPITAL ONLY*

Did you see the same doctor at each hospital visit ? *if yes, go back to Q. 7.*
if no, continue.

Continuity of Care ? Can you remember how many different doctors you saw while you were pregnancy ?
How did you feel about that ?

Sex of doctor ? Were they male or female ? did this make any difference to you ? - did you have a preference ?

Interaction ? How did you get on with them ?
Was there anything you particularly liked about them ? any of them ?
Was there anything you disliked or put you off about them ? any of them ?

Attitude to doctors Role For you what were the main advantages of your visits to the clinic ?
Were there some things about your pregnancy that only a doctor could help with ?
Did you feel that all your visits to the clinic were helpful ?

Question	
8. continued	How do you think the doctors regarded you as a person - what impression did you get from the way they treated you ?
Attitude to role of self as patient ?	Can you remember whether you ever felt you would have liked to ask the doctors about something but didn't ? On your visits what did you talk to the doctors about ? - and what did they talk to you about ? Did you talk about labour and delivery ? *if no,* why was that ?
Summary	In your opinion, how would you describe the medical care you received during your pregnancy - in general ? Can you sum up by saying what is the most important thing you expect from the doctor when you are pregnant ?
	If you had a friend who was pregnant, would you advise her to have the same medical care that you had ?

uestion

9. Attitude towards nurse and nurse's care

Now I'd like to ask you about the nurses you had while you were pregnant.

No care or advice from nurses go to Q.12.

Contacts with Nurses

Let me just check now you saw.....
list number of nurses seen as in Q.29,Sec.1.

One nurse only go to Q.11.

How did you come to have care or advice from these particular nurses ?
Did that suit you ? *if not,* what would you have preferred ?

Interaction ?

How did you get on with them ? - was there anything that you particularly liked about them ? any of them ?
And anything that you disliked or put you off about them ? any of them ?

Attitude to nurses'Role ?

Was one type of nurse more helpful to you personally than another ? Can you say why ?
Did you think all your visits to the nurses were useful / helpful to you ?
What were the main advantages of the visits?
Were there things regarding your pregnancy that only the nurses could help you with ?
How do you think the nurses regarded you as a person - what impression did you get from the way they treated you ?

Attitude to role of self as a patient ?

Can you remember whether you ever felt you would have liked to ask the nurse(s) about something but didn't ?

Question

9. continued

On your visits to the clinic or the nurse, what were the sorts of things you talked about ? Did you talk about labour and delivery ? Can you remember whether you talked to the nurse about some things that you didn't talk about to the doctor ? - why was that ?

Summary

In your opinion, how would you describe the care you received from the nurses while you you were pregnant in general ?
Can you sum up by saying what is the most important thing you expect from the nurse when you are pregnant ?

If you had a friend who was pregnant, would you advise her to have the same nurses ?

10. *TO THOSE WHO WENT TO FORMAL ANTE NATAL CLASSES ONLY (others go to Q.13.)*

Can you remember what made you decide to go to the ante natal classes ?
What were the main advantages of the classes ?
And the disadvantages ?
Ideally, was there anything about the classes that you think could have been improved ? For example, did you get all the information you wanted or needed ? *PROBE* Did you ask questions ? (if not) why not ? etc.

uestion

II. *THOSE WHO SAW ONE NURSE ONLY*

Why did you have that particular nurse ?
Did it suit you ? *if not,* what would you have preferred ?

Interaction ?

How did you get on with her ?
Was there anything that you particularly liked about her ?
Anything you disliked or put you off ?

Attitude to Nurse's Role ?

Did you think all your visits to her were useful ?
What were the main advantages of the visits ?
Were there things regarding your pregnancy that only she could help you with ?
How do you think she regarded you as a person ? - what impression did you get from the way she treated you ?

Attitude to role of self as a patient ?

