

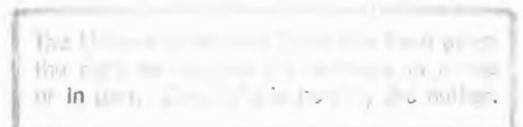
MEDICALISED MATERNITY

AN INVESTIGATION INTO WOMEN'S EXPERIENCES OF MEDICALISED CHILDBIRTH

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for the degree of Master of Social Science (Sociology).

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ABSTRACT

This dissertation reports on a qualitative study of the childbearing experiences of 20 women having their first child. The study attempts to examine the dominant discourses surrounding pregnancy, childbirth and motherhood, with specific reference to the medical discourse, and to describe the way in which these impact on the women's experiences.

The non-probability, convenience sample used in the study comprised women attending an antenatal class held at a Cape Town private hospital. The sample was relatively socially and medically homogeneous. The size and nature of the sample makes broad generalisations tentative.

Individual interviews based on in-depth and open-ended questions were conducted. These were aimed at gathering qualitative data on the women's perceptions of their experiences. The women were interviewed during the last trimester of pregnancy about their experiences of pregnancy and their anticipation of childbirth. A further interview conducted a few weeks after birth focused on their experience of childbirth within the hospital setting and their impressions of early motherhood.

It was found that the women's accounts of their experiences of pregnancy, childbirth and early motherhood were shaped to a large extent by the discourses within which the process of childbearing has been constructed. These include the medical, 'natural' birth and feminine discourses. The dominance of the medical discourse of birth was evident in the fact that the medical view was thoroughly incorporated into the women's perceptions of their childbearing experiences. This view of birth, along with the dominance of scientific medical knowledge, was found to limit the perception of acceptable birthing practice.

The medical discourse intersected with both the 'natural' birth discourse which, as a social construction, was shown to uphold essentialist and prescriptive notions of motherhood, and the feminine discourse. This discourse, along with its assumptions regarding the mothering role, was found to impact on the women's experiences through the creation of unrealistic expectations and ideals, which contributed to the shock and stress of first-time motherhood.

CONTENTS

Abstract

Acknowledgements

Chapter 1: Introduction	1
Chapter 2: Contextual Framework	8
Chapter 3: Methodological Considerations	27
Chapter 4: The Experience of Pregnancy	38
Chapter 5: The Experience of Childbirth	69
Chapter 6: The Experience of Motherhood	123
Chapter 7: Conclusion	144
Appendix A: Interview Schedule	161
Appendix B: Price lists of private hospital services	164
Appendix C: Cost analysis of a typical natural delivery at a private hospital	166
Appendix D: Glossary of relevant medical terms	167
References	169

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CHAPTER 1

INTRODUCTION

Treichler (1990:113-4) refers to a current 'childbirth crisis', particularly in America and Britain, which involves significant challenges to long-standing, medically managed, hospital-based childbirth. Widely accepted practices and assumptions have been called into question and women have expressed dissatisfaction with traditional obstetric care and called publicly for alternatives. In connection with this, Foster (1995:41) has pointed, with alarm, to a dramatic rise in the Caesarean rate in America and Britain over the last two decades. The Caesarean rate of a country may be regarded as a useful indicator of the extent of medical intervention in the birth process. In Britain, the national Caesarean rate was around 13 percent in 1992, nearly three times the rate of 4,9 recorded in 1970. America's Caesarean rate is even higher, at about 24 percent in the mid-1980s. In comparison, South Africa's Caesarean rate is currently over 50 percent and is still growing (Lilian, 1996:155). In view of this, the state of childbirth in South Africa is of considerable interest as an area of investigation. Lilian (1996:155), a qualified midwife and journalist, expresses alarm that there is not more of an outcry about the South African situation. She questions whether it is correct to perform a Caesarean for an apparent complication that clinics, birthing centres and homebirth practitioners the world over have dealt with in a non-surgical way and with great success. She cautions women selecting a doctor to ascertain his/her Caesarean rate. A rate of more than 10 percent, in her opinion, might indicate, at best, that the doctor is more versed in emergency procedures than in supporting the natural process or, at worst, it might mean that s/he actually directs things along an interventionary path, all at the woman's physical, emotional and financial expense (Lilian, 1996:81).

A further issue with regard to South Africa, is that large socio-economic discrepancies have given rise to large discrepancies in terms of the quality of health care received. This means that while women able to attend private hospitals for the delivery of their babies are subject to extremely high rates of medical intervention, poorer women have limited access to basic antenatal and obstetric care.

It cannot be denied that childbirth has been situated within the context of a male dominated medical profession within a strongly patriarchal society and that technologies used in childbirth, as with all technologies, derive their meaning from the social and political context in which they are embedded. Nor can the very real iatrogenic dangers of the use of unnecessary medical procedures and technologies be denied. However, at the same time, it is clear that medical advances, in most cases made by men, have saved lives and in critical situations, where their use is warranted, they have been invaluable. The point is not that technological intervention is never appropriate, but that the existence of sophisticated technology does not mean that it must always be used.

Martin (1989:13) has cautioned that in criticising many central ideas in medicine, doctors as individuals should certainly not be held solely responsible. Medical culture has a powerful system of socialisation which extracts conformity as the price for participation. It is also a cultural system whose ideas and practices pervade popular culture and in which we all participate to some degree. Riessman (1992:123) adds to this that women should not be regarded as simply passive victims of medical ascendancy. To cast them solely in the passive role is to perpetuate the very kinds of assumptions about women that feminists have been trying to challenge.

THE MEDICALISATION OF LIFE

Medicalised childbirth may be situated in the context of what several writers have referred to as the 'medicalisation of life'. This is where more and more critical events and human problems are coming under medical inspection. For example, alcoholism, drug use, violence, sleeping patterns and learning difficulties are considered proper subjects for medical attention (Jordan, 1993:49). Other areas such as weight and beauty are also burgeoning medical industries. The medicalisation of life is particularly evident with regard to women, where normal, physical functions in women such as menstruation, reproduction, menopause and ageing are being understood and treated medically. Riessman (1992:124) argues that through the process of medicalisation, the experience of these events and conditions has been transformed. She adds that the medical profession's jurisdiction over these human conditions extends considerably beyond its demonstrated capacity to 'cure' them.

Writing in Britain, Stacey (1992:16) argues that the fallibility of scientific and medical judgement has become apparent. No longer does the majority unequivocally believe in progress or that science is the main agent of progress. In South African society, medicine has been glorified and doctors have been afforded a high status. The social dynamics of the medical profession have not been questioned to the extent they have been in both Britain and America.

CHILDBIRTH AS A SOCIAL CONSTRUCTION

Childbirth is both biological and social. As a social construction, it has been widely demonstrated that birth can take many forms, depending on the values held by a society, as well as the meaning

attached to childbearing and the status of women as childbearers. The rules governing the practice of birth in a society specify the location of birth, the kinds of birth attendants, the nature and extent of intervention in the birth process and the behaviour that is deemed acceptable during labour. The variability of birthing practices, explored by writers such as Jordan (1993), reveals the extent to which the treatment of birth in Western society as a medical event is only one way of looking at birth.

RESEARCH AIMS

The present research starts from the premise that the medical management of reproduction effects the meaning of reproduction and maternity to women. The main research aim is to examine the discourses surrounding pregnancy and childbirth, with particular reference to the medical discourse, and to investigate the ways in which these influence and determine women's experiences of pregnancy, childbirth and early motherhood.

The transition to motherhood is a key phase in most women's lives, bringing about substantial changes in their life-styles and identities. These changes are augmented by the fact that women do not simply give birth physically to a child, but rather they give birth within a specific social context, which encompasses a set of definitions of the mothering role. Childbirth is then constructed not only in terms of the medical discourse, but also the discourse of femininity and its corresponding assumptions and expectations about the mothering role. In the discourse of femininity, motherhood is culturally equated with the achievement of female identity and regarded as the ultimate fulfilment for women. In view of the role played by the feminine discourse in the experience of childbirth and motherhood, an examination is necessary of the

interrelationship between the stereotyping of women as maternity cases, within the medical discourse, and general social ideologies of women.

With regard to the medical discourse, part of the interest in pregnancy and childbirth as a field of study is that the medicalisation of these events implies the paradox of healthy people being subjected to medical control. Relevant here is Parson's (1963) discussion of the 'sick role' as a mechanism for social control. While pregnancy is medicalised, the pregnant woman does not fit the characteristics of people belonging to the sick role. The obligations attached to the sick role are to get well as soon as possible, to seek technically competent help and cooperate with medical authority. The corresponding rights are the exemption from normal social role obligations and from the responsibility for one's own state. Pregnant women are, however, not exempt from normal social role obligations and 'curing' is not an aim of the medical care they receive (Oakley, 1980:82).

Drawing on Foucault, the significance of the examination of the discourses surrounding childbirth and motherhood lies in the notion that our perception is structured, to a large extent, by existing discourses. Foucault argues that claims to the status of truth and knowledge can only be made from within a discourse. We can thus only have an understanding of the world through our ideas about it. He argues further that when particular knowledges about the world are dominant, when they are broadly shared and accepted across social institutions, they become true in the sense that they structure the world and exclude other interpretations of the world. In this way, power and knowledge intersect to produce socially accepted conventions about knowledge and the nature of social reality (Crowley & Himmelweit, 1992:237). This relates to childbirth in the sense that the acceptance of the definition of childbirth as a medical event, has allowed the

medical establishment to gain control over the management of childbirth and in so doing exclude alternative and equally valid models of childbirth.

The experiences of childbearing women were ascertained through interviews with 20 pregnant women attending antenatal classes at a Cape Town private hospital. The women were interviewed prior to the birth and after the birth of their babies. The fact that they were attending the same antenatal class ensured a degree of homogeneity in terms of their medical and social background, as well as their childbirth education. Interviewing the women before and after birth allowed for a comparison to be made of expectations and reality. It was also borne in mind that accounts of events prior to the birth may be coloured by subsequent events. Perceptions may change when viewed retrospectively after the birth, such that a mother's satisfaction with and relief at delivering a healthy child may make other considerations pale into insignificance.

THE SOCIAL CIRCUMSTANCES OF CHILDBEARING

An investigation of women's childbearing experiences in terms of the dominant discourses needs to be combined with the examination of the contribution of other factors related to the social circumstances of the women. Relating women's birth experiences to the social context of their lives is particularly important considering that the study of reproduction has, in the past, lacked an appreciation of its social character. A number of relevant social factors that may effect the emotional response to motherhood include gender socialisation, which influences the preparation for and expectations held of motherhood, the behaviour and personality of the baby and the general background of the mothers such as whether or not they are employed or have supportive partners. An examination of these variables is necessary because a mother's response to the birth

of her child may be influenced as much by the circumstances of her life as by the medical management of the birth.

CHAPTER 2

CONTEXTUAL FRAMEWORK

Childbirth in Western, industrial society has been polarised into two mutually exclusive dominant discourses, the medical model of childbirth and the natural childbirth model. Both discourses have the power to shape the way in which childbirth is conducted and organised. This involves issues such as where and within what surroundings birth takes place, who is present, who is in charge and how much intervention is used.

The predominance of the medical discourse of birth is revealed in the fact that pregnancy and childbirth are treated as fundamentally medical events, with the vast majority of women having their babies delivered in hospitals. Great advances have been made in obstetrics, with epidurals allowing women to be awake during birth without feeling any pain and fetal monitors able to detect fetal distress. However, the nature and benefit of the medical model in the context of childbirth is at the centre of debates surrounding childbirth. The rapid decline in infant and maternal mortality in Britain since the beginning of the century appeared to coincide with the increase in hospitalisation of pregnant women. This then became regarded as evidence that hospitalised childbirth is safer. The decline in mortality rates, however, pre-dates many medical advances and it is unclear to what extent the decline was the result of improved living conditions such as proper sewerage disposal, clean water and improvements in housing and diet (Doyal, 1979; 1995; Hart, 1986:21). The fact that the majority of births take place in hospital is testimony to the dominance of the medical model. However, the way in which childbirth is

conducted is ultimately determined conceptually. It is by defining childbirth as a medical event and getting official acceptance of that definition that the medical institution has been able to gain a monopoly over the treatment of childbirth and make hospitalisation almost universal (Treichler, 1990:116).

CHILDBIRTH AS A MEDICAL EVENT

Modern medicine, under which childbirth has come to be categorised, is based on and dominated by the principles of the biological sciences. Prevalent in this biomedical paradigm is the pathological view of childbirth where pregnant women are seen and treated as patients and pregnancy as an illness (Oakley, 1980; Doyal, 1995:135; Garcia, Kilpatrick & Richards, 1990:4; Rapp, 1988:108). The increasing use of technology in obstetric practice reflects a philosophical orientation towards childbirth as an inherently risky business (Michaelson, 1988:11). Doctors are trained to see labouring women as 'at risk' and dependent on sophisticated medical technology for the safe birth of their babies. The act of birth is interpreted as a crisis to be managed by the application of science and technology.

The biomedical model of the birth process is accompanied by a technological ideology where people are thought about in mechanical, industrial terms. In the development of obstetrics, the metaphor of the body, and specifically the uterus, as a machine, existed in combination with the use of actual mechanical devices such as forceps. It is often argued that metaphors of the body as a machine continue to dominate medical practice in the 20th century, as seen in the rising rates of artificial intervention in the birth process. Where ideas about machines are applied to people, the aim becomes to make them more efficient, productive, rational and controlled. As a result,

bodies are hooked up to machines and body functions are monitored and managed (Rothman, 1989:49-53, Martin, 1989:54).

A central issue with regard to this technological ideology is that while the increased use of technology opens up ways of doing things not otherwise possible, it also closes down or reduces other possibilities (Bergum, 1989:131). These may include non-technical interventions in the birth process. Better prenatal care, increased education on childbirth and good support systems of family and friends during delivery are alternatives that may improve the success and satisfaction of childbirth (Michaelson, 1988:13).

The main criticism directed against the biomedical model with its reliance on technology to treat the pathological body, is that it has facilitated a disregard for the emotional experiences of women during pregnancy and childbirth (Hart, 1986:22-3; Doyal, 1995:16; Mishler, et.al. 1981:2). The physiological dimensions of pregnancy and childbirth have been emphasised to the neglect of the social and cultural contexts in which they occur. This demonstrates the reason why more importance needs to be placed on the value of eliciting the subjective accounts of the experiences of childbearing women (Oakley, 1980).

THE IATROGENIC POSSIBILITIES OF MEDICALISED BIRTH

Other negative implications of medicalised childbirth have been extensively explored. It has been pointed out that many procedures were introduced into obstetric practice without a systematic evaluation of their effectiveness and safety (Oakley, 1986:18). Although the use of technological and pharmacological procedures is appropriate and beneficial in the handling of high-risk births,

few interventions have proven effective in routine use. Yet practices that benefit a minority of mothers are applied to the majority, who are generally healthy and need little or no medical management through the birth process (Michaelson & Alvin, 1988:143; Bergum, 1989:6; Kitzinger, 1991; Treichler, 1990:121).

Many unnecessary interventions have no impact on infant mortality or on the improvement of the health of the mother or child, but are, instead, costly, economically and in terms of the physiological and psychological effect it has on women, such as increased discomfort and anxiety (Michaelson & Alvin, 1988:143; Foster, 1995). The physiological effects include the iatrogenic possibilities introduced by the routine use of technology, which have been well-documented (Oakley, 1980:25; Arms, 1975; Kitzinger, 1967; Doyal, 1995:138; McIntosh, 1989:187; Foster, 1995). Obstetric interventions often form an interconnected system with one intervention leading to additional risk factors which require new interventions. For example, the use of monitoring equipment makes it impossible for the woman to move around freely or even change positions in bed with ease. The freedom to move is important because movement, as well as staying upright while giving birth, shortens labour and decreases the pain felt (Kitzinger, 1991:21; Comport, 1987). The requirement that the woman remains still in bed slows her contractions which may encourage the use of pitocin to speed up the contractions and then anaesthesia to reduce the pain brought on by the rapid induced contractions (Michaelson & Alvin, 1988:150). A further problem in relation to fetal monitors is that they have been found to be frequently misused or misinterpreted so that sometimes normal deliveries are taken to be problematic. As a result, unnecessary Caesarean deliveries are performed (Whitebeck, 1988:50; Foster, 1995:40).

The induction of labour has also been shown to have iatrogenic consequences. Induced labour has been connected with increased rates of premature labour, fetal distress, jaundice and maternal infections (Doyal, 1995:135). Cartwright (1979) in her comparison of induced and spontaneous labours found that the women whose labours were induced were more likely to have been given some pain relief during labour. This is because induced labour is faster and thus more painful than labour that starts naturally. Inductions tend to be associated with high technology, with machines being used to measure contractions and monitor the baby's heartbeat.

The routine use of technology further emphasises the pathological view of pregnancy and reinforces women's views that this is the right way to have a baby. If these procedures were reserved for a small proportion of maternity cases, it would emphasise the probability of normality, but using them for the majority stresses the probability of abnormality (Oakley, 1980:21). The natural process of birth is then perceived by women as risky and dependent for its success on medical technology.

NATURAL BIRTH MOVEMENT

The natural birth movement can be traced back to the work of Dick-Read (1933), considered by many as the father of natural childbirth. He began a trend in the direction of intervention-free birth with his argument that fear and its effects are what causes the pain of childbirth. He believed that fear activates tension in the muscles in the lower uterus which instead of relaxing as the cervix opens now work to close it in an attempt to delay birth until danger has passed. However, longitudinal muscles further up the uterus continue to contract because they are not affected by the fear initiated inhibitory tension. Two sets of muscles are then opposing each other

which results in physical pain. Dick-Read argued that painless birth could be achieved with an understanding of the origin of fear. He believed that effective prenatal care should be largely instructional in preparation for intervention-free birth.

Others have put forward methods of achieving natural childbirth involving relaxation techniques. Fernand Lamaze introduced the Lamaze breathing techniques as a method of control during labour. French obstetrician Leboyer (1975) was interested in the well-being of the fetus and newborn. He aimed to provide an environment conducive to welcoming the newborn into the world in a gentle way. This involves dimming the lights in the delivery room and decreasing unnecessary noise. He believed that by reducing trauma to the newborn, the child would grow up happier, more intelligent and physically stronger. His views are beneficial in that they encourage a more human approach to childbirth. The focus of the natural birth movement on the surroundings and atmosphere in which birth takes place and the nature of pain has meant that the woman's subjective state of mind is given primary importance, as opposed to seeing her as an object. The focus is turned onto the emotional experience of birth.

In these natural birth stories, one needs to be wary of essentialist notions of motherhood, as seen in Dick-Read's use of the image of the 'primitive' woman giving birth painlessly and joyfully in the thicket by herself. The image of this primitive woman is a cultural construct incorporating the maternal ideals of a particular society (Cosslett, 1994:10). The image of natural childbirth set out by Dick-Read and his followers carries ideological prescriptions about natural motherhood. Motherhood is viewed as an essential attribute of womanhood. The problem arises when these ideas are used to reinforce the culturally conditioned role of mother as natural.