Can you remember whether you ever felt you would have liked to ask her about something but didn't ?
What sorts of things did you talk about on your visits ?
Did you talk about labour and delivery ?
Can you remember whether you talked to the nurse about some things that you didn't talk to the doctor about ? - why do you think that was ?

Summary

How would you describe the care / advice you received from her in general ?
Can you sum up by saying what is the most important thing you expect from the nurse when you are pregnant ?
If you had a friend who was pregnant would you advise her to see the same nurse ?

Question

I2. *TO THOSE WHO HAD NO CARE OR ADVICE FROM NURSES DURING PREGNANCY.*

DID YOU CHOOSE NOT TO SEE ANY NURSES DURING YOUR PREGNANCY ? *if yes continue.*

if no, go to section below - no nurse available.

Can you say why you felt it suited you not to see any nurses ?
Would you do the same in a future pregnancy ?
Would you recommend a friend who was pregnant, to do the same ? *Go to Q.13.*

No nurse available

Why was no nurse available ?
How did you feel about that at the time ? and now ?
Ideally, what would you have liked in the way of nurses' services ?

I3. *TO THOSE WHO WENT TO A PRIVATE ORGANIZATION FOR SOME ANTE NATAL CARE OR ADVICE.*

Can you tell me your reasons for going to.....
*name of organization - refer back to Q.*30. Sec. 1
How did you get on with the people there ?
Was there anything you particularly liked about them ?
And anything you particularly disliked or put you off ?
What were the main advantages of your visits ?

:stion

13.continued.

How do you think they regarded you as a person ?
- what impression did you get from the way they they treated you ?

Can you remember whether you talked to them about things that you didn't talk about to the doctor ? *or nurse ?*

How would you describe the care / advice you received from..... in general ?

If you had a friend who was pregnant, would you advise her to go to the same organization ?

SECTION 111 - LABOUR EXPERIENCE

NOW I'D LIKE TO ASK YOU ABOUT YOUR LABOUR. CAN YOU REMEMBER WHEN IT STARTED ?

PROMPT - and then what happened ? allow mother to relate details spontaneously, prompt where necessary to ensure following points are covered ?

Question	
1. Onset of Labour	
Spontaneous ?	How did you know you were in labour ?
How confirmed ?	
Admission prior to labour ?	Do you know why you were admitted before you started labour ? - how did you feel about that ? *Go to Q.5.*
2. Support During Early Labour	Who was with you at the beginning ? Was this helpful / not helpful ?
3. Duration of Labour at Home	How long were you in labour at home ?
Admission decision.	Who decided when you should go to hospital ?
Household Arrangements	Did you have to make any special arrangements before you went into hospital ? any difficulties with this ?
4. Transport	How did you go to hospital ? was this satisfactory ?
Escort ?	Who went with you ?

uestion	
5. Pre-admission Expectations	Can you remember how you felt about the thought of going into hospital ? - did you have any particular worries or fears ?
6. Admission Reception	And what happened when you arrived at the door of the hospital ?
Admission procedure Difficulties ?	Can you remember anyone or anything being particularly helpful ? - or particularly unhelpful ?
Staff attitude to Escort ?	Did you notice how the staff got on with .....*? name of escort* how do you think they regarded him *her ?*
7. Prep. Procedures	Did you have any prep. procedures ? *Prompt with list if necessary ?*
Enema / suppos ?	*ask of each :*
Shave ?	What did you think of that ? *probe if*
Bath / shower ?	*necessary,* what did you like about it ?
Hospital gown ?	what didn't you like about it ?
8. Internal exams	Did you have any internal exams ?
Number ?	Can you remember about how many ?
By whom ?	Who did the examinations ?
Permission ?	Were you asked to agree to the examinations ?
Explanation	Were they explained to you ?
Attitude	How do you feel about internal exams ? *probe if necessary ?*
9. Intervention ?	
A.R.M. ?	What was done to start your labour ? Was it explained ? did you feel you understood ? How did you feel about it ?

Question	
9. continued.	
Syntosin augmentation ?	Was anything done to speed up your labour ? Did you feel you understood what this was ? Was it explained ? - did you ask ? How did you feel about having syntosin at the time ? and now ?
Monitor ?	Did you have a monitor for the baby or your self ? - how did you feel about that ?
10. <u>Staff - Patient Interaction</u>	
Own doctor	When did you first see your own doctor after you were admitted ? - how did you feel about that ?
Other doctors ?	Did you see any other doctors during your labour ? can you tell me about that ? Did you know who they were ?
Nurses	Can you remember how many nurses looked after you during labour ? Did you know them ?
Evaluation of relationships	Of the doctors and nurses that you saw during labour, who was the easiest to talk to ? And who was the hardest ? Why do you think that was ? Who was the most helpful ?
Information	How much did you know about what was going on ? Who gave you the most information ? Did you ever ask for an explanation of something or why something was being done ? Did you ever feel you wanted to ask something but didn't ?

stion

10. continued.

How did you feel about explanations that you were given ? or reasons why something was done ?

Decision making

Who made most of the decisions about what to do or what was to happen during your labour ?
How did you feel about that ?
Did you ever feel under pressure to agree to something ?

Summary of staff Relations

Have you any general comments on your relationship with the staff, - how you got on with them ?
Can you think of any changes in the way staff do things or say things that might make it better for other mothers ?

11. Pain

NOW I'D LIKE TO ASK YOU A BIT ABOUT PAIN.
How did you find the pain during labour ?
What helped ? What didn't help ?

Staff Attitude

What did the staff think of your pain ?
Did you get any impressions from the way they acted or what they said ?

Analgesia

Were you given anything for the pain ?
Can you tell me about that ?

yes *Probe for circumstances - staff / patient pressure, consultation ? staff / patient reluctance ? epidural ?*

no Why was that ? How did you feel about that ?

Attitude

What would be your ideal method of pain relief in a future pregnancy ? Did you know about epidurals ? how ?

Question

12. Labour Ward / suite Environment

Can you tell me what the room was like, that you were in during labour ? Did it suit you ? Do you think it had any effect on how you felt during labour ?

How did you pass the time during labour ?
Do you remember anything about the rest of the labour ward ? were there other women in labour ?
Were there facilities for drinks etc for you ?
for .....?.*escort*
What was your general impression of the place ?

13. Summary of Labour Experience

Looking back, how would you describe your experience of labour ?
Can you think of any particular reason for this ?
What do you think of your part in it ?

SECTION 1V - BIRTH EXPERIENCE

COULD YOU NOW TELL ME ABOUT THE FINAL STAGE OF LABOUR AND THE BIRTH OF.....
.....*name of baby,* CAN YOU REMEMBER HOW LONG YOUR LABOUR WAS ?

estion		
1.	Commencement of the Second Stage	How long were you in labour before you started pushing ? What stage were you at when you were moved to the delivery room ? *if moved.*
2.	Delivery Room Environment	Can you describe how you felt when you were moved ? What was the delivery room like ? - what did you think of it ? Were there different staff there ? did you know them ?
3.	Position for Delivery	What happened when you arrived in the delivery room ? When were you moved to the delivery table / bed? What did you think of the bed ? How were you positioned for the birth ? - was that your idea ? how did you feel about it ? *probe - did you say anything ?*
4.	Analgesia	Did you have any pain relief in the delivery room ? what did that do ?
	Epidural ?	
	yes	Can you tell me what it is like to give birth under a epidural (spinal) anaesthetic ? Would you have it again ?
	No	Would you have liked an epidural ? Did you ask ?

Question

5. Companion at Birth — Was anyone besides staff with you at the birth ?

Yes — Did it make any difference to you having him *her* with you ?
Do you know how he *she* was feeling at the time
How about the staff - how did they feel about h *her* being there ?

No — *GENTLY* Can you tell me why that was ?