The fact that medical male experts, who have no experience with which to substantiate or validate their advice, were addressing childbearing women about natural childbirth was rectified by Sheila Kitzinger, a mother of six, all of whom were born at home, who proposed a female-centred approach to natural childbirth. In 1982 she placed an advertisement in a London newspaper reading "If any mother out there is unhappy with her experience of birth, I wish to meet her." It attracted over 2000 women to the first meeting. The natural birth movement gained support because of the considerable amount of dissatisfaction with the medical management of childbirth and the desire expressed by women to control the circumstances of giving birth. Women's right to be informed, conscious and to experience childbirth as a natural process was asserted.

Advocates of the natural birth movement point out that while good obstetric care is essential, there is little evidence to show that home births, under the correct conditions, carry more risk. In fact, research done by Tew (quoted in Foster, 1995) in Britain and received with hostility by colleagues, challenged the assumption that hospital delivery is safer for all women. Her examination of maternal and perinatal mortality rates showed that these rates for comparable groups were always higher in hospital than at home whether the predicted rate was high or low.

The possibility of non-intervention birth is demonstrated most clearly in the case of some European countries, most notably Holland. This is one of the countries on which Jordan (1993:46-63) focuses in her cross-cultural analysis of childbirth. The fact that Holland has one of the lowest birth-related mortality figures in the world is the result of comprehensive, universal and free prenatal care. This serves to sift out those who are socially or medically at risk, who then give birth in hospital. However, over half of all births take place at home and delivery by

midwives, at home and at hospital, are common. The woman is treated as competent to manage her birth and the midwife's function is simply to give encouragement, watch for complications and perform a few technical tasks such as cutting the umbilical cord. The Dutch system regards birth as a natural process and the deep-seated conviction is held that the woman's body knows best and that, given enough time, nature will take its course. This also means that in the overwhelming majority of cases the Dutch mother expects and gets no medication of any kind. This is because the notion of childbirth as a natural event precludes the use of drugs for women who, under similar conditions, would be given medication in other countries.

The possibility of non-intervention birth has also been shown in South Africa where it has been observed that only 15 percent of women whose births are handled by an organisation of midwives require Caesareans, vacuum extractor or forceps deliveries at hospital. In contrast, artificial intervention in private hospitals is between 50 and 80 percent (King, 1997:50).

Challenges to the medical model of birth have resulted in various reforms ranging from natural, intervention-free childbirth at home to alternative birthing centres. Many of those who advocate a non-technological approach to pregnancy and childbirth feel that the biomedical model of birth is a construct of Western medical culture and that other models may serve as well in the safe management of birth (Michaelson, 1988:14).

The midwifery model, in opposition to the biomedical model, has become gradually favoured by some because of its treatment of birth as a natural physiological process. The use of competent midwives at home are regarded as preferable to the hospitalisation of all pregnant women. It is argued that difficult or risky pregnancies should be monitored closely by midwives

and the pregnant woman referred to specialist medical services only if the need arises. There are several advantages to home births. The atmosphere is more relaxed and peaceful and the familiar surroundings give security, comfort and privacy. In comparison, the hospital setting, part of a bureaucratic, hierarchical system of care, is often experienced as alien to women. Furthermore, home births allow the possibility for the mother to share an equal relationship with her caregivers. Caregivers at hospitals are trained to focus on the medical aspects. In addition, professional care may be authoritarian, where the patient is involved in a dominant-subordinate relationship. At home, the woman receives the concentrated care of one midwife whom she already knows. The family is close-by and the mother is never separated from her baby (Kitzinger, 1967; 1991).

Alternative birthing centres with a cosy atmosphere are being developed in response to the problems of institutionalisation. However, in many cases alternative birthing centres are simply rooms furnished in a homelike way and are not accompanied by the necessary fundamental change in the philosophy of birth management. Attention is still focused on the mother's physiological state, rather than on her emotional and psychological needs (Michaelson, 1988:25). Birthing centres have been characterised by some as token demedicalisation and a fairly superficial response to public demands for change.

In the discussion on changes being made to the way in which birth is managed, it must be borne in mind that there are differences in what women want from their birth experiences which are affected by social position and cultural background. Not all women may want a return to natural childbirth. There have been found to be considerable class differences in women's attitudes towards childbirth and its management. It has been observed that working class women tend to

be less opposed to medical intervention. This may be because they have been socialised in a passive approach to childbirth and are more accepting and trusting of the medical system (McIntosh, 1989:190).

The option to choose alternatives to medicalised birth is largely limited to the middle-class who have greater access to information and are able to assert their right to control their own birth experience. In addition, with regard to home births, it should be pointed out that the benefits of home births are more applicable to middle-class women who have better living conditions. For some poorer women who live in less than ideal circumstances, hospitalisation may be appreciated as a holiday from home.

POWER RELATIONS WITHIN THE BIRTH PROCESS

The way in which the birth process is managed reflects a great deal about the values, norms and the socially legitimated distribution of power within a society. The medicalisation of the birth process and the increased use of technology has been widely criticised for its potential encroachment on the control and knowledge of women concerning the birth of their children.

As the process of pregnancy and childbirth have come under the control of medical professionals, many women are left with the feeling of being mere onlookers in the process of giving birth (Stanworth, 1987:15). This is because in the Western biomedical model of childbirth, the knowledge and control of the birth process is 'legitimately' held by biomedically trained physicians. The greater value placed on medical knowledge, to which many mothers do not have access, has meant that there is an unequal distribution of power between the participants in the

birth process. A more general discussion of this is provided by Foucault (1973) who states that in hospital, knowledge has been culturally appropriated in a specific way by biomedicine and its practitioners and consequently it stands in a hierarchical relationship to other kinds of knowledge. This means that the superiority of the doctor's objective knowledge and clinical experience often overrides the woman's own subjective perceptions, knowledge and past childbearing experience, further widening the increasingly well-documented gap between medical and maternal discourses (for example, Oakley, 1980:9; Rapp, 1988:108; Miles, 1991:174).

The idea that the institutionalisation of childbirth as a medical event has involved placing doctors in the active role and mothers in the passive position of patient, recipients of services rather than the controllers of the birth of their children is illustrated by Treichler (1990:117). She quotes a definition of birth in Stedman's Medical Dictionary, "The passage of the offspring from the uterus to the outside world, the complete expulsion or extraction from its mother of a fetus..." This focuses on the journey of the offspring rather than the labour of the woman and implies through the word 'extraction' that the doctor has the active role in the birth process.

Some feminists argue that control by doctors may be asserted through the use of technical language, inaccessible to the layperson and technology, over which the doctor has command. Furthermore, it has been suggested that this technology is used to disempower women by extending interventions initially justified in exceptional circumstances to routine use (Hamner, 1993:225).

An example of the exercise of power within the birth process that is fortunately becoming less frequent, is the use of stirrups (the lithotomy position) in childbirth. The lithotomy position, where the woman is horizontal, was favoured by many doctors because it made the use of medical equipment easier and thus afforded them greater control over the birth process. However, apart from being unpleasant and awkward for women in labour, there is evidence that this position alters the normal fetal environment and obstructs the natural process making spontaneous childbirth more difficult (Kitzinger, 1991; Brook, 1976:46). Studies of tribal societies tend to confirm the idea that the crouching position is the most instinctive one. The vertical position was adopted in earlier times by most women in labour as it ensured easier expulsion because of gravity aiding the birth process (Gelis, 1991:122). Advances have been made with regard to the position in which women give birth. However, the use of equipment such as forceps and vacuum extractors do place restrictions on the positions available to women.

Differential power relations that exist between medical professionals and patients because of their different practical concerns and differential access to power may also organise how they exchange information. This has consequences in terms of the decisions reached. In her examination of the decision-making process within the medical setting, Fisher (1988:32-45) demonstrates how doctors may influence women to have hysterectomies that are not mandated on medical grounds. Her study was motivated by the discovery of a trend that older women who had had their families, poor women, minority women and women on welfare seemed more likely to have hysterectomies recommended.

Other studies (Oakley, 1980:280,290; Hauser, 1981:106; Doyal, 1995:135; Cartwright, 1979) have also found that decisions regarding the medical procedures undergone were dominated by

the medical professionals involved. The doctor's knowledge and expertise, as well as his/her position of authority are used to influence the decisions of the women who believe that the doctor knows best. These women do not have complete control over the decision-making process because they lack the necessary information and knowledge of the options available. The majority of women in these studies reported that they were given 'sales talk' for epidurals and inductions and pressurised into other pain relief, which they later regretted. Dissatisfaction was shown by some women who felt that while epidural analgesia allowed them to give birth consciously while feeling no pain, childbirth is not experienced if the feeling of giving birth is missing (Oakley, 1980; McIntosh, 1989:202). Such evidence necessitates the questioning of access to knowledge and power where it affects women's experiences.

It has been observed that in some cases doctors may enforce their individual, moral and social judgements using the authority of the medical role. This is made possible because of the assumption made by many doctors and patients that medicine is so complex that those without specialised training cannot grasp it. Another assumption made is that the authority of the doctor is legitimate, which excludes the possibility of the impact of personal beliefs and financial interests on the medical decisions reached. Fisher (1988:80) argues that to assume this authority is legitimate is to ignore the social and political process by which doctors have maintained their monopoly over the delivery of health care.

The latitude afforded doctors in making decisions is illustrated by the fact that in the UK the induction epidemic of the 1970s resulted in fewer and fewer births taking place on weekends and public holidays and more deliveries taking place during office hours and at times of convenience. Obstetricians have also reported that the use of inductions has improved their job

satisfaction and made the running of maternity departments easier (MacFarlane & Mugford, 1984; Kitzinger, 1991:20; Cartwright, 1979:116).

A further aspect of control comes into play where gender is seen to be a relevant factor. Despite the lessening of the imbalance between male and female doctors, medicine is still a male-dominated profession. The more senior positions are dominated by men and men are more often awarded promotions up the hierarchy (Miles, 1991:144). Where doctors are predominantly male, the power relations between the doctor and pregnant woman mirrors the broader gendered power imbalances in society. Though the situation is gradually changing, in South Africa, the majority of gynaecologists and obstetricians are still men. It has been argued that the attitudes of male doctors have, to some extent, mirrored the current views on women in society. These views are reflected in gynaecological texts and reinforced in other aspects of medical training (Fisher, 1988:39). The predominant view of women within modern medical ideology, as influenced by Freudian thought, has emphasised their reproductive capacity. This view is based on the belief that women's reproductive role is the pivotal point of their personality structure and important for their psychological well-being. Social attitudes and expectations regarding the 'natural' attributes of femininity such as passivity, dependency, domesticity and emotionality have been reflected in medical practice and have influenced women's experiences of medical care (Doyal, 1979:215).

HOSPITALISATION

The fact that childbirth usually takes place in a hospital setting necessitates an examination of the medical context and its impact on women's experiences of childbirth. Evidence suggests that

hospitalisation in pregnancy is a stress-inducing event (Kirk, 1994:64-5). The sociological literature regarding hospitalisation has highlighted the means through which the hospital depersonalises individuals and removes their control over most activities. It has been demonstrated how during the course of hospitalisation, various messages are sent out to the pregnant woman. On admittance to the hospital, her clothes, the markers of her individual identity, are removed and replaced with a hospital gown, projecting the message that she is no longer autonomous, but dependent on the institution. She is then confined to bed which intensifies the message that she is a patient (Davis-Floyd, 1988:160-1).

Research undertaken in America has shown that many women who choose out-of-hospital births are less interested in having the comforts of home than avoiding the stark and regimented hospital environment. Many women reported extremely negative previous experiences in hospital care. They distrusted the medical system and feared that harm would come to their babies as a result of hospital procedures (Ruzek, 1991:80). Other common complaints of hospital treatment include feeling depersonalised, like items on an assembly line, being dissatisfied with the explanations given by doctors and the insufficient medical information made available.

The considerable and well-documented dissatisfaction with hospital treatment has more recently resulted in advances, where some hospitals are attempting to be more humane and less rigid and authoritarian in their approach. Private hospitals, which are becoming fiercely competitive, can no longer afford to discount patient's requests. Some hospitals are now allowing women to wear their own gowns and encouraging them to walk around as this stimulates labour. In addition, fathers are being allowed in the delivery room and routine perineal shaving and enemas, proven to fulfil no useful medical purpose (Foster, 1995:38) and experienced as unpleasant and

degrading, are occurring less frequently.

CHILDBIRTH AND FEMINISM

In the past, feminist debate around childbirth has been limited due to the ambivalence shown by many liberation feminists towards motherhood. The concerns of organised feminism since the 1960s have been with freeing women from their childbearing and childrearing roles and increasing their participation in the non-domestic world. Feminism has been based on demonstrating that women can do other things besides bearing and raising children. Liberation Movement feminists (such as Millet, 1971; Firestone, 1972; deBeauvoir, 1960) have been distinctly anti-natalist and have tended to speak of children unsympathetically and to project the view that they are a major barrier to fulfilment outside the home. The function of childrearing has been denigrated and regarded as burdensome, unchallenging and a hindrance to self-expression and creativity (Kaplan, 1992:10).

While these feminists have raised important issues regarding the unequal division of labour within the home and the importance of freeing women from compulsory motherhood, they may be criticised for failing to disentangle the biological and social aspects of childbirth and childrearing, as well as for their assumption that pregnancy, childbirth and childrearing are essentially humiliating and oppressive activities (Bryson, 1992:205). The view that pregnancy and childbirth are not fulfilling or creative experiences is contradicted by the perceptions and experiences of many women who have found fulfilment in motherhood.

More recent feminism has shown a move towards appreciating the ability of women to give birth and raise children as a valid and valuable aspect of being a woman. They have recognised the difference between the institution of motherhood, portrayed as women's sole occupation in patriarchal society, and the experience of motherhood. The regulation of women's reproductive power by men through their control over contraception, fertility and gynaecology has come to be seen as an important part of the patriarchal system. A key argument against the male-dominated medical system has been concerned with the idea that midwifery was once solely a female occupation. Rich (1976) describes how for centuries the knowledge of pregnancy, birth and the female anatomy was accumulated entirely by women. Women had babies without any medical help, with little or no intervention in the natural process. The birth took place in the home in a family setting and was attended by midwives. During the 18th century, female community-based control of childbearing began to be challenged by the emergence of technically-minded male midwives. The male-dominated medical profession rose out of the suppression of women healers. The inferiority of the midwife was asserted and she became associated with ignorance and superstition.

Rich (1976:170-1) sees the way women are treated by the medical institution during birth as emblematic of their oppression in society at large. She states, "No more devastating image could be invented for the bondage of women: sheeted, supine, drugged, her wrists strapped down and her legs in stirrups, at the very moment when she is bringing new life into the world." Other feminists have regarded the increasing medicalisation of childbirth within the male-dominated medical profession as the attempt by men to appropriate childbirth. O'Brien (1983) has explained what she sees as a relentless male desire to master nature and to construct social institutions that will give men an illusion of procreative power and continuity, by referring to men's alienation

from reproduction. This entails their feeling of disconnection during the process of conception, pregnancy and birth. In accordance with O'Brien's views, the increasing technological control over birth is an attempt by men to overcome their alienation and gain control over motherhood itself.

In relation to this, it has also been argued that technologies for managing birth are designed less to improve the experience and safety of birth than to appease men's envy of women's reproductive power, termed womb envy (Baruch, 1988:135). In this view, technological intervention in birth is presented as a manifestation of a patriarchal science and its need to control women's bodies. Feminists arguing that the motives underlying the development of reproductive technologies and technologies for managing birth are not based on the needs of women, point to the fact that women rarely have much input into their planning or the processes of design and development. They argue that financial concerns are greater motivators. The introduction of new technologies has enhanced the status of medical professionals and increased the funds they can command. In addition, many pharmaceutical and medical supply companies have a vast financial interest in the manufacture of these technologies (Stanworth, 1987:13; Foster, 1995:182).

These critical perspectives have been put forward by feminists forming part of the more radical element of the women's liberation movement. Various criticisms may be directed against them such as their failure to fully recognise those women who have benefited from medical and pharmacological developments. Women do not form an homogeneous group and so their interests cannot be unilaterally agreed upon. A further problem lies in their implicit subscription to a 'male conspiracy' theory. As Bryson (1992) argues, within feminist theory, a false dichotomy has been created between male and female culture that ignores any shared values. Radical

feminists may be criticised for considering men as the enemy, whereas it would be more useful in the future to regard men as potential allies rather than adversaries by distinguishing between the structures and agents of oppression. In relation to this, it should be reiterated that the many benefits of medical procedures, developed mostly by men, are undeniable, but only where their use is appropriate and necessary.

There are then a number of aspects surrounding the medicalisation of childbirth that are relevant to women's experiences of birth and need to be taken into account when examining these experiences. The biomedical model that dominates modern medicine determines the nature of the medical care received and hence the experience of hospitalisation. The power relations within the birth process, particularly where they are gendered, and the relationship between the labouring woman and the medical professionals involved, influences where the decision-making control lies regarding the management of birth. These factors, as well as the technical and pharmacological procedures undergone during the birth process, all play a role in determining the emotional consequences of childbirth and the state of mind in which the woman begins motherhood.

CHAPTER 3

METHODOLOGICAL CONSIDERATIONS

Qualitative and quantitative research methods are situated at opposite ends of a continuum of methodological approaches, each with different underlying principles and assumptions. In constructing a research design, the benefits and shortcomings of each method need to be assessed in terms of the nature and objectives of the research being conducted. With regard to the present study of the experiences of childbearing women, qualitative methodology was judged the most suitable. Within the qualitative paradigm, an emphasis is placed on understanding the situation from the perspective of the participants. This means that people are not regarded as objects with readily measurable characteristics, but rather as agents active in constructing and making sense of the realities they encounter. In relation to this, Rubin (1976) argues that hundreds of representative studies of aspects of family life exist. Probability statistics are numerous on marriage and divorce, for example, but they tell us nothing about the experience of the flesh and blood women and men who make up the numbers. They thus leave us with only a fragment of knowledge.

Qualitative interviews were conducted in order to discover the nature of the experience of childbearing. Though the administration of questionnaires, the primary quantitative research method, has the advantage of efficiency in dealing with large numbers, as well as the use of statistical analysis, the factual information obtained through questionnaires would not, in this case, sufficiently reveal the subjective nature of the women's experiences. Nor would such data

be subtle enough to pick up the diversity of the thoughts and feelings of the women. Qualitative interviews are better able to capture the fullness and complexity of experience due to the fact that responses may be elaborated upon and placed within the context of the rest of the subject's life. This is of particular importance in the case of childbirth as the transition to motherhood leaves no aspect of a woman's life unaffected. Furthermore, she brings to the experience of birth, opinions and feelings that are the culmination of her past experiences and social circumstances.

A further benefit of qualitative interviews in the present study concerns the fact that questions may be interpreted differently by respondents. Interviews allow the opportunity to clarify the meanings of questions and achieve greater uniformity of understanding. They also avoid the problem inherent in the use of questionnaires whereby listing items may 'lead the witness' in a way which does not necessarily correspond with the participant's perspective. An additional advantage is that the personal nature of interviews enables rapport to be established and non-verbal responses noted.

One problem inherent in interviewing as a method of research is that while interviews reveal attitudes, they do not reveal the corresponding behaviour. In other words, it is not possible to assess the extent to which what participants claim to believe is reflected in their everyday behaviour. In this way, interviews amount to the interviewer's perception of the respondent's perception of reality (DeJongh, 1990). In this study, it was not possible to observe the women in the mothering role for an extended period. But this was not a major problem since it was their perception of their experience that was of main relevance to the study.

SAMPLING

A series of antenatal classes was attended, taking place at a private, up-market hospital in Cape Town. The classes took place on one night of the week and lasted about two hours. Each series of classes spanned eight weeks. The number of classes that are run at a time depends on the demand. At the time of the research only one class was in operation. The content of the classes included breathing exercises for early labour, the medical options available for birth, what occurs during the process of birth, the set-up of the hospital and what to expect after the birth.

The women and their partners who were present at the first of the classes attended by the researcher were addressed as a group and the nature and purpose of the research project was explained. All of the women present were willing to participate in the study, thus constituting the sample. Their names and telephone numbers were collected and they were later contacted individually by telephone to arrange times for interviews. As only ten women were attending the initial class, new women joining the class were recruited to the sample to expand the sample size to 20.

Due to the fact that not all members of the relevant population, women nearing the end of their pregnancy with their first child, had a known probability of being selected, the sample would be defined as a non-probability sample. Furthermore, the fact that one hospital was selected that was accessible to the researcher, makes it a convenience sample. The drawback of this type of sample is that it is not representative of the relevant population. Generalisations can then not be made. However, it is very common for women whose doctors operate through private hospitals to attend antenatal classes. The series of classes was not an isolated event. The sample may thus

be seen as consisting of typical mothers attending a typical class.

The head nurse of the maternity section of the hospital had a list of all the women registered at the hospital who were expecting their first babies. These women were made aware of the antenatal classes and were expected to, and did, attend. Some women who were consulting doctors not aligned with the hospital in the study had chosen to attend the series of classes either because the hospital at which they were registered did not offer classes and thus their doctors had recommended the classes, or because the maternity section of the hospital at which they were registered was under reconstruction and the antenatal classes had been temporarily cancelled.

An advantage of selecting all of the women attending the classes is that they were then exposed to similar levels of childbirth education. The relatively socially and medically homogeneous sample also made the comparison of the different effects of various social and medical factors on their childbearing experiences possible. This was because these factors were less likely to be confused with other extraneous factors. Furthermore, the fact that all of the women attending the classes were interviewed also overcomes the problem whereby only volunteers anxious to tell their stories are selected.

DEMOGRAPHIC CHARACTERISTICS

The sample was made up of 20 women in the last month or two of their pregnancies with their first child. The women were all white, middle-class, urbanised and English-speaking. Their ages ranged from 25 to 37 with 13 women above 30 and an average age of 30,8. All were married except for two who were involved in stable long-term relationships. They all lived alone with

their partners except for two whose households included other family members.

In terms of education, all the women had some form of tertiary education and were employed in full-time jobs prior to their pregnancies. These jobs can more accurately be termed careers in that they required specific education or training and were chosen according to personal interest and aspiration. Seven women were involved in their own businesses. The remaining women were involved in teaching, management, medical and creative work. Their partners' jobs were comparable to these. Generally, the jobs were considered by the women to be rewarding and fulfilling and not solely motivated by financial necessity. Only two women decided to give up their careers to become full-time mothers. The rest intended to return to work on a full-time or part-time basis at some stage after the birth of their babies.

In terms of religion, all of the women were Christians of various denominations, except for one who had converted to the religion of her husband, Buddhism. This did not appear to affect her views or experiences in any way that could suggest religion to be a significant factor in the study. The women were registered at three separate hospitals, one state and two private hospitals. Amongst them they were dealing with 12 doctors, four of whom were women.

The sample consisted of women who were, to a certain extent, in an ideal situation. They were within secure relationships and their pregnancies were welcomed. They had careers and were, for the most part, financially secure. In addition, they were healthy, with no medical complications with regard to their pregnancies, and they had access to adequate medical care.

DATA COLLECTION

An interview schedule of in-depth, semi-structured questions, along with open-ended questions, was judged to be the most suitable way of eliciting the information sought. Several questions involved describing experiences of certain events and situations. The open-ended nature of these questions allowed for self-expression and flexibility because the women were free to emphasise what they regarded as relevant or significant. The questions were also, however, sufficiently focused to prevent aimless wandering during the interview and a lack of comparability. The interviews were tape recorded with the permission of the women and transcribed in full by the researcher. This was time-consuming, but necessary, so that direct quotes could be used in the analysis without misrepresenting the women. Having access to full transcripts was valuable in that themes not previously considered and thus initially neglected, were able to be explored through rereading the complete interviews.

The women were interviewed on two occasions, before and after the birth of their babies. The interviews took place at an average of a month before and three to four weeks after birth. This was affected by the variability of expected and actual due dates. These times were chosen because a few weeks before the birth, the women would have begun considering their birth experience in terms of their expectations, hopes and fears. A few weeks were allowed after birth for the women to settle at home with their newborns. This is generally regarded as a very stressful period, during which the women would probably not have had sufficient time or inclination for an extended visit.

The interviews began with routine, emotionally-neutral questions concerning demographics, such as age, education and occupation. A demographic profile could then be sketched. The first interview dealt with issues relating to the experience of pregnancy and the accompanying changes. Expectations about birth were also ascertained in this interview. The second interview centred around the women's experiences of childbirth and the early weeks of motherhood.

The interviews took place mainly in the women's homes. A few women were interviewed at work, as they had not yet begun maternity leave. The interviews were scheduled at the convenience of the women. This was particularly necessary with regard to the second interview considering the time pressures faced by new mothers. It was important that a relaxed atmosphere was created with no time constraints so that attention could be given to a crying baby where the need arose. In several cases the women breastfed during the interview as it is hard for new mothers to find an hour or more in which no maternal tasks need to be performed. The interviews occurred mostly during the day when the women's partners were not at home. This allowed for privacy. The average length of the interviews was about an hour and a half. The second interview was generally longer as it involved additional activities such as being introduced to the baby, looking at photographs and attending to the baby's needs.

The analysis of the interview data involved comparing similarities and differences across the participants, particularly where these were accompanied by clear differences in key variables, such as maternal feelings, baby care experience and the support received. Reading the interview material as a whole allowed patterns and themes to emerge.

VALIDITY AND RELIABILITY

Validity is the extent to which empirical measures adequately reflect the real meaning of the concept under consideration (Babbie, 1983:117). Internal validity may be attained where qualitative interviews make possible the accurate and valid description of meanings. The achievement of external validity, concerning generalisability of results, was limited by the size and type of the sample.

An important accompaniment to validity is reliability, which concerns whether a particular technique, applied repeatedly to the same object, would yield the same result each time (Babbie, 1983:113). The extent to which reliability is achieved depends on the researcher, the participants in the research, the measuring instruments used and the circumstances under which the research is conducted (Mouton & Marais, 1990:79).

In terms of the effect the researcher has on the research setting and participants, it needs to be observed that the researcher, as a member of a particular culture at a specific historical moment, has his/her own understanding and theoretical or conceptual orientation. In the analysis of data, the identification of themes by the researcher may be influenced by his/her personal assessments of what is most important or relevant to the subject under investigation. Interpretations may also be biased by preconceptions.

Mouton and Marais (1990:16) state that 'objective' ought not to be identified with 'neutral' or 'universally valid'. The criteria of rationality, reliability and validity are always context dependent and so it is impossible to conceive of objectivity in a decontextualised manner.

Entirely objective research is then not possible. However, it is necessary to be explicitly conscious of one's attitudes and opinions about the subject under investigation and to minimise the effect of personal opinions impacting too strongly on the analysis and interpretation of the data.

While the issue of bias is relevant in all research studies, to improve reliability, interview bias was minimised as far as possible. 'Leading' questions were avoided where the women would be influenced in a certain direction. Questions were straightforward and direct and allowed the women to speak for themselves. Furthermore, in order to achieve comparable answers and avoid the problem of different perceived meanings of terms, where participants could conceivably misinterpret questions, the question, as intended, was elaborated upon. The fact that qualitative interview questions can be clearly explained is an obvious advantage here.

In conducting interviews, the age, gender, race, cultural group and status of the interviewer may also affect responses. In the present study this worked as an advantage because the researcher generally matched the profile of the women and so they could relate to each other. Throughout the research, gender provided a common bond, several women making remarks such as "If you have children you'll find that..." The fact that the researcher was, on average, seven years younger than the women, meant that they were made to feel valuable in that they were offering useful advice and guidance.

A further consideration with regard to the affect the researcher and the context have on the participants was the need to make it clear that the research was being conducted as a requirement for a university degree and was not affiliated with the hospital in any way.

In terms of bias, it is acknowledged that in the study, the choice of problem area and methods meant that one side of the medical interaction (that of the pregnant women) was emphasised at the expense of the other (doctors and the medical institution).

REACTIVITY AND REFLEXIVITY

Reactivity concerns the fact that people react to being participants in research. It was thus necessary to put the women at ease. They had to be made to feel comfortable about the interview situation if honest and open answers were to be given, especially regarding areas such as, for example, the more negative aspects of motherhood. The fact that the interviews took place in the women's homes helped in this regard, as they were in familiar surroundings. The interviews were also conducted at the women's convenience over a cup of tea. In this way the atmosphere was more of a relaxed visit than a formal interview.

Having met the women at the classes meant that they were familiar with the researcher. By the second interview the formation of some sort of relationship or familiarity became an advantage. A sense of continuity was developed where some women made reference to issues discussed in the earlier interview, such as "Remember I said that... well...".

The women were generally happy to discuss a topic that was uppermost in their minds. They were very forthcoming about their experiences, sometimes regarding the interview as an opportunity to air their grievances or 'talk baby' to a willing and attentive listener. Not much concern was expressed regarding confidentiality and anonymity, but this was assured.

Reflexivity concerns the process of being aware of how one's thoughts and behaviour influence the research process. It is necessary to be explicitly conscious of one's attitudes and opinions and ensure that these do not have too great an impact on the analysis and interpretation of the data. In the study, the researcher was working from a feminist standpoint, in response to the patriarchal nature of both South African society and the medical profession, and the resulting negative effects this has on women's experiences. The researcher was also responding to the extensive and widespread criticism directed against the current state of obstetric care in Britain and America.

CHAPTER 4

THE EXPERIENCE OF PREGNANCY

RESPONSES TO PREGNANCY

The women in the study responded to the news of being pregnant with a mixture of excitement, apprehension and, once the realisation set in, shock: "There have been periods of big adjustment where I actually was really rather shocked at the enormity of what we'd done, even though it was very planned and preconsidered."

Most of the women had deliberately delayed the decision to conceive for many years for financial or career reasons. Accepting the pregnancy was more difficult in these situations where motherhood was the result of careful consideration, rather than simply assumed. The delayed decision meant that the childfree lifestyle had been experienced, which, standing in stark contrast to the parenting lifestyle, highlighted the sacrifices entailed in raising a child: "I've been feeling a bit emotional about it. I wouldn't say depressed, that's too harsh a word, more over-awed. You start realising that things are going to change completely. It's almost like baby-blues but before the baby arrives."

The medical discourse of childbirth has been accused of portraying pregnant women in mechanistic and physical terms, as reproductive machines in need of specialised medical attention. The internalisation of this image is clearly evident through the physical terms with which the women described their experiences of pregnancy. Physical symptoms such as nausea

and tiredness were referred to, while emotional responses such as weepy periods and irritability were seen as hormone related. Seldom did other emotions related to the developing fetus or the social and relational aspects of pregnancy warrant mention, except when directly enquired about. At first response, pregnancy was interpreted primarily as a physical condition.

A frequent criticism of the medical view is that it abstracts pregnancy and childbirth from the rest of the woman's life and treats them as isolated medical events. However, pregnancy, as a time of preparation for motherhood, is integrated with all aspects of life, entailing the redefinition of identity and the reorganisation of roles and relationships. Having a child necessitates giving up work, temporarily or permanently, which, in turn, involves the consideration of work replacements or the organisation of reliable baby-care. A shift then occurs from career woman to housewife, an undervalued role in society. Subsequent changes in the financial situation may also become an issue, such as the consequences of sacrificing a second income and the financial burden of a child. In addition, new concerns about the housing situation develop, such as organising a room for the new baby and making the home baby-proof.

More important changes occurring during pregnancy relate to the woman's identity, as she prepares to undertake the social role of mother. The greater emphasis placed on the physical state of pregnancy than the social role accompanying it means that the acknowledgement and recognition of changes that are unrelated to physical complaints, is frequently slow in coming. These changes are often unanticipated and are more stressful than physical ones as they accompany a re-examination of the woman's identity and role in society. The importance placed on the physical, visible component of pregnancy, as opposed to the emotional component, is revealed in the comment, "When you're under 3 months pregnant, you feel like you're pregnant,

but nothing shows so you want to say to people - I'm different, but you don't look different."

THE IMPORTANCE OF CONTROL

The physical complaints of pregnancy extend into other aspects of life most notably where they impinge on a woman's sense of control. A common feeling during pregnancy was expressed here: "There are times when you feel out of control. The world can pass you by. You really can't cope". These feelings of hyper-sensitivity and occasional emotional outbursts are common in pregnancy (Affonso & Mayberry, 1989:41) and may impinge on the woman's self-image and relationships with others. Where the rational and scientific is valued over the irrational and emotive, feelings of being out of control are frightening and alien, particularly for successful career women for whom control, in whatever form, may be central to their identity. Furthermore, the loss of control was not anticipated and was found perhaps more debilitating than the physical complaints. In general, the emotions felt during pregnancy were frightening and difficult to handle, more so because they were not anticipated in the way that morning sickness is taken to be an accepted part of pregnancy: "The scary part is that you have no control over your emotions. You think you're going along perfectly and then someone will say something and you'll just burst into tears. It's totally irrational."

It was common for women to struggle with the restrictions placed on them by their pregnancy: "I get annoyed with myself because I can't understand why I can't do the things I used to do. I've had to physically slow down. It's frustrating. You have to sit back and let other people do things for you. It makes you feel a bit inadequate, which is silly." Tiredness in particular, which was experienced by all the women, meant that normal tasks and responsibilities became difficult to

carry out: "The worst was feeling so tired, constantly really tired. I had to work at the same time. Everything was dreadful. Every night by 8:30 I'd had it. I had to go to bed. I couldn't function." Not only did this frustrate the women, but, in some cases, their partners inability to acknowledge or understand the extreme tiredness as a part of pregnancy resulted in tension in their relationship.

The sense of lessened control is amplified with the permanent or temporary resignation from work. Where work is motivated by financial necessity and holds no career prospects, resigning may be a desirable option. In the case of all the women in the sample, however, their resignation meant leaving a chosen career, as opposed to a job. This was, further, accompanied by a move away from the role as financial contributor to that of housewife. After participating in the labour market, becoming a housewife often entails a major adjustment because of the nature of housework as unpaid, isolated, repetitive and low in status, reflected in the commonly-heard remark 'just a housewife'. In leaving paid employment the pregnant woman then becomes separated from old roles and incorporated into new ones, such as dependant, housewife and later, patient.

The changes in physical appearance accompanying pregnancy may have a detrimental affect on a woman's self-image. This was, however, only mentioned by one woman who said that "towards the end you feel a bit fat and ugly. You want your waist back." The pregnant woman's expanding waist conflicts with the stereotyped standards of attractiveness applied to women, which emphasises slimness. Gaining in size marks the imminent presence of a baby and in some cases induced a change in perception, reflected in the case of some women who acquired the nickname 'mommy' from their partners. For the women in the study their change in appearance had the

effect of making the pregnancy more of a reality to their partners and supplying a constant reminder of the imminent presence of a third party in their relationship.

THE MEDICAL DISCOURSE OF PREGNANCY

In terms of the medical discourse, the defining of pregnancy as a pathological condition contributed to the perception of pregnancy, held by several women, as an assortment of unpleasant physical symptoms. One woman placed so little value on the experience of pregnancy that she regarded forgetting about it as good fortune: "The rest of the pregnancy was fantastic. I haven't really noticed it. It's been fantastic. I forget about it completely, other than adjusting my clothes slightly. We put it out of our minds."

The negativity surrounding the perception of the physical side of pregnancy, if not shared, was acknowledged: "All the advice I got was very negative. It's going to be hell. Pregnancy's going to be gross. You're going to be tired and miserable. I cut myself off from those people. Otherwise I was going to be quite rude to them." This was further illustrated by comments such as, "It hasn't been hell", the implication being that the experience was expected to be far worse.

The negativity expressed or commented on contradicts the common perception of a pregnant woman blossoming or glowing, which was expressed by only two women. Another woman mentioned this perception, but only to discredit it: "People are not realistic about what pregnancy does to you. It takes it out of you. I have never felt so tired and out of control. Your body just does its own thing. That's not what they tell you. They tell you you're going to walk around glowing. I walked around feeling green." The portrayal of the physical state of pregnancy,

represented as an illness, within negative terms, contrasts sharply with the more positive social implications of pregnancy, the birth of a new baby and the role it confers on the pregnant woman.

EXPERIENCES OF MEDICAL CARE

None of the women suffered from serious complications. Their pregnancies would be described medically as low-risk or 'boringly normal' as many had been described by their gynaecologists. Apart from the physical complaints of nausea, tiredness, low energy, indigestion, specifically occurring during the first three months, the pregnancies were straightforward. In most cases after the first three months the women felt healthy, except for the increasing heaviness and discomfort.

The medical discourse of pregnancy is seen clearly to mediate women's experiences of pregnancy. Pregnancy, constructed as a specifically medical event, is not only spoken of mainly in terms of a list of physical complaints, but also the corresponding medical opinion. Many remarked that their doctors were very pleased with them, placing great value of the medical assessment of their progress and placing other indicators in a secondary position. "My doctor says..." recurred frequently. Furthermore, birth was spoken of in technical language, with which all of the women were comfortable. They displayed an extensive knowledge of the medication and medical procedures available during birth, such as pethidine and epidurals and were well informed as to their uses and benefits. The experience of pregnancy was clearly thought of and responded to through the medical paradigm in which it is embedded.