Own Request / *Partner refused* / *Unable to be there* — Any special reason ? *GENTLY* How did you feel about that ?

6. Accoucheur — Was it your own doctor or someone else who delivered you ?

Own doctor — Do you think it made any difference to you having your own doctor ?

Another doctor — How did you come to have this doctor ?
Did you know him *her* ?
Did having that doctor make any difference to you ? - ideally, what would you have liked ?

Nurse — How did you come to have a nurse delivering you ?
Did it make any difference to you - ideally, what would you have liked ?

7. Intervention — Was anything done to help the baby out ?

Episiotomy ? — Did you know about episiotomies ? - how ?
Did you expect to have one ?
Was it explained - what it was ? why you were having it ?
How did you feel about having it then ? and now ?

uestion

7. Continued	*Forceps ?*	Did you know about forceps ? Did you expect to have them ? Was it explained - what it was - why you were having them ? Can you describe what it was like ? How did you feel at the time ? and now ?
8. Moment of Birth		Can you describe in your own words how you felt as the baby was being born and how you when you first saw him / her ? And what was .....*'s* reaction ? *person accompanying.* And what was the reaction of the staff - can you remember ?
9. First Contact with the Baby		How long after the birth were you first able to hold the baby ? *before or after cord cut ?* When did ..... *person accompanying* first hold the baby ? Was the baby put to the breast in the delivery room ? *if yes whose idea ?* did that suit you ?
10. Personal Satisfaction		What were your feelings about yourself once the baby had been delivered ?
11. The Baby		How was the baby when he *she* was born ? Did any of the staff say anything about his *her* condition ? *what happened ?*
	Baby not well	Did you feel you understood this at the time ? *GENTLY* Do you think the staff could have done or said anything else at the time that would have helped ? Did you or .....*companion* ask any questions ?

Question		
11.Continued	*Separation from Baby*	How long was the baby with you after the birth ?
	In delivery Room	Why was the baby taken away at that time ? How did you feel about it ? When did you next see him *her* ?
	Post delivery Room	How did you feel about the baby being moved from you then ? When did you next see him *her* ?.how did you feel about that ?
12. Third stage		Now, a bit more about you again. Did you have any problems with the delivery of the placenta ?
	Suturing ?	How about when the stitches were put in - how was that ?
	Complications ?	Anything else happen to you apart from being tidied up ?
	Leaving the Delivery Room	When were you moved from the delivery room ? Where did you go ? Who was with you
	Relaxation & Recovery	Did you have an opportunity to be with ..... *companion* in private to relax and recover - talk things over, have a cup of tea etc. *baby present ?* How did you feel about that ?
13. Summary of Birth Experience		What were your general feelings about the birth ?
	Participation of self ?	How do you feel about your part in it ?
	Staff ?	How do you feel about the the staff who were involved in it ? - was anyone particularly helpful or unhelpful ?

Question

13. continued *Improvements ?* Was there anything about the delivery that you think could have been done differently to suit you better ?

14. CONCLUDING COMMENTS ABOUT LABOUR AND DELIVERY

Multiparas

How did this labour and delivery compare with your past experience ?
What would you say was the main reason for this ?
What were the best aspects of this time ?
And the worst ?

Primiparas

In general was having a baby anything like you expected ?
What were the best aspects of it in your view ?
And the worst ?

SECTION V - POST NATAL EXPERIENCE

NOW I'D LIKE TO ASK YOU ABOUT THE REST OF YOUR STAY IN HOSPITAL.

Question

1. Post Natal Accomodation — When were you moved to the post natal ward ? - did that suit you ?

   Room — Can you describe the room *or rooms* you had ? How did this suit you ? Did you have a choice ? *if no,* would you have liked something different ? - did you ask ? - what happened ?

   Ward — What was the rest of the place like ? What were the best things about it ? And the worst ? Ideally, would you have liked something different ?