It has been observed that pregnant women, due to their vulnerability and the desire to do what is best for their babies, have in the past tended to trust experts blindly without questioning the

accepted practice. This is seen in the outcome of the use of drugs such as Thalidomide (Raphael-Leff, 1991:140). (In the early 1960s thousands of babies were born with serious physical impairments which were directly traceable to a drug prescribed for nausea in pregnancy.) Although most women accepted the dictum 'doctor knows best', others showed an awareness of potential problems with regard to medical care and acted accordingly. This involved shopping around for a doctor, following up recommendations or making enquiries about different doctors: "My husband and I had many many times discussed when I have a baby who will our doctor be. So we've looked long and hard at everybody's Caesar rate. You only need to speak to the nursing staff to know who they would have their babies with. They're usually a good measuring stick."; "A friend of mine went to this doctor and couldn't stop raving about her. At that stage I was hunting around and I thought - I don't really want to go to a male. I felt more comfortable with a woman."

Seven of the 20 women specifically chose a female gynaecologist. This was motivated by the belief that "men can't really understand or relate" or feeling more comfortable with a woman who "knows exactly what one goes through." For these women a female doctor made a huge difference to how they experienced their medical care: "I'm lucky. I have a long relationship with my doctor. She's quite a forward-thinking woman, very much a feminist. She's actually a pleasure. She's very sensitive to your needs. She's very human, not a typical doctor at all. I've been to men gynaecologists before and it's not the same. They can't relate to what it's all about."

The medical care during pregnancy involved regular visits to the gynaecologist becoming increasing frequent as the due date approached. General check-ups involved the measuring of the weight, blood pressure and heart rate of the woman, as well as blood and urine tests. Blood tests

were performed to check for fetal abnormalities, either as a matter of course or optionally. On average three ultrasound scans were conducted to monitor the growth of the fetus, to assess its level of maturity and to check for any abnormalities.

With the exception of a few minor complaints, most women were happy with the medical care they had received. A high value was placed on being able to discuss aspects of pregnancy and birth with their doctors. An ongoing relationship with the same doctor throughout pregnancy meant that respect and trust were developed. Many appreciated this as a vital part of feeling confident and prepared for the birth. These women, of course, form a privileged minority. In provincial hospitals, which attend to far more women and so can afford each one little time and personal attention, women's experiences of medical care are very different. A different doctor or nurse may be seen on each visit, denying them the continuous and trusting relationship so appreciated by those attending a private hospital. A woman who was attending a provincial hospital, fully aware of the constraints faced by the hospital, simply commented, "You're not getting spoilt, put it that way."

Ultrasound scans were a new experience for the women. In some cases they were aware of their over-use, as well as their cost. [The medical aid rate is approximately R210 (personal observation of account rendered to a patient)]. This is seen in comments such as: "She doesn't do a lot of scans. She does them for reasons, not just sommer net."; "I've had two scans. A lot of my friends who've been pregnant, every time they go their gynie does a scan." Where the scans were accompanied by a full explanation they had much value in reassuring the women as to the well-being of the fetus and giving form to the image held in their minds: "The 20 week scan, you can see the brain, the heart, the spine. It was holding a fist. It was swallowing. It's great to be able

to see that there's actually is a little human in there. It's not just this funny thing that moves around."; "It was only when I had the scans that I could come to terms with this thing that was living inside me."

This function of scans is very important in view of the fact that many women struggled to relate to the fetus as a living baby. In many cases pregnancy was viewed more as an illness culminating in a baby, than an ongoing relationship with a developing baby, as commented upon below.

THE PRESENCE OF THE CHILD

Beginning the transformation from woman to mother is vital during pregnancy, but is often stunted through the common response of denial: "I suppose I still don't really believe that it's actually happening, if the truth be told, it's not going to result in a person." This denial, especially of the actual birth, meant that some women found it hard to conceptualise the fetus as a developing baby and thus envision having a baby as a permanent part of their lives. The few references that were made to the presence of the fetus were generally expressed in these terms: "Sometimes when it kicks you think - hey, what's this? It's like an alien inside you."; "It's quite an alien thing. It feels alien inside you. It's a strange feeling. I don't think that one can really conceive that there's a human being inside yourself. It's like some sort of growth almost, an electric eel or something."

Where there is no continuity between the pregnancy and the birth, it is often difficult to begin establishing a relationship with the child after birth. Being able to envision the fetus as a baby makes establishing a relationship with the new baby easier, a continuation as opposed to the

arrival of a stranger. It may be the case that the inability to relate to the fetus as a child is a response to the medical paradigm's emphasis on the body physical and a lack of attention paid to pregnancy as a developing relationship. Alternatively, questions as to the extent of prebirth bonding may be raised. Evidence of maternal indifference in the face of harsh social conditions (reported by Shorter, 1975 and Scheper-Hughes, 1992) disputes the tendency towards prebirth bonding. In these cases social and cultural circumstances intersected with and 'over-rode' anticipated maternal responses.

PREGNANCY AND RELATIONSHIPS

Pregnancy is often characterised as a marital crisis, as a period of conflict and stress in which marital roles are reorganised (Sanders & Robins, 1989:14). The way in which this 'crisis' is handled may lead to the growth and development of the relationship, as opposed to the decline and dysfunction often observed in the literature. In this study, pregnancy had a positive effect on the relationships of the women and their partners. Working towards the common goal of preparing for the birth of a child served as a unifying bond in many cases, strengthening and solidifying the relationship. It also added a new dimension to the relationship and a sense of warmth and excitement. The antenatal classes were an important part of this as they involved the men, making the pregnancy more of a reality to them.

The women spoken to were fortunate in enjoying close and in some cases egalitarian relationships with their partners. All the partners were excited at the news of the pregnancy, after accustoming themselves to the idea. In some cases the women were pleasantly surprised at the amount of support they received and spoke of their partners' involvement with mild amusement.

In terms of gender equality, it is still the case that the participation of men in the traditionally female domain is infrequent and so specifically commented upon, as opposed to taken as a matter of course. Most men took an active role in preparing for the arrival of the baby by organising the nursery, buying baby magazines and attending antenatal classes. The close involvement of many is most clearly illustrated in the case of one woman who regarded parenthood as a 'joint venture' to such an extent that throughout the interview, she spoke of "our" pregnancy.

With the progress of pregnancy, roles need to be reorganised, as the woman withdraws from the labour market to take over domestic responsibilities. This may involve the husband taking over as sole earner if the woman is not on paid maternity leave. The existing division of labour within the home is thus disturbed, necessitating changes in household arrangements. Some couples in the sample shared relationships based on equality, which extended to household tasks. This was often the result of active role negotiation: "He's got a full-time job and I've got a full-time job. But he's also got a side-line job, an extra income and while he's doing that I do the housework, cooking and ironing. That's the decision. He does that job extra and my extra job is the house."

It is clear that a supportive partner and a well negotiated relationship are two of the most influential factors that ease the stress resulting from pregnancy and its accompanying changes. It was noted that ideas as to what constitutes 'support' vary considerably, to such an extent that some women regard occasional help in the kitchen as added support, while others regard this added support as the taking over of household tasks by their partners, as in this case: "I haven't cooked a meal in the last 8 months. I haven't felt like it. We work together, long hours. Whoever gets home first does the meal. It's never been my role to do that."

From the women's accounts, it would appear that the interpretation of the amount of support received is more consequential than the actual contribution. What is important is that responsibilities and expectations are mutually accepted. This prevents resentment or conflict with regard to domestic issues. In one case negotiations concerning after the birth were already in progress: "Some mornings my husband will stay at home and I'll go to work. It's important for them. I think it's sad that they're always the ones that have to work. I want to make an effort, me going to work so he can stay at home. We're both new at it." The flexibility here was allowed because 'work' was a jointly-run business.

Where the nuclear family is more prevalent than the extended family, the husband and wife dyad form a distinct unit separated to a certain extent from other members of the community. The spouse is then the primary source of daily support. The isolation felt by pregnant women in this context was evident in the interviews through the frequent acknowledgement of and at times frustration with their partner's inability to understand and relate: "When he couldn't see it he didn't understand why I was so tired. I actually got a bit cross. The minute there was a tummy there it seemed a bit more real and when he could feel it kick. It's difficult for him. He had trouble realising it was something real."; "For the man it takes much longer for it to sink in. They don't think about it as much as you do because I can feel the moving around inside. It's not as all-consuming for him as it is for me."

Their partners detachment from their pregnancies made the contact with other women in the same situation an important source of comfort and understanding. It also highlighted the value of antenatal classes as a way of educating men in the changes involved in pregnancy so that they are better equipped to deal with them sensitively.

PREGNANCY AND EMPLOYMENT

The decision of whether to continue work after the birth of the child or become a full-time mother is a seriously considered one, made in the presence of conflicting pressures. All of the women in the sample intended to return to their jobs with the exception of three who made the decision to become full-time mothers. Most had some form of tertiary education and many would be regarded as career women, placing a high value on the satisfaction gained from their careers. To these women the decision to be a working mother was based largely on a reluctance to leave a career in which they had invested many years: "It's our own business. You're leaving something that you've put your heart and soul in for years. You don't just want it to fall apart."

The financial aspect of employment was particularly important, not only because of the need for two incomes, but because of the independence a separate income allows and the need to contribute equally to the household's finances: "I feel I need to be able to contribute as much to the household. The thought of asking my husband for money doesn't appeal to me."

The social interaction and stimulation attained from work are important for maintaining an identity outside of 'mother': "I enjoy my work too much to give it up. It's very important to me to interact with people. Anyway I need to work for my own sanity. I could never stay at home all day. I'm not a housewife sort of person." Often a part-time job was considered as a way of maintaining outside interests. However, as a few pointed out, these are difficult to find. Part-time jobs are also seldom given enough status, nor do they carry the same rewarding salaries or the security of pension and promotion that accompany full-time jobs. Some employees are reluctant to accommodate working mothers, as one woman found out: "People at my work are cross that

I want maternity leave. The attitude is - that's it, we knew you'd do this, that's why we shouldn't have female managers."

The decision to maintain a career was also influenced by judgements of the quality of their own mothers' lives: "My mother's from that era where the women stay at home and raise the children, that's your function. She wasn't satisfied. I can see it now. She doesn't know what to do with herself. She has no confidence. She never got involved in anything but the children."; "I think my mother was very angry that she had to give up her career. It was the done thing in their day. My husband's mother was studying for her doctorate and she gave it all up as well."

Despite the clear-cut nature of the decision for most of them, guilt was still evident in the fact that many found it necessary to substantiate their decision: "Most mothers have their work nowadays. They don't just give it up." Others went to lengths to justify their decision: "My sister decided to stay at home with her child. She was worried about him because she said he wasn't interacting as well as other kids and I said maybe he wants kid's company. They need the stimulation of kids their own age. So she sent him to play-school and the change in this child is incredible. It came as a shock to her. She gave up her career to give him everything and she couldn't. It is possible to do both, you just need the right balance."

Another woman spoke of her friends' decisions not to work: "They make you feel quite guilty about going back to work. But I get satisfaction from my job and I need that. They've chosen not to work and I feel that puts a lot of pressure on their relationships with their husbands, financial pressure, pressure to succeed in their jobs. They seem to think they're offering their child the best by being at home. But they're these ratty, unfulfilled people who feel frustrated about being at

home. So I think in a sense they're not giving their child the best."

The guilt felt resonates back to the idea that children are harmed if their mothers work outside the home. Such ideas, present in theories of contemporary psychology and child development, arose from the influential works of Bowlby (1953; 1969) who insisted that the first two years of life are the formative years and stressed the importance of mother-child interactions and attachments in influencing the child's development. This opinion was held by the three women who decided to remain at home: "I'm not going to work in the beginning because I feel it's important for the mom to be at home. I think for a lot of people in society, half the problem is that women don't stay at home, even just for a little bit."

Bowlby, who concluded that a warm and continuous relationship with the mother in infancy is indispensable for good mental health has since amended 'mother' to constant, primary caregiver. Similarly, evidence has been reported that the children of mothers working outside the home are not harmed as long as a satisfactory care-giver is provided (Chess & Thomas, 1987; Shreve, 1988). In fact, it has been argued that full-time motherhood is not always best and that mothers are more stable and able to meet their infants' needs better when parenting substitutes are available. This is because the unending and demanding nature of baby care can wear down a mother's patience, often resulting in anger and frustration (Melville, 1983:360).

Many women now no longer regard motherhood and a career as mutually incompatible. The change in perception of the full-time mother as the best mother is revealed in the fact that one woman experienced guilt about leaving work as opposed to guilt at not leaving work: "The first two weeks that I was working half-days I went through quite a lot of guilt, the fact that I wasn't

working. Now I'm getting quite used to it. I don't feel anything!"

PERCEPTIONS OF FEMINISM

Only five of the women in the sample were committed feminists. The majority acknowledged the need for equality between the sexes, but were wary and sometimes very critical of the feminist movement. A very common response to the question of being a feminist was along these lines "No, I'm not a feminist. I believe in women's rights." Feminism has been defined by a Dictionary of Sociology (Abercrombie, et.al., 1988:96) as a doctrine suggesting that women are systematically disadvantaged in modern society and advocating equal opportunity for men and women. By this definition, the majority of the women's lives and approaches suggested a feminist outlook, but because the label 'feminist' had come to be interpreted differently by them, they were unwilling to align themselves with it.

Feminist thinking has become synonymous with the radical feminist approach. This is seen in a few references to the view that they are not feminists in that they would not go around with a banner or burn their bras. One woman stated this more explicitly: "The feminist movement's been entirely taken over by the hairy legs brigade." In the case of the women in the study, radical feminists appear to have alienated many women who are in fact practising or aspiring towards feminist ideals.

Not only have many radical feminists in the past (such as deBeauvoir, 1960; Millet, 1971; Firestone, 1972) shown a disregard for the fulfilment derived from the role of mother, but in their attempts to attain new freedoms for women, they have failed to realise or acknowledge that being

a mother and a career person carries an incredible burden. Women now feel under pressure to be successful at both. As one woman said, "They have taken the dignity out of being a full-time mother just for a few years." The resentment felt by women towards certain evaluations made by the feminist movement was demonstrated by another woman: "There's a documentary I saw about women in their late 30s and early 40s in America who feel that at that stage they start wanting to have children and they've gone through feminism feeling that wasn't a choice they wanted to make initially. A lot of them are quite cross with feminism, feeling that it has given them the wrong message."

SOURCES OF KNOWLEDGE

There are a number of formal and informal ways in which knowledge about pregnancy and childbirth is transmitted. Childrearing has become increasingly commercialised with many advice books and magazines on the market. In addition, antenatal classes are increasingly attended. These formal sources of knowledge combined with the stories and advice of friends and relatives are often conflicting and confusing. Some women respond by discounting these stories: "I heard a lot of stories about childbirth, some great, some horrific. One tends to block one's mind to any more stories. It's such an individual and different experience. You get so many different opinions. In the end you think - stuff everyone else, just go through it and cope with it when the time comes."

Women make sense of their experiences in part through the medium of popular culture. Books and commonly held beliefs, whether accurate or not, are very influential in the formation of their own personal ideas. "If it's your first time round, you don't know what to expect. You're really

going by what other people have experienced." Women are reliant on outside sources for reassurance and confirmation that their feelings or responses are normal. "I hear that's normal" was a commonly heard expression. It can become easy for women to rely too heavily on the opinions of professionals and doubt or devalue their own knowledge or instincts. The order in which this woman listed her sources of support is indicative of this mind-set: "I know bugger-all. I'll rely on the doctor, a book and common sense."

The nature of the antenatal education and the preparation for birth a woman receives, affects the type of birth she chooses. A natural or medical bias is clear in most literature. This is seen in the case of a book aimed at South African women. Throughout the book childbearing women are referred to as patients, already portraying birth as necessarily a medical event. Furthermore, at one point the book states: "When the baby's head is visible during contractions at the second stage of the labour process, a left lateral episiotomy must be performed under local anaesthetic" (De Wet, 1987:27). While it is possible that the author was basing her advice on the most accepted medical knowledge at that time, this assessment that an episiotomy is required in all cases as a matter of course is unfounded. It has been pointed out that in Holland and other European countries, episiotomies are rarely performed. This is because in the majority of cases women do not tear and in those cases where they do, a small tear is preferable to a deliberate incision (Jordan, 1993:89). The presentation of episiotomies as a matter of course implies that such a medical procedure is prerequisite for a successful birth.

THE SOCIAL ROLE OF MOTHER

The decision to have a baby is motivated by the anticipated fulfilment of motherhood and the desire to start a family. Motherhood may be assumed from childhood involving little debate: "That's one of the ends of marriage, not always the reason you get married, but it's a natural consequence of marriage, it goes without saying." Alternatively it may be deliberated about for many years, with increasing age being the deciding factor. Most women spoken to had always wanted to be mothers at some stage, the issue being 'when' rather than 'if'. Despite this, the decision to conceive was not simply assumed. For many it was planned with career and financial considerations in mind and the final decision was based on a number of factors: "I'd achieved everything I wanted to. I'd established myself in my career. I'd been married a year, got the house, settled in here. We always wanted a family at the right time and I wasn't getting any younger."

Five of the women had previously suffered infertility problems. Their experiences of childlessness coloured their responses to pregnancy and motherhood. Pressure and a lack of understanding was experienced by these women: "You get all the negatives thrown at you." This is on top of the anger and frustration felt at their inability to conceive. For these women, in one way motherhood was regarded as a gift and in another way problems arose where a childless status had been accepted and an identity had been assumed outside of motherhood.

Responses to pregnancy and childbirth are conditioned by the values of a society. In South Africa the role of mother is highly valued, as seen in the treatment of pregnant women and the stigma of childlessness, to which a few women testified. As one woman commented "a pregnant woman

gets a lot of attention." Incidents of kindness and concern shown to them were frequently reported. The caring responses generated from even strangers, and the excitement surrounding their pregnancy indicates the status attached to pregnant women and the romanticised image held of motherhood.

Despite an increase in voluntary childlessness, womanhood is, for the most part, regarded as synonymous with motherhood. In this study, even though motherhood was seen more as an option than a given, it was still regarded as a marker of femininity, where femininity is women's socially constructed gender role and identity. The view of motherhood as women's natural function is demonstrated by the women's expectations of baby care. Although they found the prospect anxiety-provoking and in some cases terrifying, many women expected baby care to come naturally: "It's quite a daunting task so I'm quite nervous about the whole thing. I think instincts take over and it all comes naturally." Half the women spoken to strongly believed that all women have a maternal instinct: "There's that natural instinct that you can't get away from no matter what you do. You can suppress it, but it will always pop back up." Most of the others believed in an instinct but doubted that it was shared by all women.

Several other comments pointed to the view that motherhood is a natural function of women and a desirable and inevitable social role: "Motherhood is the ultimate fulfilment for a woman. I believe that women are created to raise children" and "Motherhood is very important. It's what we're made for, what we're there for." It is not always the case that a successful career cannot be combined with motherhood or that women have to be single-minded in their approach to work if they are to succeed, as seen in the stereotype of the hardened, unmaternal career woman.

The pressure increasingly placed on mothers not only to fulfil their child's physical needs, but also his/her emotional, intellectual and developmental needs has meant that motherhood is not only challenging and demanding, but anxiety-provoking. Aside from this pressure placed on mothers, feelings of anxiety may be attributed, in part, to the lack of continuity between generations common to modern society. The predominance of the isolated nuclear family in modern society often restricts preparation for motherhood to doll playing, which is unrealistic and idealistic. In contrast, in the past, the presence of many siblings and extended families meant that children were able to observe parenting and learn through experience. This is testified to by the fact that five women who had younger siblings or many nieces and nephews with whom they had close contact, were far more confident of their ability than those without that contact.

Fifteen of the women reported that they had little or no experience with babies. The outcome of this was not only anxiety, but often a difficulty in identifying with the role of mother: "I don't have a clue about baby care. That's probably more anxiety-provoking than the birth. One day you're like this and the next day you have a human being who's totally dependent on you. It's like the one day being single and the next day married. I don't relate as a Mrs. I'm still just me and that's it. So the whole thought of being a mother is a strange one. I'm really hoping that it will happen naturally."

EXPECTATIONS OF BIRTH

For a natural process and despite the fact that social advances have made it safer, childbirth is surrounded by an enormous amount of fear, foreboding and anxiety. In the case of first time mothers the unknown is an important factor in this. Only four of the women in the sample

expressed confidence in their ability to cope with the experience. The remaining 16 described their feelings about the birth in terms of fear, terror and nervousness, often culminating in denial. This woman referred to the feelings most commonly expressed: "I'm feeling nervous, extremely nervous and terrified. It's not something I want to go through. Most of the time I tend not to think about it because I'd probably work myself up into a panic. As time draws nearer it's an ever worrying factor. I'm hoping that it's not going to be too much to bear."

With the preference for smaller families, many women may only experience childbirth once or twice. This adds extra significance and greater expectations to the experience. However, although the significance of the experience of birth was mentioned, birth was spoken about more as an obstacle to be overcome on the way to motherhood, than as a potentially life-enriching experience. Birth was also seen primarily as a physical activity, with the issue of pain and the available medical procedures being the main chosen topics of discussion.

HOSPITAL VERSUS HOME BIRTH

Several of the women considered a home birth, but all decided that the hospital was the safest environment in which to deliver their first baby in case of any unforeseen complications. Home births are generally not presented as a viable option, especially in the case of first births. However, it has been reported that in South Africa home deliveries are gradually becoming more popular, some women preferring a simpler, more natural approach to birth. King (1997:50) reports that the number of births handled by a South African organisation of midwives, is increasing from year to year. This move is motivated by the increasing rate of artificial

intervention in birth and especially the very high Caesarean rate in this country, currently over 50 percent (Lilian, 1996:155). The heads of two maternity sections of private hospitals, when asked for their estimation of the Caesarean rate in South Africa, agreed on the figure of 55 percent, although one commented that at some stages the rate rises as high as 70 percent. A further consideration with regard to home births is the cost. 'Normal' birth in a private hospital costs about R10 000 and several thousand more if complications arise, whereas a midwife-attended home birth costs in the region of R2 500.

The consideration of home births is largely restricted to the middle class and more informed childbearing women. This was found to be the case by Cunningham (1993) who found that the home birth mothers in his study tended to be older, more educated and more feminist oriented than labour ward mothers. Furthermore, home births, where preferred, have to be actively sought and negotiated as many doctors in South Africa are not in favour of home births or even midwife-supervised deliveries at hospital (King, 1997:50).

Through the antenatal classes the women had been exposed to the notion of medical birth. However, many brought to the classes ideals of a natural, intervention-free birth. "As natural as possible" was the most common birth plan. A degree of conflict was evident between wanting pregnancy and birth to be a natural experience and making use of the available medical procedures. This is a direct response to women being told that pregnancy is a natural function while receiving the implicit message that childbirth can only be successfully accomplished within a medical setting. This conflict between the medical and natural discourses was a big issue to some: "To me it's important that it's a natural thing that's happening and not a medical thing essentially. I could in some way have my baby at home, but my husband feels very strongly that

I should be where there's care. To me, still, to be as natural as possible, to be allowed to move around and do your own thing, is important. I'll read something and then it will make me all unhappy. How am I supposed to have this natural birth in this hospital setting?"

NATURAL CHILDBIRTH

The natural childbirth movement is valuable in drawing attention to women's subjective experience of birth as opposed to their objectified bodies. Furthermore, it has opened up the debate surrounding the issue of who should control women's bodies and the process of birth. Most importantly, the natural birth movement has emphasised the possibility of intervention-free childbirth. However, in this regard, while a highly medicalised birth was generally not favoured by the women, it cannot be assumed that a natural birth is the preference of all women: "To be frank I don't really go in for this earth-mother great cataclysmic life experience thing. When we were facing up to the fact that we probably wouldn't have children, I was quite keen to adopt. The fact that I was going to miss out on the experience of pregnancy and birth I didn't feel was really a factor. It's wonderful that I'm going to have that experience, but I don't set a huge store by it."

It cannot either be assumed that birth itself holds great significance for all women, as illustrated by this comment: "Initially I thought numb me out straight away and be done with it. Reading about it I think I would like to get by without pain relief. But if I feel I'm not handling it I won't hesitate."

In discussing natural childbirth in contrast to medicalised childbirth, it is necessary to point out that the natural childbirth movement, though advocating a return to simpler, more natural

methods, is as much an artificial construct as the medical discourse. The construction of the natural childbirth movement, in response to the medical discourse of childbirth, is most clearly demonstrated by the irony that women need to refer to books, of which the most influential was written by a man, Grantly Dick-Read (1933), to learn the technique and skill required to give birth naturally. Furthermore, the extent of the cultural variation of the birth process explored by authors such as Jordan (1993) would imply that there is no one absolute natural childbirth. Societies differ markedly in their approach to birth, such as the way in which pain is handled, who is present at the birth, the position of the woman and the surroundings in which she gives birth.

The danger in advancing methods of achieving natural birth is the implication that there is a right way to give birth. This places pressure on women to master elaborate breathing or relaxation techniques in anticipation of the natural process. Furthermore, the natural birth movement may be construed as prescriptive where all forms of intervention are discouraged even as possibilities so that women feel pressurised to go the natural route: "I was under a certain amount of family pressure, this natural birth. Actually I think the midwife was very sensible. She said you wouldn't dream of having your teeth out without an anaesthetic these days. So why a baby?" What is important, in relation to the natural birth movement, is that women are given greater freedom with regard to their birth experience.

BIRTH AS MARKER OF FEMININITY

Ideas of natural childbirth reverberate back to ideas of femininity, that a woman is not a woman until she has given birth to a child. In the discourse of femininity, motherhood is culturally

equated with the achievement of femininity or female identity. Some women expressed this sense of achievement at conceiving a child: "I was happy when I fell pregnant. I said - see I can also do it....It's something your body can do. It's a physical thing. It's quite hard to rationalise but I think you'd like to go through that experience because you're capable of it."; "I think it's something quite special, that only women can experience, being pregnant and giving birth. I'm glad I could do it."

The women's repeated mention of their concern about being able to cope and knowing what to do could also be seen as reflective of this idea of birth as a test of femininity, as something to be achieved in pursuit of full adult identity: "My sister said that she only really felt like an adult when she had her first child." The pressure of the achievement of a natural birth is evident in a few references to bravery, such as: "I don't know how brave I'll be."

Where the natural childbirth movement presents childbirth as primitive or innate, there is the additional danger that women who are adamant about their refusal of any form of intervention may feel disappointment or a sense of failure if they were to have to resort to medical procedures. While most women expressed concern about being able to cope and doubted that they would know what to do, three women showed faith in their bodies' ability to handle intervention-free childbirth with comments such as: "I would like to think that I'd be able to handle the pain. I've always trusted my body. So I'd expect my body to be able to do this. I know I would be a bit disappointed if I had to go the epidural route."; "My mother had two children without any pain-killers. If she could cope, I can. An epidural is an unnatural invention. My body has been made to deal with a natural birth. I don't want to prevent my body from doing its natural thing by using an epidural. I know my body is equipped to deal with natural birth."

RESPONSES TO THE MEDICAL DISCOURSE OF BIRTH

The women responded to the medical discourse in which birth was presented either with reservation or with acceptance. Women resisted or questioned the medical discourse through their weariness of medical procedures, treatment or approach. A common comment was, "I don't want to be told to lie on my back." Open discussion with their doctors eliminated these reservations: "I was worried that if it was too big and I said to them, I need a Caesar now, that they wouldn't listen to me. They tend to brush you off and do their own thing. My doctor told me straight away he doesn't believe in that. He's put my mind at rest."; "I'm a very healthy person. I've never been inside a hospital. I just don't want to be tampered with in any way whatsoever. There are after-effects. I think we were made to have babies born one way."

Acceptance of the medical discourse often bordered on passivity. As Oakley (1980:269) has pointed out, patienthood and femininity are similar stereotypes, both being thought of in terms of submissiveness, passivity and dependence. Most of the women accepted the doctor's authority without question, with comments such as, "They must do whatever they have to do." The differential status of the woman and the doctor, evident in the interviews, is not only because of the doctor's medical expertise, but also because of the high social status accorded to doctors in society.

Compared with the accounts of other researchers of childbirth, the women in this study displayed more acceptance of authority and willingness to place most of the control in the hands of the doctor. Some actively preferred a passive role: "I'm sure when it comes down to it, it will be largely out of my hands. I shall not have to worry or think about anything, just be there and do

whatever I'm told to do." Others assumed a passive role in relation to the doctor's superior knowledge: "If something happens and a Caesar becomes necessary, I'm quite happy for them to do that. I'm not going to be awkward about it. I'll go along with them. I have my own ideas but if they feel a certain thing is best then that's OK with me." In one case, an otherwise confident, independent woman was prepared to give her doctor the authority to make a decision regarding something as subjective as her level of pain: "I'll listen to what they have to say. If they think I don't need an epidural, I'll listen. I won't go in stubborn and pig-headed about it."

ANTICIPATION OF MEDICAL PROCEDURES

Preparing for birth in a hospital setting involves a consideration of the medical procedures available. Every woman had an opinion on epidural analgesia. This is an anaesthetic injected around the spinal nerves. It works by numbing the sensory fibres from the uterus and thus dulling the sensation of the contractions, while leaving the mental consciousness of the woman unclouded. It is a specialised procedure performed by an anaesthetist.

In medicalised society the now 'optional' nature of pain has resulted in a belief that pain must be relieved or avoided. The removal of pain in childbirth, in particular, is regarded as a primary and necessary goal. The notion of pain as negative is reinforced by the pathological view of childbirth, as a medical event carried out in an environment associated with sickness and injury. Only one woman, who had given the issue much thought, saw the pain of childbirth as potentially positive and uplifting.

Women who have given intervention-free natural birth speak of the extraordinary exhilaration and stimulation of bringing a child into the world while fully conscious of their physical and emotional sensations. Pain is viewed as a worthwhile activity, rewarded by the birth of the baby and accompanied by an enormous sense of accomplishment (Van Kuik, 1997:7; King, 1997; Kitzinger, 1991). Expectations of this kind of birth influenced the way in which some women envisioned their birth: "I believe that birth is a experience. I don't want to dull it. No matter how painful it is, I'd like to experience it. I don't see how a woman can say she had a fantastic birth when she didn't feel a thing. To me, she hasn't given birth. Somehow it's been taken away from her. Natural birth means you're experiencing the whole thing."

Within the medical setting, women are continually made aware of the availability of epidurals and other forms of pain relief and their effectiveness. The continued suggestion of the need for pain relief could have been partly responsible for the lack of confidence displayed by the majority of women with regard to their ability to cope, as it confirms the fear that women cannot handle the pain of childbirth. One woman said, in relation to this, that: "In the classes they really annoy me because they start with this pain thing. It's our fear of the unknown. A friend of mine had two births naturally, no anaesthetics, nothing. She sailed through it. She said it was painful, but you've got to realise what you're working with. It's control over the mind."

Four out of the 20 women planned to request an epidural at the outset. The remainder wanted a natural birth without an epidural, except where absolutely unavoidable. Epidurals were planned for reasons such as "It's available so why not have it?" and "I'm a bit chicken when it comes to pain." One woman's comment was very indicative of the medical preference for this type of birth: "The one doctor said the definition of a natural birth is epidural and no make-up!"

The women were well informed as to the benefits and particularly the potential problems involved in the use of epidurals, having read extensively on the topic. Stories were relayed, such as one of a friend who had suffered persistent back ache for many years, for which she held the epidural accountable. A main reason for not wanting an epidural was its numbing effect, disallowing the woman active participation in her labour and delivery. Other reasons are reflected in these comments: "I think pain relief affects the child. They say it doesn't. She was saying, it's nothing to worry about, they can always give it Novocaine. I think that's wrong, starting off having one drug after another before it's even had a chance. That's what puts me off."; "I think epidurals are good if you know that you don't have the confidence to give birth naturally, but I think it takes away the beauty of natural childbirth because you can't actually feel anything. You can't push properly. Basically you're just like a dummy."; "I'd rather not have an epidural. I don't like the thought of needles going into my spine. The major thing that goes wrong is paraplegia. I've see two patients admitted post-epidural. But it was probably done in some hospital in the middle of the Karoo, so it's unlikely. It's more the low blood pressure, head-splitting headaches. You can't get up to go to the nursery. The bonding process is affected. Also it might not actually work."

Another medical procedure brought up by many women was the Caesarean. It was generally agreed that, unless absolutely necessary, a Caesarean was to be avoided. The reasons for this were the extended recovery period required and its subsequent effect on the bonding process, as well as the nature of the procedure, being a surgical operation. The antenatal classes placed an emphasis on the possibility of a Caesarean and attempted to allay any fears with regard to the procedure. This extra attention was a response to the fact that where Caesareans used to be performed rarely and only in emergency situations, the Caesarean rate has now risen

considerably, increasing the possibility for an expected natural delivery to turn out to be a Caesarean.

Reactions of disappointment, depression and inadequacy have been commonly found among women following an unplanned Caesarean (Raphael-Leff, 1991:302). The women were aware of this. Many stories were reported of friends who felt like failures because they had to resort to a Caesarean. A story was relayed of a woman being admitted to a psychiatric hospital because of her inability to accept the fact that she failed to give birth naturally. Several women, in response to these stories, mentioned that they would not be terribly disappointed if they had to have a Caesarean. The need to keep an open mind with regard to birth plans was repeatedly mentioned.

The hospital stay and particularly the anticipation of medical procedures was a large source of fear. References to the hospital as an alien and unwelcoming place were made, but several of the women had met the staff and toured the maternity ward as part of an antenatal class. This contributed in a significant way to distilling their fears about being in hospital. Some women were apprehensive and at times paranoid about medical procedures such as epidurals, episiotomies and enemas: "For me the most threatening thing is having to have an enema. And the fact that everyone's going to be glaring at you, which invades your privacy. That's something you don't look forward to, but you know that it's part of it. I'm anxious about that."; "One of my biggest anxieties is having an epidural. I'm more scared of that, more so than natural childbirth. The thought of them sticking a needle into my spine doesn't work. It's a risk. I'm worried that I won't get my feeling back if something goes wrong."

CHAPTER 5

THE EXPERIENCE OF CHILDBIRTH

THE MEDICALISATION OF BIRTH

The most obvious indication of the medicalisation of birth within the group of women in the study, is that all the births took place in hospital, attended by medical professionals. The natural deliveries took place in the labour ward and Caesarean deliveries in the operating theatre. The births therefore took place within medical surroundings, particularly the Caesareans, being surgical operations, where "everyone's in green and very sterile." All of the women were accompanied into the delivery room by their husbands or partners with the exception of one whose mother-in-law took her husband's place. An average of three people attended the natural births, including the partner, gynaecologist and a nurse or midwife. The Caesarean births were attended by six people on average. This included the partner, gynaecologist, anaesthetist, paediatrician and nurses or assistants.

The extent of the medicalisation of childbirth is revealed in the fact that all of the women had some form of medical intervention. Where natural childbirth in its narrowest sense refers to intervention-free childbirth, none of the women experienced strictly natural births. All took drugs of some kind and made extensive use of medical equipment during the birth. Eight of the 20 women (40%) had their babies delivered by Caesarean section. Of the remaining 12, eight had epidurals, all of which were instrumental deliveries. Half of the women giving natural birth (6

out of 12) were induced and five had episiotomies. On the whole, 16 of the women (80%) made use of analgesia of some kind, 13 epidurals and three spinal blocks. The four women who managed without an epidural made use of pethidine in the form of an injection, supplemented with entonox, given in gas form. This dulled the pain, but did not remove it. All of the women who gave birth naturally made use of fetal monitors, while four of the natural births and all of the women who gave birth by Caesarean had a drip and catheter inserted. The four women who did not use an epidural were the only ones who did not have a drip. Generally the number of medical procedures required was not anticipated, with 14 of the women stating that their babies' births differed markedly from what they had expected.

The descriptions given of the birth of the women's babies were predominantly in medical terms. They demonstrated a full understanding of the apparatus and procedures involved. The amount of technical information used in their personal accounts illustrates the thorough incorporation of the medical view of birth into their perceptions of their birth experiences. This is significant because the medicalisation of birth begins conceptually, where birth is defined in medical terms, before any medical procedures or drugs are even administered. It is the definition and meaning attached to childbirth, as a medical event, that transforms the human experience into a medical and technical problem.

While the extent of medicalisation was evident in the case of all the woman's birth experiences, it was directly commented on only by a few women. This was surprising in view of the fact that most of the women anticipated and favoured a natural birth. Only one woman commented on the fact that the natural process of birth is seen as pathological: "The one thing I didn't like was that they were monitoring me quite a lot. It's a medical system that's constantly looking at symptoms.

It makes you feel as though you're sick, as though you're somebody who has to be taken care of. One can easily get anxious about it."

THE START OF LABOUR

Due to anxiety and anticipation, many women in the study were slow to acknowledge the beginning of labour, as indicated by the onset of progressive and consistent contractions, a bloody show or ruptured membranes. Once the start of labour had been confirmed by a phone-call to the hospital, the women checked into hospital immediately, accompanied by their partners. Most (16) of them did not deliver their babies on the calculated due date. Eleven women were early, seven of which were artificially started by way of Caesarean or induced labour, and five women were late. While waiting for full dilation, the stage at which delivery takes place, some women made use of the bath, where it was available. Others paced the corridors, as this helped to alleviate labour pain to a small degree and helped to pass the time. After epidurals were administered, however, the women were confined to bed.