2. Physical Condition — Can you describe how you were feeling physically in the first 24hrs ? and later ?

   Pain ? — Did you have any particular pain or discomfort ?

   Analgesia ? — How was this treated ?

   Sleep & Rest — How do you feel about the amount of sleep and rest you got ? What helped ? What didn't help?

3. Medical & Nursing Care

   Doctor(s) — How would you describe your doctor's care of you in hospital ? Can you remember how often you saw him *her ?*

   Nurses — How would you describe the nurses' care of you

Question

4. Interaction with Baby — Can you describe your feelings towards the baby at first ? and later ?

Degree of Contact — Over your stay in hospital, when was the baby with you and when was he *she* apart from you ?

Full rooming in 01
Day rooming in 02
In only for feeds 03
Never in room 04
Other 05 _____ *specify* | | |

Choice ? — Were you able to choose the amount of contact you had with your baby ?

No — Can you say why this was ?

Mother/baby ill — *GENTLY* Did you feel under the circumstances you had as much contact as was possible ? Would anything have improved the situation for you ?

Hospital / doctor Regulation — How do you feel about having no choice ? Would you have liked different arrangements ? Did you say anything ? - what happened ?

5. Feeding — Can you now tell me something about your experience of feeding your baby in hospital ?

Method — Did you breastfeed or bottlefeed ?
Before the baby was born did you have a preference ? - did anything in particular influence your decision ?
Were you able to carry out your wishes ? - *for a while - not at all ?*

Question

5.continued. *First 24 hours* How was the baby fed in the first 24 hours ?

Breastfed throughout stay in hospital

Let me just check now, how long after birth before he *she* was put to the breast ? *What did you think of that ?*

Demand / Schedule ?

Who decided when the baby was to be fed ?
And what was that ? *demand / schedule ?*
How did this suit you and the baby ?

Clinical Problems ?

Did you have any problems with your breasts or other problems that interfered with breastfeeding ?
Did the baby have any problems that hindered feeding ? *Jaundice ? etc.*

Emotional Attitude

Would you say breastfeeding was easy or difficult for you in hospital ?
What do you think were the main reasons for this ?
What were the best things about breast-feeding ? And the worst ?

Staff Supervision ?

What did you think of the supervision, advice or instructions you were given in hospital ?
PROBE what was helpful and what was unhelpful

Areas for improvement ?

Can you think of anything that would be more helpful to mothers breastfeeding in hospital

Changed to Bottlefeeding in hospital

GENTLY What were your feelings about changing to bottlefeeding at the time ? - and now ?
Who decided the change ?
Was there a special reason for the change ?
What would you do another time ?
Who or what was helpful ? - unhelpful ?

tion

5.Continued

Bottlefed	*GENTLY*	Did you choose to bottlefeed your baby ?
Yes	*GENTLY*	Can you say why bottlefeeding suited you best ? Did anyone ever say anything about your decision ? what did you think of that ?
No	*(clinical reason)*	Did you have any particular feelings about bottlefeeding at the time ? Who or what was helpful ? Who or what was not helpful ?
Demand / Schedule ?		Who decided how often the baby was to be fed ? - and what was that ? How did this suit you and the baby ?
Clinical Problems ?		Did the baby have any problems that hindered feeding ? *Jaundice ?* *if problems probe - what happened about that ?*
Emotional Attitude		Can you say whether you found feeding easy or difficult in hospital ? What do you think were the main reasons for this ?
Staff Supervision		What did you think of the supervision, advice or instructions you were given ? *PROBE what was helpful - unhelpful ?* How did you feel about the instructions for making the feeds ? Were you recommended a particular brand of milk powder ? did you in fact use this at home ?