THE EXPERIENCE OF MEDICAL PROCEDURES

Prior to birth the majority of the women made clear their intention to have as natural a birth as possible. Although they were prepared for the possibility of having a medical birth and accepted the medical model of birth, many viewed natural birth as the ideal. Throughout the reports on their birth experiences, the women regarded the major drawback of the use of medical procedures and equipment as the fact that they are unnatural. An ideology was thus being upheld that 'natural is good'. This is based on the belief, shared by most of the women, that the female body

is equipped to deal with natural delivery and thus interference should, in most cases, not be required. Furthermore, while it cannot be denied that advances in medical intervention can save lives and improve health, it has been reiterated that in the case of childbirth, intervention is often unnecessary and, in some cases, detrimental, and hence has little advantage over the natural process. As such, the 'natural' is often the best option.

INDUCTION

Induction is the artificial initiation of the process of labour. It is recommended where the woman is unable to continue the pregnancy or the placenta is failing to support the baby's life and so it is safer to deliver the baby early. Six of the women in the sample were induced. One of these women's induction was medically necessary because the placenta was not working sufficiently to sustain the baby until the expected date of birth. The remaining five could be considered to be convenience inductions because they were not necessary for medical reasons. For two women, the decision to induce was prompted by the desire to disallow the baby to grow any further because any increase in size might have necessitated a Caesarean delivery. Three women were induced because there were signs of labour beginning but things were progressing very slowly and the doctors and the women wanted to quicken the process. It has been reported that inductions have increasingly been performed for reasons of convenience (Cartwright, 1979; Kitzinger, 1991; MacFarlane & Mugford, 1984). The convenience of the use of inductions was also revealed in the case of one woman who was woken by a nurse at four o'clock in the morning to prepare to be induced. This was to ensure that her birth did not extend into the night.

An induction is justified where it is undergone for valid reasons and is supported by the woman concerned. However, problems arise where the woman and her doctor do not agree. One woman, in this regard, commented, "Surely they just come naturally. He came naturally even though I wasn't dilated enough. From the doctor's point of view he's not coming because I haven't dilated, but from his point of view, he was coming and he came. I can't see why if you're not dilating enough that gives them the right to think they should induce you because that doesn't mean he's not going to come."

The problem with convenience inductions lies in the fact that they do not always have the planned effect and may initiate a set of undesirable consequences. In the case of three women the inductions did not have any effect. Some might argue that this is because the baby was not ready to be delivered, needing longer in the womb owing to reasons such as the mental and physical state of the mother and the environmental conditions of pregnancy (Brook, 1976:86).

The knock-on effect, where one intervention leads to another, has been found to be common with inductions. The woman is immobilised which makes it more likely that dilation is slow and that artificial oxytocin will be administered to speed it up. Immobility also necessitates a catheter. Owing to the fact that artificially induced contractions are quicker and more powerful, epidurals are commonly requested for the pain and the blood pressure of the woman and heartbeat of the baby need to be monitored. Epidurals in turn usually necessitate instrumental deliveries because of the woman's inability to push (Cartwright, 1979; Kitzinger, 1991:21). This occurred in all six cases. All the women who were induced had epidurals and required instrumental deliveries, as well as monitoring and the insertion of catheters and drips. One woman explained how her induction had necessitated the use of an epidural, to which she had been ardently opposed: "They

put the drip in you that makes the pains so incredibly intense and so quick. Your body doesn't have time to build up its natural pain-killers. It got so bad I couldn't endure it. I was in tears. I started hating her. So we went for an epidural. When it gets so bad, you wonder why you ever got pregnant. It gets quite negative."

A further consequence of the use of inductions is revealed in the fact that causal links have been found between induction by pitocin and the failure to dilate fully or 'uterine inertia'. This was termed a 'lazy uterus' by one woman who described it as "your uterus gets to a certain point and says I'm not doing any more." It is possible that the pitocin itself or the medication needed to counteract the powerful and painful contractions caused by the pitocin contributes to or causes 'uterine inertia' (Martin, 1989:151).

It would thus appear that inductions should be avoided, except where medically imperative, because they do not always have the desired effect and the need for medical intervention is increased. This, in turn, carries the risk of additional complications. It has been reported, in this regard, that the chance of having a Caesarean delivery is doubled with elective inductions (Llewellyn-Jones, 1993:239). In addition to this, the experience of inductions is generally not pleasant: "I don't think I could be induced again and I wouldn't recommend it to anyone." This view is supported by other researchers who have reported that those women in their studies who were induced disliked the experience and would not wish to repeat it with later births (McIntosh, 1989:202; Cartwright, 1979).

One woman's description of her experience of a convenience induction illustrates the additional and unnecessary complications that may be introduced, as well as the resultant emotion distress.

In her case the process of induction had to be repeated five times, each time accompanied by a painful and intrusive internal examination: "They inserted a gel which is really hideous and apparently pretty intense. The main worry is that by introducing something into the uterus it gets over-active and the baby gets distressed. So they're monitoring to see that the baby remains calm. For that hour you're not allowed to move. At five o'clock my contractions were so strong the woman didn't want to give me any more. She was scared for the baby and then I went on to have another four. I was frantic. Every time they did it all I could think about was what this woman had said in the morning because she went off duty."

THE VALUE OF MONITORING

All of the women giving birth naturally were monitored at some point. As the monitoring was done routinely, most women accepted it as part of the process, not regarding it as worth comment. It is argued that fetal monitoring is valuable in high-risk births where the infant's well-being may be compromised in the process of labour and delivery. It is of less value when routinely used in low-risk births in part because the restriction placed on the woman's movement may slow down her contractions. This is often responded to by speeding up her contractions artificially, which in turn necessitate drugs to reduce the pain brought on by the rapid contractions (Michaelson & Alvin, 1988:150). One woman requested that the monitors be removed because they were restricting her movement, which she found helped to relieve some of the pain.

Monitoring, except where necessary, has been further criticised because where the readings from the monitor become the primary focus of attention, a clinical detachment from the birth process

is cultivated. Laing (1982:16) has argued that the fetal monitor estranges us because instead of listening to the baby's heart by putting our ear close, we turn away from the baby and look at abstractions on a fetal monitor. Bergum (1989:141) adds that this abstraction may change the experience of the contraction for the woman, as she is no longer in touch with what she is feeling, but is being directed by others who have a visual understanding of her contractions. Monitors may indicate the number of contractions: "When you get there they put you on a machine to see how many contractions you're getting" and the strength of contractions: "They put a monitor on me and they spoke about them as massive contractions." In both cases information about the contractions from the monitors meant that others were able to direct and control the woman's labour. Bergum (1989:147) argues that in such a situation the woman would not experience the baby inside, but rather as a separate being who is delivered through the coordinated efforts of others.

One woman found the monitoring equipment uncomfortable: "They had the monitor when I first got there, which was horrible. That was very painful. When the contractions came, it seemed to make it even more sore, the pressure of this thing around my waist." However, most women did not consider it an unnecessary piece of equipment, but rather appreciated the security and reassurance it supplied: "They take your blood pressure constantly. They have this machine thing on you. And the heartbeat monitor and contraction monitor is on all the time. They were monitoring every single thing and I knew that if there was any distress, the operating theatre was literally around the corner." Furthermore, while the monitors did become an important focus of attention, the women did not express any feelings of being disconnected from the birth process as a result. An additional benefit was that the monitors helped the partners to feel more involved in the labour, not only because they could visually anticipate the next contraction, but because

the machinery allowed them a chance to participate: "They put monitors on you and he was eventually readjusting them and putting them on and putting jelly on my tummy."

EPIDURAL ANALGESIA

Of the 16 women who used some form of analgesia, 13 were epidurals. The difference between an epidural and a spinal block lies in the area of the spinal cord into which the anaesthetic is injected. An epidural is less invasive, but takes longer to take effect than a spinal block. Of the 16 women, 13 had stated prior to birth that they did not want an epidural. This means that only three of the 16 who made the decision to avoid the use of an epidural were able to do so. The main reason why women chose to have epidurals was because they found the pain of early active labour so severe that they doubted they would be able to handle it if it got any worse: "I thought if the baby was imminent, I could handle it, but the idea of going through the whole day, I just couldn't face it. So I thought, no, I don't have to do this. So I chickened out."

The possibility of pain relief was so appreciated in the face of intense and alien physical pain that any reservations had to be put aside. One woman who had made her intention to cope without pain relief clear stated, "I don't want to dwell on the labour. You don't want to put people off, but to friends who're having babies I'd say - walk in before your labour starts and say, just give me that epidural." Many of those who were suspicious and distrustful of the use of epidurals ended up recommending their use after birth. It could be that the fear of the unknown applied as much to the use of epidurals as to the anticipated pain of childbirth.

It has been suggested that the support of a trusted individual can reduce a labouring woman's need for pain-relieving drugs (van Kuik, 1997:7). This was supported by one woman who offered another reason for the use of an epidural. She was adamant that she could not cope with the pain because she was alone and afraid. "When I was in labour I would've liked to have somebody there. The pain for me was excruciating. But maybe if I had somebody there things would've gone differently. I was all alone in that room. They just sit there at the desk. There were two of them. I don't know why the one couldn't stay with me." In relation to this, Kitzinger (1967:46) regards not being left alone during labour as a major advantage of home births.

A main advantage of epidurals over other forms of pain relief is that they leave the woman alert. This is, however, except where the contents of the drip aimed to speed up the labour, have the effect of making the woman drowsy: "I was very happy because the doctor suggested a general anaesthetic, which made me feel quite upset because it felt like I was losing out on everything. Then the anaesthetist came and said we can do an epidural. Then I felt much more positive because I could be awake and alert."

The best use of an epidural appears to be to remove the most severe labour pains thereby reserving the woman's strength for the final pushing stages. Many women experienced labour pain as exhausting: "Eventually at the end of one contraction I was in quite a daze, trance-like. It's quite exhausting." Leaving the epidural to wear off allows the woman enough feeling to participate in pushing the baby out of the birth canal. However, it is difficult to assess whether the epidural should be topped up at a point or allowed to wear off. This is because of the many unknowns involved, such as the length of the labour, when full dilation will be reached and the rate at which the effects of the epidural will wear off.

Of the eight women who were giving birth naturally with the aid of an epidural, seven remarked that their epidurals had been mistimed, either because they were given too soon or too late or because they were or were not topped up, as seen in this case: "They decided to top it up which was the worst thing they could've done because by the time it came to give birth I couldn't feel a thing. I was numb and when they were saying push, push, I couldn't push." Those women who were completely numb from the epidural found their inability to push frustrating and difficult because complete participation was not possible and they could not be sure whether their attempts at pushing were genuine or imagined.

The administration of the epidural was experienced as scary and uncomfortable. Previously expressed concerns related to the numbing effect and subsequent inability to push, the side-effects and the thought of a needle going into the spine. The risk, albeit small, of being paralysed for life was a very real fear: "The epidural wasn't pleasant, them doing it. It wasn't extremely painful, but I think it's because of them working in your spine. There's something about your spine being fiddled with. It's such a yucky thing that you're quite tense."; "The spinal block was a nightmare. They couldn't get the needle in. He started off and he pricked and got bone, so he quickly had to take it out, prick, bone again. He said I might have to do a general and I said, no, it's fine, keep going. I'm now trying to remain calm. I'm sitting there while he's pricking this needle in my back. He did it a third time and hit bone. Then he went right low down and he managed to get the needle in and within ten minutes my legs were gone."

As with inductions, it is possible that a relationship exists between the use of epidurals and a failure to dilate. One woman commented that, "The dilation was going quite quickly in the beginning and then it just started slowing down completely. Epidurals are inclined to slow things

a bit." Though it may be coincidental or unrelated, the four women who did not have an epidural were the only ones who dilated to ten centimetres fairly quickly. For these women epidurals were avoided because of their desire to experience the pain so often spoken about. They opted instead for the use of pethidine. This has the advantage of being less intrusive and extreme than an epidural and because it only takes the edge off the pain without removing it entirely, the woman is able to experience her body's sensations to some extent. The negative is that it also has the effect of a sedative, making the woman drowsy.

INSTRUMENTAL DELIVERIES

The deliveries of nine of the 12 women who gave birth naturally were aided by forceps (four women) or vacuum extraction (five women). All those who had epidurals had instrumental deliveries as a result of their inability or reduced ability to push, as well as episiotomies. The use of instruments was regarded as an accepted and unavoidable component of an epidural birth. Atwood in her novel 'Surfacing' (1979:74) describes the use of forceps: "They take the baby out with a fork like a pickle out of a pickle jar." As a highly technical procedure, the use of forceps is unpleasant for a woman during delivery: "I knew she was going to be a forceps delivery and at that point I didn't want her to be a forceps delivery. But it was 23 hours later, she must now get born. With all of that technical stuff, when the doctor took it out, I just didn't look. I didn't want to look or think about all of this."

The use of the vacuum extractor was preferable to that of forceps. While it was still experienced by some as a "contraption": "I was unaware of stuff. I lifted my head and saw this box thing coming towards me", it was also seen as gentler on the child and less harsh and mechanical than

forceps. Furthermore, it left the baby with a slightly elongated head, as opposed to often extensive facial bruising, as described here: "Her nose was dented and she had a big, big blue bruise. It was nearly black. She looked like she'd really been through the wars."

Episiotomies are performed to prevent unnecessary tearing of perineal tissues during delivery and to prevent loss of tone in the pelvic muscle. While some women accepted episiotomies as the norm, saying they had heard most people have them, others considered it something to be avoided. It appears that the use of episiotomies depends on the doctor's assessment. Some believe that a cut heals faster and is easier to stitch than a jagged tear. Others "prefer to cut so they can control it." One woman who had been particularly wary of an episiotomy insisted that her doctor allow her to tear instead. She felt that although some gynaecologists think otherwise, "a natural tear will heal faster than an artificial cut because a tear is only through a couple of layers and is often superficial, while a cut goes through everything." In her case, her insistence, in the presence of "the big episiotomy scissors", that she be allowed to tear proved beneficial for this reason.

POSITIONS FOR DELIVERY

During delivery, most of the women were partially seated because the back of the bed was lifted. Most of the women who gave birth naturally propped each leg against the hip of their doctor and their partner or nurse. This is preferable to being on your back, about which one woman commented: "You're on your back unfortunately. You don't really have much choice. You're lying there like a beached whale." Five of the women made use of stirrups. This was done as a matter of course and the accepted reason was practicality because of their inability to feel their legs and the necessity of an instrumental delivery. One woman commented on the use of stirrups:

"You're in a sitting position with your legs in stirrups. At the time I didn't care at all. You lose all your inhibitions when you give birth. You don't care if people pick your fat legs up and put them in stirrups. And also my doctor's a female so that's more comfortable." Those who managed to avoid the use of stirrups were appreciative of this: "What I liked about the whole thing was that you weren't strapped down on these metal things with your legs chained down."

THE EXPERIENCE OF LABOUR AND BIRTHING PAIN

The first pain experienced during labour was described as menstrual abdominal pain, increasing in intensity with time. For some women, the pain was felt in their backs, which was unexpected and meant that they were initially unsure whether or not the pains were labour pains. The pain of childbirth was a primary source of concern during pregnancy. However, despite being prepared for the fact that childbirth is very painful, the nature and extent of the pain was what shocked the women most about giving birth. Some women could not believe that it was as painful as it was: "I started vomiting uncontrollably, which I believe is absolutely normal. I was in shock because I thought this can't be so painful." The shock of the severity of the pain and the physical pain itself was what made them decide to have an epidural despite earlier reservations. Two women swore they would never go through labour again because of the pain.

Pain thresholds vary considerably and the experience and perception of pain is highly subjective. How a woman copes with labour is not only a function of her pain threshold, but also of her approach towards pain, her expectations and her preparation for it. It has further been argued that culture dictates whether to expect and tolerate pain and thus patterned attitudes towards pain behaviour as appropriate or inappropriate expressions of pain are culturally prescribed (Morse

& Park, 1988:122). Jordan (1993:52) found in her study of childbirth in different cultures, that the experience of pain is observationally more visible in US obstetric wards, comparable to private hospitals in South Africa, than in Holland, Sweden or Yucatan. She argues that the acceptance of pain in these countries as a natural part of the birth process and the rare use of any form of pain relief meant that the women accepted the pain more readily than American women.

Having the option of pain relief so close at hand and the fact that it was so regularly offered did make it easier for the women in the study to request an epidural. Furthermore, while it was acknowledged that remaining active by walking around or taking a hot bath were effective ways of soothing or alleviating labour pain, medicinal pain relief was accepted as the only guaranteed relief for pain. Other potential forms of pain relief such as relaxation exercises, massage, aromatherapy and homoeopathic remedies were rarely considered. While one woman felt that concentrated breathing helped her cope with a pain that she felt washed over her whole body, a more common opinion was: "All that rubbish, that breathing, a pile of nonsense. You can't breathe through a pain that's that bad, you really can't. It's not sensible. At first it's just common sense, that's the way your body reacts to pain, to breathe in a certain way, but after that it's really too much to cope with breathing." Another woman saw the value of breathing exercises as giving confidence, "When you go in you think you know what you're doing. But once you're in there, I don't really think it helps. Once you're in labour, you're not really thinking about what they told you in your classes."

Although there is a danger in romanticising pain, it should not be assumed that all pain is negative and needs to be removed. Many women appreciated the pain they felt for a number of reasons. It was appreciated as being part of the natural process that millions of women have

experienced: "I think the pain was a necessary thing. I'm glad I did it the way I did, instead of having the epidural and not experiencing anything. It seems to make it more... It just seems to be the way it should be."; "I was pleased I went through the day because it felt like I was part of the natural process." Curiosity as to the nature of the pain was another reason why it was appreciated: "I let it go so far because I wanted to know what the pain would be like. It was really bad."

The sense of achievement felt after coping with the pain without help is enormous: "When I think about it now, I'm glad I felt all that pain because now I know. Every time I look at her I think - gee wizz! It was definitely labour, hard work, exhausting work." It has been suggested that the pain of childbirth be likened to that of mountain climbing or marathon running where it is expected that the limits of your endurance and physical strength are going to be tested. From this perspective, pain is interpreted as the pain of achievement rather than the pain of illness.

CAESAREAN DELIVERIES

It was agreed by the women prior to birth that a Caesarean should be avoided where possible because of the extended recovery period and the fact that it is an operation. However, some of the women who had experienced early labour pains considered a Caesarean to be a pleasant alternative. The extent of the pain appeared to sway their feelings on medical intervention. Eight out of the 20 women delivered their babies by Caesarean Section. Most did not anticipate this outcome.

The reasons why Caesarean deliveries may become necessary are where the mother's pelvis is too small to allow for the comfortable passage of the baby's head; in cases of maternal illness such as toxæmia; slow labour progress (dystocia); fetal distress, which is indicated by a fluctuating heartbeat or meconium-stained amniotic fluid and where the baby is in the breech position (Beaton, 1983:5).

In this study, three of the Caesareans were required for medical reasons. These included a kidney condition; the unusual condition of a flipped uterus and a situation where the baby was not getting sufficient oxygen through the placenta. In these situations the decision was made because a natural delivery was judged as a risk to the baby. The decisions in the case of another three of the Caesareans were more precautionary and based on the desire to avoid any potential problems. In two of these cases, the size of the baby was an issue. The remaining two Caesarean deliveries were motivated by a desire to speed things up. Dilation was taking place slowly, the labouring women were exhausted and they decided against waiting to allow the process to occur naturally. One woman commented with regard to her decision to have a Caesarean after 15 hours of labour and a failure to progress further, "Someone said to me, you're actually wasting time. At the end of the day what matters most is to have a healthy baby. Stop trying to prove - you know. It hasn't happened. Now get on with it."

The considerable increase in the incidence of Caesareans, now estimated as 55 percent at private hospitals in South Africa, has led to much speculation as to the reasons. Many of the women interviewed volunteered an opinion on the increase, most of which were negative. One theory put forward that legitimates the increase is the view that with mothers eating more healthily, taking vitamin and mineral supplements and not smoking, babies are born bigger (van Kuik,

1997:8). This may have been the case with two women whose decision to have a Caesarean was based, in part, on the size of the baby. Rich (1976) observes that certain physical facts suggest that women in racially homogeneous and simple societies might have had shorter and easier deliveries than those in racially heterogeneous and urbanised societies. This is because the fetus and the mother were of the same body type and there was less chance of a small-boned woman mating with a tall, heavy-boned man.

Llewellyn-Jones (1993:322) comments that many of the reasons for the increased Caesarean rate are justified, but some are inexcusable, either because the doctor takes the 'easy way out' or the patient demands the operation. Reference was made to this: "There's this culture which says, book yourself for a Caesar. It's more convenient. Never mind thinking about a natural birth." Related to this is the view that Caesarean babies are more attractive. Bergum (1989:90) points out that some doctors and mothers see a Caesarean birth as increasing the possibility of having a 'perfect' baby. A woman who had undergone a Caesarean observed that, "These natural birth babies are not very pretty babies and they go through such trauma being born. The girl next door to me, her baby was blue and bruised." The idea that Caesarean babies are more 'perfect' implies that artificial procedures are more effective than, and thus preferable to, the natural process. Furthermore, it fits with the image of birth as a system of production, where the baby is the product of the doctor's services (as explored by Rothman, 1989:155).

In relation to the idea that Caesareans are the 'easy way out', another woman made a commonly heard point: "Some doctors are very knife-happy. Others are prepared to wait, stick it out as long as possible. I'd already discussed it with him. He assured me that he doesn't just do a Caesar if the labour's a bit long, so he can get home and have supper. It sounds a bit callous, but some

doctors do that, or if there's a little hint of anything going wrong they do a Caesar."

Another very common perception is that the reason may have to do with the cost involved: "You tend to hear that the Caesar rate is quite high there. At the classes the sister was asked why it was so high and she kept saying, but we give birth to normal, healthy babies. Maybe they do it just because it's more expensive to have a Caesar. Maybe it's just the financial thing. It's also less time consuming. My baby was out in four minutes, instead of having 16 hours of labour. It's quite a good thing if the doctor's got something else on." Another woman who felt that the cost of Caesareans was the most likely reason for their increase pointed out that, "You can come up with a hundred reasons why something had to happen."

Garson (1995) has noted that in America, with the threat of litigation hanging over their heads, doctors will be increasingly forced to practice 'defensive medicine'. Furthermore, along with a litigation-conscious society comes soaring medical costs. Already gynaecologists in America pay the highest insurance premiums and medical negligence is a growing field. Doctors are increasingly cautious and many interventions are precautionary.

In the view of the women, the main disadvantage of having a Caesarean is that it is the most unnatural type of birth, the highest form of medical intervention. Hillan (1992:159) states, in this regard, that although Caesarean delivery is now safer than it has been before, it is still a major surgical procedure and thus can never be an entirely safe alternative to vaginal delivery. The extended recovery period, mentioned by all the women who had Caesarean deliveries, was also a serious constraint: "The Caesar clobbers you because its not like natural birth where you can get up the next day. And you're sore. You've had a major operation. You can't get out of bed. It's

hard to physically recover. You're trying to recover and look after someone else and you don't have a chance to get strong."

It has been pointed out that the suddenness of the birth of Caesarean babies means that their breathing and circulation often need extra attention (van Kuik, 1997:8). In addition, babies born by Caesarean tend to have more difficulty with mucus than vaginally delivered babies because in the case of the latter the passage through the birth canal squeezes the chest and helps the baby bring up mucus (Beaton, 1983:21). Some of the Caesarean born babies in this study needed their lungs cleared because of this and all of them spent a few hours in an incubator. The extra attention paid to Caesarean babies, where unexpected, may be frightening to the mother: "The sound of that suction machine and not having been warned about it. You didn't know if something was wrong or this was just part of the process. You panic." Another consequence of the extra attention is that the mother has less early contact with her baby. This is on top of the fact that the extended recovery period limits contact by restricting the mothers ability to get up and feed or hold her baby.

The experiences of Caesarean deliveries varied markedly, with half the women who delivered their babies by Caesarean finding the experience positive and enjoyable and the other half finding it traumatic: "I don't think anyone prepares you for what a Caesar's all about. Maybe having natural birth is frightening enough, but a Caesar's really brutal."

There were a number of factors that affected the way in which the women experienced Caesarean deliveries, such as the extent to which the woman felt in control and whether she was aware, conscious and informed. One woman, after a failed induction and a bad reaction to large

quantities of medication said, "I didn't really enjoy it all that much. I don't really suppose you're supposed to enjoy it anyway. I was slipping in and out. I had so many drugs inside me. I wasn't really conscious. I was feeling confused and tired. The longer it went on the more nervous I was about giving birth." What occurred prior to the Caesarean, as well as the suddenness of the decision to have a Caesarean left her shocked, scared, drowsy and feeling out of control. She was unaware of what was happening for much of the time and afterwards could not fully recall the much awaited delivery of her baby.

The women's experiences of and responses to Caesarean deliveries were further, dependent, in part, on how strongly they felt about having a natural, intervention-free birth. A woman who had a positive and memorable experience remarked, "They said she wasn't getting adequate oxygen. They were against going through a natural birth. I honestly wasn't fazed about how she came out. I just wanted a healthy baby." Another relevant factor was the nature of the decision to have a Caesarean. This involves whether it was actively chosen at the outset (elective Caesarean) or became necessary for other unforeseen reasons after a failed attempt at a natural delivery. Research has found reactions of disappointment, depression, inadequacy and detachment to be common among women who have undergone unplanned Caesareans (Raphael-Leff, 1991:305). A few women commented on the opinion that "you're not a real woman if you don't have a natural birth" and stories were relayed of friends experiencing feelings of inadequacy and guilt. Disappointment was, however, the only negative emotion expressed by the women in the study.

In some cases, potentially negative experiences were made positive or tolerable by being in a safe, secure environment surrounded by their partner, their trusted and specially selected doctor and supportive medical staff. A relaxed atmosphere within the operating theatre also removed

the tension of an unexpected Caesarean: "Everyone was chit-chatting, about holiday houses, all sorts of things. So it was very social." Some women might feel that this detracts from the significance of the moment of birth, but others appreciated the distraction from what was happening.

Similarly, where a woman trusted her doctor, had discussed the options and understood the reasons behind the decision, an unplanned and unexpected Caesarean delivery was not experienced as traumatic. It was the explanations provided that allowed this woman to accept her Caesarean delivery: "The Caesar was great because I had a very nice anaesthetist. He was with me all the time, telling me what to expect, which helped a lot." In the face of much speculation as to the real reasons behind the rising Caesarean rate, knowing the reasons why a Caesarean became necessary was particularly important: "My doctor explained it all. I was able to see on the monitor that the baby was in distress. It wasn't just him wanting to go off and play a game of golf. It wasn't like everyone was trying to con me into having a Caesar."

None of the women questioned the necessity of their Caesareans, either because they were in full support of the decision or because the reasons were explicit. Neither was blame accorded to the medical interventions, even where this was a possibility: "I can't criticise anybody because that was just the way my body was. I can't say I wish this or that. I can't say I wish the hospital could've done more."

THE ISSUE OF TIME

The prominence of the issue of time in this study is seen in the fact that all of the women in the sample made some reference to time, from an awareness of their biological clock to the length of their labour. Measurements of time began with the onset of labour. Some women made reference to the correct stage at which to go to hospital, which was when their waters broke: "When my waters broke I was quite relieved because at the antenatal classes they kept saying, don't come to the hospital too early, but when your waters break you must come in. So I thought, at least when I get there, they're not going to send me home." A sharp contrast was drawn between the speed and efficiency with which a Caesarean delivery was able to be performed: "I was quite happy with it, even though it was a Caesar. The main thing was that it was over quickly" and the slowness of natural labour: "It was going on and on, watching the clock on the wall."

Llewellyn-Jones (1993:236) points out that today it is unusual for a woman to continue in true labour for more than 24 hours without help being given to deliver the baby. In fact, many doctors intervene if the woman has been in labour for 12 hours. Rothman (in Martin, 1989:141) has also shown that the time allowed in the hospital for both first and second stage labour has been reduced steadily since the 1940s. This is despite the fact that there is no evidence that reducing the length of the second stage makes labour any safer or produces healthier babies (Kitzinger, 1991:28). Several of the women in this study had medication injected into their drips to speed up the process. In addition, the reason for most of the inductions was to speed up the process or to get it under way.

For three women, the decision made by their doctors to have a Caesarean was motivated in part by the anticipated length of labour: "It dragged on and on and by lunch-time my gynie said, Okay we've had enough, now we'll do a Caesarean because things aren't moving quickly at all. So that's what they did. I think I could've probably dilated further, had it gone on, but the idea nowadays, I think, is to let it go so far and if nothing happens get on and get the baby out. My mother was 52 hours with me. I was doing it very slowly, same as her, but they let her."

In her comparison of Caesarean rates in state and private hospitals, Lichtman (1988:137-8) found that the midwives in state hospitals had a vested interest in helping to achieve vaginal birth and displayed a greater willingness to extend the time limits of what is medically considered normal in labour. She also found that in private hospitals it was often recommended that a Caesarean is performed if labour is longer than 'normal', even if there are no other problems.

Martin (1989:141) found that many of the women in her study were aware of the time issue and attempted to reduce the amount of time spent in hospital by delaying admitting themselves as long as possible. This allowed a shorter time for their labours to be defined as ineffective and the baby to be extracted operatively. The women in this study, however, did not resist any suggestion of speeding up the process. Fear, anticipation or the pain of labour motivated them to adopt any approach that would bring the experience to an end.

The danger in adopting a timetable approach to pregnancy and birth is that those that diverge from the normal or vary slightly may become regarded as pathological, requiring medical intervention. The fact that 16 out of 20 of the women did not give birth on their due date indicates the variability of births. A study on 537 women found that only 4 percent of their

babies were born on the due date with 47 percent a week or more early and 49 percent a week or more late (Barnett, 1964:74). Experience is unique and varies considerably. Some babies may need a longer or shorter time in the womb due to different rates of development or different physical conditions of pregnancy. Due dates may also be incorrectly calculated.

Furthermore, adopting a rigid timetable approach leaves open the possibility of contradictory assessments. Rothman (1985:125) has observed that the start of labour is often defined in precise biomedical terms, rather than according to the woman who is experiencing the labour. While many women relied on their doctor's assessment as to whether they were in labour, one woman's opinion contradicted that of a sister: "She said I must go home because the doctor checked and I wasn't that dilated, but I knew the baby was coming. She said I wasn't ready to go to the labour ward and as I got up my waters broke." A problem arises where the definition of the doctor or medical staff is regarded as more valid than the woman's own sensations of labour.

CONTROL WITHIN THE BIRTH PROCESS

An important theme when examining childbirth is that of control. The alienation of the woman from the birth and her baby has been described as the the most important and consistent theme in modern obstetrics (Rothman, 1989:157). The very term 'childbirth management' implies a situation directed by doctors, in as much as 'to manage' means to direct or control, or to make submissive to one's authority.

Feminists have pointed to the unequal distribution of power between participants in the birth process. This is the result of the biomedical model of birth which defines birth as a medical

event, thus bestowing control over the process to those with specialised medical knowledge and placing them in an active role during the birth process and the birthing women in a passive role. This was evident to a certain extent not only through the fact that accounts of birth resembled a chronology of medical procedures, but also in the way in which decisions were made.

The women generally felt satisfied that they had made the important decisions during the process of birth. The options had been discussed: "The doctor said I could either wait until I went into spontaneous labour and then see, or I could be induced because I was getting big, or I could just book myself for a Caesar."; "When we were discussing whether I should have a Caesar, he actually let us speak and then told me medically why he wanted me to have a Caesar. He didn't say, oh well, this is what's going to happen and that's it." Yet despite this, during the course of their accounts statements were frequently made implying that important decisions concerning medical procedures were dominated by the medical professionals involved (a situation reported in several studies such as Oakley, 1980 and Doyal, 1995). Accounts were repeatedly dotted with phrases such as "they decided": "My doctor decided to get the anaesthetist to give me the epidural."; "They decided that he wasn't going to come out naturally, so I had a Caesar."; "They decided to induce."

Furthermore, several accounts were related with the doctor as the active person and the women as the passive person, as revealed in statements such as "they let me." Martin (1989:83) found that the women in her study saw birthing and labour as states that you go through or things that happen to you, as opposed to actions that you perform. This applied to at least half the women here, to whom actions were very much being done. One of the more blatant examples of this is: "She was sitting on my tummy. I think they even started breastfeeding her at one stage." Bergum

(1989:93) argues, in this regard, that the fact that the hospital is a foreign place where someone else is in charge makes it possible for 'them' to do things to 'you'. It is easier for nurses or doctors to take responsibility because it is their space.

One could also question the extent to which some decisions were made by the women because of the fact that many actively chose and preferred a more passive role in relation to the doctor: "You don't always know exactly what they're doing. They do tell you, but you put yourself in other people's hands and hope that they know what they're doing."; "I did what they told me to do. At that point you're tired. You've been through a lot and all you want is this out."

The willingness to give control over to the medical professionals demonstrated by many women prior to the birth was sustained through the actual birth. This was because the women believed that the doctor was in a better position to make judgements about what was best for them and their babies due to their medical knowledge, not available to the women: "He was basically telling me what was going to happen but doing so in a way that made it seem very reasonable. I don't have the medical knowledge to make those decisions. I did feel he was talking me through the decisions."

The decision to put the control in the hands of the doctor may also have been motivated partly by the fact that many women expressed the concern prior to birth that they might not know what to do or be able to cope. Where such worries were significant, handing over control to the doctor is a source of security. One woman who felt she was not in control did get a sense of security from the fact that "they've done it plenty of times before." Prior to the birth, many women also felt a certain amount of loss of control over their bodies and lives, which was frustrating and

frightening. During their stay at hospital, it was thus reassuring to them to be in the charge of a doctor with whom they had developed a trusting relationship. This allowed them to relax somewhat, knowing that they were in capable hands. This emphasises again the importance of a good relationship with the doctor and the privileged position in which most of these women were to be able to enjoy such a relationship.

The difference between the lack of control revealed in much literature on medicalised childbirth (Oakley, 1980; Martin, 1989; Arms, 1975 and so on) and the situation here is that a more deliberate and conscious decision appears to have been made to hand over the control to the doctor, as opposed to the control being taken from them. In addition, the use of interventions was accompanied by explanations, which were greatly appreciated and commented upon by many women: "You ask all the way and they were very good at explaining, so you didn't feel that anything was being done to you that you didn't want done. I felt totally safe, in control."

CONTROL WITHIN A MEDICAL CONTEXT

The attitude towards intervention was in most cases one of acceptance. It was treated as an inevitable part of the process of giving birth. This was because the possibility of making use of the medical procedures available was expected and thus not questioned. Some of the women were accepting of the fact that certain procedures were necessary, even if they were not desired: "It was the gynie's thing that it had to be forceps and I wouldn't have liked that because I was quite anti, but that was the way it had to be." Bergum (1989:135) argues, in this regard, that it is the authority of obstetric expertise that makes it easy to say, whatever will be will be.

It was clear that the context of the hospital determined what options were available or encouraged. Being in a medical context encouraged a medical response and the adopting of the medical mode of thought. Michaelson (1988:36) argues that the medical language used and the ritual of hospital birth structures a parent's perception of the appropriate course of action. Decisions are made on the basis of the medical definition of the situation. Medical ideology and terminology thus structure decision-making by controlling the parameters of discourse. In the present study, medical solutions were offered and sought first. Some women mentioned that they were continually offered pain relief or that they were offered epidurals far earlier than they were needed: "They said to me a couple of times, would you like something for the pain? I kept saying, no no no, it's not necessary, it's not necessary."; "They just wanted to give me pain-killers. I'm not one for taking many pain-killers." This occurred to such an extent that one woman commented, "Some of the things were unnecessary, like they'd come in at 5 o'clock in the morning and ask you if you want anything for pain. They'd actually wake you up to ask you if you want anything for pain!"

In relation to this, Oakley (1980) found that the women in her study were given 'sales talk' for epidurals and pressurised into pain relief that they would otherwise not have used and later regretted. This is perhaps indicative of a mind-set of some medical personnel which was elaborated upon by one woman: "I have a friend who's a paediatrician and she hadn't even seen him yet and when I phoned her about his belly button being infected, she said, oh, he's going to have to go on antibiotics. How can she say that? That's how doctors' minds work. They believe that modern medicine is a miracle and they want to use it again and again to prove it."

This forms the basis of an argument by one of the most well-known critics of modern medicine, Illich (1975). He wrote about the moral and iatrogenic evils of society's dependence on medical culture, arguing that most doctors will treat even self-limiting and socially caused illnesses medically with drugs, specialist referrals or surgical treatment. He believes that modern medicine thus causes harm not only through the use of questionable procedures, but by striving to control the responses to critical life events and social problems and in so doing reducing the ability of people to handle their own lives. In connection with this, a repercussion of the increasing Caesarean rate is that the need for Caesareans places childbirth squarely and exclusively in the hands of the doctor. Vaginal deliveries, in contrast, can be the province of other experts such as midwives (Riessman, 1992:130).

Part of the critique of the medicalisation of life in general is that non-medical problems are seen as having medical solutions. Medication is then prescribed too readily, before the real roots of the problem are examined and less severe alternatives have been considered. The willingness of doctors to use the procedures and techniques at their disposal has been connected to the high incidence of Caesarean deliveries: "On the phone already when they'd phoned him to say the heart-rate was decreasing, he'd already said, get her ready for a Caesar. But then he came and said, this is why."