Question		
5.Continued	*Baby in NNU.*	*GENTLY* When did you first feed the baby ? What was that like ? Did having the baby in the NNU affect feeding ? Did you get help with this ? What were the staff in the unit like ? Who gave you the most help / support And the least ? What would you say about the unit ? *what did you like about it what didn't you like ?* Can you think of anything that would be more helpful for mothers in the same position as you ?
6.	Emotional wellbeing	Now I'd like to know a little about your moods while you were in hospital. How would you describ your mood while you were in hospital - in general Was this different from your normal mood ? What do you think were the main reasons for this *PROBE* Anything about :- *Staff* *Hospital* *Baby* *Family* *Physical condition* *Previous experience* *Your feelings about yourself* that affected the way you felt ?
7.	Contribution of Hospital to Quality of Childbirth Experience	Looking back over your whole stay in Hospital, how would you sum up your experience of childbirth - in general ? *if hesitant I mean in a few words ?*

tion

7.Continued

Was this due in any way to the particular hospital where you had the baby ?

If no You think then this would have been so in any hospital ?

If yes What do you think were the main things about the hospital that affected you ?

Would you advise a friend to have her baby there ?

If no Where would you advise her to go - why is that ?

. Going Home

Can you remember when it was about time to go home how you felt ?
Who decided the actual day ? *how did you know you were going home ?*

Satisfaction with Length of stay ?

Did you feel the length of stay suited you ?
How long would you stay another time ?

Confidence on Discharge ?

When you knew you were going home, how did you feel about being at home alone (?) with the baby ?

if nervous

Was there anything in particular you were worried about ?
Did you meet the Plunket or Public Health nurse before you were discharged ?
Can you think of anything that the hospital could have done to make going home easier ?
Looking back do you think that there was some advice or information that you needed but didn't have ?
Did you feel that there was always someone you could contact if you were worried about something ?

Question		
9.	The Past Five Months	Finally, can you tell me how things have been over the past five months ?
	Emotional and Physical State	How has your health been ? And your mood ?
	Easy / Difficult Baby ?	What kind of baby is.....*? name*
	Support systems	Have you needed any help or advice about yourself or the baby since you have been home ?
	if yes	Did you get it ? who from ? did it help ?
	Hospital influence on outcome ?	In your opinion, would you say your experience in hospital has anything to do with the way things have been at home ?

APPENDIX III

BARRINGTON-GRAY CLASSIFICATION OF SOCIAL CLASS FOR NEW ZEALAND WOMEN

UPPER MIDDLE CLASS

1. Women with University Entrance or higher, and husband's (or rank 2 father's) occupation ranked 1 or 2 on the Elley-Irving scale.

2. Women with University Entrance or higher, and own occupation ranked 1 or 2 on the Irving-Elley scale.

MIDDLE CLASS

1. Women with no educational qualifications, and husband's (or rank 1 father's) occupation ranked 1, 2 or 3 on the Elley-Irving scale.

2. Women with School Certificate, and husband's occupation ranked 2, 3 or 4 on the Elley-Irving scale.

3. Women with University Entrance, and husband's (or rank 1 father's) occupation ranked 3 or 4 on the Elley-Irving scale.

4. Women with School Certificate, and own occupation ranking 3 or 4 on the Irving-Elley scale.

WORKING CLASS

1. Women with no educational qualifications and husband's occupation ranked 4, 5 or 6 on the Elley-Irving scale.

Source: Gray (1981)

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APPENDIX IV

MEDICAL PROCEDURES CLASSIFIED AS 'INTERVENTIONS' [1] AND RATES REPORTED BY THE STUDY WOMEN (Percentage)

MEDICAL PROCEDURE	RATE
Artificial Rupture of Membranes	71 [2]
Episiotomy	38
Electronic Fetal Monitoring	25
Intravenous Syntocinon	17
Forceps Assisted Delivery	15
Epidural Anaesthetic	8

1. Procedures such as the giving of oxytoxic drugs to expedite expulsion of the placenta, perineal shaving and vaginal examinations were not included, as such procedures appeared to be routine practices for all birthing women.

2. Includes 15% where procedure was part of induction process.

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APPENDIX V

HAVING A BABY

THE EXPERIENCE FROM THE MOTHER'S POINT OF VIEW

My name is Anne McSherry. Thank you very much for agreeing to take part in the study.

This study is sponsored by the Medical Research Council. One of the Council's concerns is that maternity services in New Zealand are as good as possible and meet mothers' needs as far as possible. This particular study looks at these issues from the mother's point of view.

Having a baby is a very personal affair and no two experiences are exactly the same. By asking a lot of mothers how they felt, what were the things that helped or didn't help, what pleased or didn't please them about their maternity care, I hope to be able to point out what mothers really feel about having a baby and what things are important to them.

No personally identifiable details will be passed on to any other person or agency in any circumstances.

Of course you are not obliged to take part in the study but hearing about your experience would greatly assist the study.

The study will form part of my Masters Degree at Massey University but I also expect to publish the findings so that mothers' opinions are made widely known.

My telephone number is Rongotea 776

Please call (collect) if you have any questions at all.

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APPENDIX VI

THE PARTICIPANTS*

BASE HOSPITAL SAMPLE

Sandra	26 years	Working Class	Married	One Child
Barbara	21 years	Middle Class	Married	One Child
Linda	22 years	Working Class	Married	One Child
Brenda	25 years	Working Class	Married	One Child
Janice	18 years	Working Class	Single	One Child
Wendy	20 years	Working Class	Married	One Child
Trudy	31 years	Upper Middle Class	Married	One Child
Raewyn	23 years	Middle Class	Married	Two Children
Jenny	31 years	Middle Class	Married	Two Children
Eve	29 years	Middle Class	Married	Two Children
Debbie	27 years	Working Class	Married	Three Children
Jill	26 years	Middle Class	Married	Two Children
Lorna	33 years	Upper Middle Class	Married	Four Children
Heather	23 years	Middle Class	Married	Three Children
Katrina	28 years	Middle Class	Married	Three Children
Janine	34 years	Middle Class	Married	Three Children
Jane	34 years	Upper Middle Class	Married	Three Children
Maureen	33 years	Middle Class	Married	Five Children
Susan	27 years	Working Class	Married	Two Children
Jacqui	30 years	Middle Class	Married	Two Children
Penny	23 years	Middle Class	Married	Two Children
Clare	28 years	Upper Middle Class	Married	Two Children
Karen	32 years	Working Class	Married	Two Children
Judy	33 years	Working Class	Married	Two Children

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LOCAL HOSPITAL SAMPLE

Carolyn	25 years	Middle Class	Married	One Child
Yvonne	21 years	Working Class	Married	One Child
Julie	20 years	Working Class	Married	One Child
Tracy	27 years	Working Class	Married	One Child
Angela	27 years	Middle Class	Married	One Child
Paula	19 years	Middle Class	Single	One Child
Sally	34 years	Upper Middle Class	Married	Five Children
Celia	30 years	Upper Middle Class	Married	Four Children
Liz	32 years	Middle Class	Married	Four Children
Donna	32 years	Middle Class	Married	Three Children
Diane	29 years	Middle Class	Married	Three Children
Robyn	34 years	Middle Class	Married	Three Children
Lynn	28 years	Working Class	Married	Three Children
Michelle	30 years	Middle Class	Married	Two Children
Joanne	27 years	Middle Class	Married	Two Children
Philippa	30 years	Middle Class	Married	Two Children
Bronwyn	32 years	Middle Class	Married	Two Children
Kirsty	23 years	Middle Class	Married	Two Children
Lisa	27 years	Middle Class	Married	Three Children
Stephanie	31 years	Middle Class	Married	Three Children
Vickie	27 years	Working Class	Married	Two Children
Alison	30 years	Middle Class	Married	Two Children
Rosemary	36 years	Middle Class	Married	Three Children
Lorraine	36 years	Working Class	Married	Four Children

*** The Participants' names are pseudonyms**

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