CONTROL THROUGH KNOWLEDGE

A different way in which to view the fact that the doctor was often in a position of greater control than the mother is to acknowledge the women's indirect exertion of control stemming from their knowledge and understanding of the procedures involved. The exertion of control, in this sense,

begins with the selection of the doctor according to his/her approach and practice, the process of learning about what was entailed in a hospital birth through extensive reading and familiarising themselves with medical terminology, as well as having written birth plans or direct statements of preference. Thus, if the women are comfortable with the doctors making the decisions, they can still maintain control, even though it might appear that they were influenced or that they were not in charge of the situation.

In relation to the issue of control acquired through knowledge, Cockerham (1992:160-9) reports on various studies in America that have shown that the belief among laypersons that the 'doctor knows best' is no longer accepted. People are generally more knowledgeable about medicine and believe they can apply this knowledge to their own health situation. Better educated people in particular, are no longer prepared to play a passive role. Instead they are tending to be more sceptical of physicians motives in providing treatment and are more likely to question whether the physician was providing services primarily to help the patient or to make money. The attitude is becoming more one of consumerism, where the consumer wants to make informed choices about the services available and not be treated as inferior.

It appeared that any discernible loss of control experienced by the women was not so much in relation to the medical professionals, but rather the natural, physiological forces of birth, such as labour pain and contractions. This woman's feeling of loss of control revolved around her inability to withstand or control bodily forces: "The pains were coming fast and then suddenly the pushing sensation started coming and they were shouting at me - don't push, you're not ready, don't push. That was the worst, them telling me not to push when there was nothing I could do about it. I actually started panicking and getting tense. Everyone was shouting at me - don't,

don't, don't. That was terrible."

The reliance on medical intervention and the precautionary manner in which it was often used suggests that medical technology was interpreted as more reliable and predictable than the natural process, seen as uncontrollable in comparison. The control it is possible to have over medical technology is what makes it appear safer and more reliable than the natural process of giving birth. Bergum (1989:90), in relation to this, interprets the increasing rates of Caesareans as indicating that the risk-taking of vaginal birth is being replaced by the risk-taking of surgical birth. In this study, the women's trust in their bodies displayed prior to birth, was replaced by a trust in medical technology. This is seen particularly in the case of the three women who had commented that they trusted their bodies to be able to cope with the natural process of birth. One of these woman who felt that her body could handle childbirth and was adamant that epidurals were unnatural and risky, admitted after birth, "It's truly a wonder drug. It's a remarkable drug. I would encourage an epidural."

In contradiction to this, however, it was the medical technology and intervention that caused three women in particular to feel out of control with regard to their bodies: "What I didn't like was a feeling of being out of control. There were all these drugs in my body that were making me feel pretty odd." The numbness resulting from the epidurals and spinal blocks was also a strange experience: "That was the most frightening, that feeling of one minute you can feel your legs and the next minute you can't feel anything. I was almost in a panic state. That was the freakiest part for me."

Martin's discussion (1989) on the fragmentation of the body during the medicalised process of birth becomes relevant with regard to these women. She argues that with Caesarean deliveries in particular, women often experience themselves as becoming the object of the doctor's manipulation. This entails an intense experience of fragmentation as the woman loses touch with her body, perceived as disjointed and segmented. Birth is then not actively experienced and she no longer has any control over the process. Martin would argue that this was what was happening in the case of this woman: "It's strange that you feel apart from the lower part of your body. If you can't feel it your mind just blocks it out because there's no stimulation. You're totally unaware of the lower part of your body."

PARTNER'S PARTICIPATION IN THE BIRTH

All of the partners were present at the birth of their babies, except for one whose place was taken by his mother because he did not feel equipped to deal with the physical realities of giving birth. They also appeared to have arranged to spend time with their wives/partners in hospital. The women in the sample were fortunate in having supportive partners who had attended antenatal classes and wanted to be involved in the birth. This is perhaps not representative of the general population.

The presence of the fathers in the delivery room is, from the women's accounts, clearly one of the most valuable reforms made. The support they provided was appreciated by all the women, many commenting, "I couldn't have coped without him." Another woman stated, "He was there all the time. It's very, not humiliating, but you need to have very close friends there. I felt that having this nurse there irritated me because I didn't know her. It's very personal. I didn't want

anyone else sharing this. I just wanted to have my baby with my husband and my doctor."

Evidence of the value of antenatal classes was given in the comments of a few women: "He was doing all his supportive stuff" and "He stood right next to me the whole time and was very encouraging. He told me to push, to relax, that I'm doing well, obviously all the things he'd learnt in antenatal."

The partners' presence at the birth, as well as the fact that they were allowed to visit at most times of the day meant that parenthood began more as a joint venture than as the primary responsibility of the mother. The fathers were made to feel more involved from the outset. In a few cases, the partners found the experience frustrating because their participation was limited. With Caesareans, the women could not see the operation because of the screen erected in front of their faces, but the partners could: "My husband could see it and he freaked. He said nobody had warned about what he was going to have to see. He said it was hideous. There was blood everywhere. Everyone had laughed and said, it's good fun, your wife's awake, everyone laughs and jokes. He said, how the hell do you laugh when she's lying on the table with her stomach cut open?"

The fact that the fathers went with the baby to the nursery to perform the tests and measurements immediately after birth also provided a sense of security for the women. A further notable benefit of their presence was that they were able to perform the role of watch-dog in some cases: "My partner knew exactly what I wanted and he was watching every little needle they put in me, every little thing they did. He made sure. We'd discussed it. He knew what I wanted."

EXPERIENCES AFTER DELIVERY

The predominant feeling after delivery was that of relief: "It's stress you go through - is my child going to be born normal. When that baby comes out and you see its got all its toes and fingers, it's perfect, that's the biggest relief." Apart from feelings of enormous relief, exhaustion and the effects of medication meant that seeing their baby for the first time was often not the way they imagined it would be. One woman described what happened immediately after birth: "Having lost all that blood, I just went light-headed and fainted while he was stitching me up. I was very uncomfortable. I couldn't have been bothered what they did with the baby. Just because I was beyond it. I was exhausted. It was not like one had dreamt of."

Eight women complained of feeling very drowsy after delivery and were unable to remember much of what happened immediately after birth: "I was so doped up I wasn't conscious until that afternoon."; "I was practically unconscious for about 12 hours afterwards. Horrible, and it gives you the shakes. I was really in a bad way, lying there semi-conscious worrying about this baby because I hadn't really seen her." The use of medication during birth has the drawback of dulling the emotional experience of birth and affecting the mother's initial contact with her baby. The risk of the negative affects of medication extended to all the women because none went without some form of medication, either that accompanying the epidural, the contents of the drip, pethidine, sedatives or anaesthetics. As it is not always known how a woman will respond to a drug, the ill effects can be unexpected and unavoidable: "I had so much pumped into me. I'd got into a bit of a state by that time so they put something in my drip. It was supposed to calm me, but it knocked me out. When I looked everything was blurry."

After birth, pain-killers were administered, particularly in the case of the women undergoing Caesarean deliveries for whom the wound was very painful: "My Caesar was done that 5 o'clock that evening, so you sleep through that entire night. Well you're knocked out anyway. They knock you out because the spinal block starts wearing off and then its pretty sore, so they give you strong pain-killers."

THE MOTHER'S RECEPTION OF HER BABY

It is possible that expectations that are too high or romanticised may negatively affect a woman's initial response to her baby. The moment may not be as imagined: "The first thing I knew was that this bundle of rags was flopped down onto my chest. I thought it was the surgical bag, you know, they have bundles of surgical instruments. I thought that's what it was. I looked down and there was this little purple frog! That's all I knew. Then it was taken away for testing." Appearance, in particular, may be the most deceiving, as seen in this woman's description of her first glimpse of her baby: "I got to look at her for maybe a few minutes. They're pretty grim when they come out. They're not beautiful. They come out covered in gunk and goo and they're all purple and wrinkled and very, very skinny."

The opposite situation occurred in the case of this woman who had not given the moment after delivery much thought or built up her expectations: "Initially I was feeling very anti. I was not interested, completely demotivated. It was almost as though she was an interruption in my life. The minute she came out and was put on my chest, it was love at first sight. All those thoughts disappeared. She was completely worth it."

Most (17) of the women were shown their babies immediately after birth or were given the opportunity to hold them. Six women breastfed immediately to facilitate lactation and 12 women breastfed many hours later because of the baby needing to be incubated or assessed and observed. A very common source of dissatisfaction, anxiety and frustration was the haste with which the baby was taken away after delivery. This occurred in all the hospitals and was necessary in order to check for any serious conditions. It was common for the women to ask where their babies were and if they could see them. Comments such as "and then they quickly whisked him away" were frequently heard, as well as "I kept asking for him." This was upsetting, not only because of the need to see the child they had been carrying for nine months and the result of their hard labour, but also because of the awareness of the importance of early bonding.

The haste with which the baby was removed also detracted from the moment of giving birth: "I was really happy. I saw him. He came out and they put him on me. That was great. I felt really exhilarated, but then they whipped him away."; "It felt a bit flat because everyone seemed to be out and about and I was there and they were busy with me and I couldn't go anywhere because of my legs. So I was a bit frustrated. They sensed this so they just knocked me out. I kept saying, where's my child? Why can't I go and see him? After about an hour you think, what's going on here? An hour's a long time when you're sitting waiting. And the one sister said, Oh, can I turn on the TV? So I said, No, where's my child?"; "They put him on the breast immediately. Once that was done, they whip him off and take him to the nursery. He was whipped away from me within half an hour of giving birth, actually not even that. It was 10 minutes. There you are, lying in this bed, your baby's gone. You want to see him."

The women who insisted on seeing their babies even after numerous refusals were eventually able to: "The next morning you're supposed to stay flat on your back until 5. Forget it. I said, no no no, I'm fine, I'm sure I can get up. So they said, no, you can't get up with your drip. I said, take this thing out, I must get up and see my baby. So they said, well you stand the risk of getting a headache and I said, oh well, what's a headache, I've just had a big operation."; "I made them bring her to my bed. I could hear her scream. I said I want her back NOW and they said, no but we can't bring her back now because they have to observe her."

The women demonstrated an awareness of the importance of early bonding as proposed by Klaus and Kennel (1976), perhaps the most prominent authorities on maternal-infant bonding. They argued that the most special period of recognition occurs immediately after birth, during which time it is important to establish maternal attachment. This awareness is revealed in the statement: "I was still being stitched up so my husband went with the baby. That's maybe why they bonded much quicker because he was there for his first bath. I was just lying there being stitched up."

The women were also knowledgeable about other matters such as the nutritional value of the initial colostrum, produced prior to breastmilk and the value in not properly bathing a baby immediately after birth because the vernix coating with which the baby is born provides a protective layer against infection (Llewellyn-Jones, 1993:244). This meant that some women experienced anxiety when what they knew to be the correct practice was not happening. This woman attending a state hospital was horrified at the treatment of her newborn child: "They must have bathed him. I didn't really want him bathed so soon afterwards because they're born with vernix on their skin. He must have been formula fed because he came to me so much later and he's subsequently had a bit of stomach trouble. He missed out on that first milk. And they say

when they're born they're very conscious for that first hour. So he missed out on that eye and body contact."

FEELINGS ABOUT BIRTH

In general, prior to birth, the women expressed the desire for as natural a birth as possible. From the number of Caesareans and epidural, instrumental deliveries, this was clearly not achieved. While many were disappointed, they did express, in retrospect, the view that had been conveyed to them over and over during their pregnancies, that one must keep one's mind open to all options. A common response was, "I was going to be this earth-mother and I wasn't. It didn't bother me at all because I was open to the possibility. Maybe because my doctor was saying, we'll see what happens on the day."

Those who had wanted non-intervention births did not resist medical intervention, but rather readily accepted it. Ironically, the strongest advocates of natural birth ended up having highly medical births. One woman prior to her experience of birth remarked, "My concern is that maybe I can't handle the pain and I have an epidural and then because of that I can't push properly and then you often have to have episiotomies or it could be that you need forceps because you can't push. One medical thing becomes another thing. That would be the kind of birth that I wouldn't like." This turned out to be an exact description of her birth experience. After birth she stated that, "I suppose a little bit of me questions that if I could've handled the pain, maybe it would've gone differently. Sometimes I think of it now and I feel a little bit sad that I couldn't participate more in that moment when she was delivered." She also found that the antenatal classes made a difference: "I think antenatal helped because we were prepared for any eventuality. I wasn't too

set in what I imagined to happen."

Most of the regret felt by the women revolved around their use of pain relief and its unavoidable repercussions: "If I had elected not to go with the topping of the epidural I probably would've got him out naturally without the help of the vacuum, but unfortunately I had to use it."; "Maybe if I didn't have the pethidine I would've been more awake, more aware. You're not 100% there all the time. Sometimes you feel you're floating away and then you come back."

The word 'cheat' did crop up in connection with epidurals, indicating that the ideal was still to experience the birth process in its entirety. "In a way I felt as though I did cheat. It was a bit of a cop-out, my birthing experience, as far as the pain goes. I had very minimal pain. In a way I would've liked to go through a little bit more pain and felt what was actually happening, rather than being totally numbed." Another woman whose epidural did not work completely said, "It was all quite exciting because I still had a little bit of pain, so I didn't feel like I was cheating too much."

Some women stated that they did not feel disappointed, but were sufficiently aware of the possibility of feeling disappointed and the fact that they should not feel that way, to make specific comments such as, "I'm not disappointed. It was fine." A related point is that so many other women have high intervention births that they were not part of a minority, who had failed to deliver naturally. Some relayed stories of how everyone in the ward had an epidural and instrumental delivery or that other women had an even tougher time: "I was lucky that it could be natural because half the people around me, things went wrong. They either had fetal distress or they weren't dilated." The women having high intervention births were among the majority

and the nature of their births was accepted as the norm.

Only two women seriously questioned the extent of medicalisation and commented on the reasons and effects. "When I speak to some of the women I was at antenatal with, a few of them had a similar experience. They got to a certain point and things just stopped. I don't know if its a thing with modern women. I went to my gynie and said to her, there were four of us, three Caesareans and me an epidural and forceps, so none of us had a purely natural birth. Does it mean that the four of us would have died in childbirth or our babies would have died? She couldn't really answer it. I find it interesting. I don't know if its a thing that modern women have lazy uteruses. Each of them had a slightly different complication, but just the fact that all of us needed quite a medical birth to have our babies. We're all fit, healthy people. And we all intended to go for natural birth. None of us really wanted all the medical stuff."

Another woman disliked the extent to which her birth was a medical operation: "There were lots of people there. It was quite extraordinary. So it was a strange feeling of a big operation. I suppose the mind becomes concentrated. You realise it's not worth getting bothered about. It wasn't the natural birth story one would have desired, but they had to be there." She did, however, appreciate the experience in spite of the medical surroundings: "There I was going into the theatre, a totally medical environment, and yet at the same time the experience was quite wonderful."

With regard to the experience of birth generally, it was noted that despite being informed and prepared through antenatal classes and reading extensively, the gap between expectations and reality was still large. Comments to this effect were made by a few women: "Nothing they tell

you can prepare you because they invariably leave out the most important things." An example was revealed by another woman: "There are so many things that they don't tell you. Things like afterwards I shook for about two hours and it turns out that its a reaction to the drugs. It's also because you're in a state of shock. It was quite bewildering. Somebody could have told me that that was going to happen. There were quite a lot of things like that." Another woman mentioned the fact that nobody prepared her for the amount of internal examinations that went along with an induction, as well as those required to assess how dilated the cervix is: "Nobody prepares you for all these internals you're having. Going through an examination is traumatic enough. And the one time I honestly nearly kicked her because I'd actually had enough. And they were sort of holding my legs - it was just gross, too much, and very, very painful. I found that totally intrusive."

THE VALUE OF THE EXPERIENCE

While a couple of women placed a fair amount of significance on their experience of childbirth, as a moment to be contemplated nostalgically, a more common response was to regard the realisation of the goal of birth, the delivery of the baby, as important and the actual process of birth as less worthy of reflection. This is illustrated in the case of a woman whose birth only comes to mind because complications related to the delivery of the placenta made the experience traumatic: "The birth was fine. The aftermath was quite horrid. It was just rotten luck. But for that experience I wouldn't think at all about it. One forgets everything about it." This is contrary to findings concerning class differences in women's responses to birth. Generally, middle-class women have been found to focus more on the experience of birth, while working-class women focus on the baby and place less significance on the actual experience (McIntosh, 1989:210).

It has been argued that the medical model of birth sees the mother and fetus as a conflicting dyad in which the needs and interest of the mother - host are pitted against those of the fetus - parasite. In the natural childbirth model, in comparison, the mother and fetus are seen as one organic unit (Cosslett, 1994:119). In the interviews, the mother-fetus dyad was related to in terms of the medical model in that the baby was considered far more important than the mother or her experience of the birth. The success of the birth was measured in terms of the apgar score received by the baby. Other indicators of a successful birth such as how the mother experienced the birth and her emotional and physical state were not awarded as a high value. Some women mentioned that they had to get over their fears and thus sacrifice their enjoyment of the birth because of their realisation that a healthy baby is what is important: "I was petrified, but I just said to myself, she's got to be born. You've actually got to forget about yourself and get on with the process."

In some cases the women wanted the birth over as quickly as possible. They did not want to savour the experience, but saw it rather as a hurdle to be overcome on the way to motherhood. The baby was what made the ordeal worthwhile. It was unanimously agreed that the best part of the experience of birth was seeing their baby for the first time. The view that a healthy baby represents a successful birth is what enabled one woman who had suffered a traumatic and frightening birth experience, involving a failed attempt at natural birth and an unplanned Caesarean, to comment, in response to how the birth went on the whole, "I think relatively smoothly, when I hear other people's stories. I think we were very fortunate. We really didn't have any hiccups. She was healthy, strong, fed from day one." It is clear that the relief at having the birth over and a healthy child dims the negatives of the experience. This is further suggested by the fact that 17 of the women judged their child's birth as a success, even though some of their

accounts were less than positive.

As mentioned prior to birth, birth was commonly seen as a specifically feminine achievement or a test. The mentioning by some women of chickening out by requesting an epidural points to this, as well as the awareness of the possibility of being disappointed. Discussions of the pain and the possible use of pain relief were very often accompanied by references to bravery: "Just before 2 o'clock the pains were coming almost constantly and I thought, let's not try to be brave here and my husband was saying, I don't want any heroics, you just take something if you need it."; "There were moments during the day when I thought to myself, I must be mad, I don't know what I'm doing here, trying to prove that I'm superwoman because honestly the agony was bad and I thought to myself, if this is only the start of it, I can't image how it progresses."

Where the health of the baby was placed ahead of the mothers' emotional experience of birth, the feeling of a sense of accomplishment was directed more towards producing a healthy child than being able to deliver him/her without intervention. This goal was also dimmed in the face of the unexpected intensity of the pain. Another consideration here is the fact that first births do carry an enormous amount of fear and anxiety, in part because childbirth is an unknown and because of the desire to bear a healthy child. It was possible that uncertainty and fear prevented some women from experiencing the births fully and that the possible birth of their second child will carry more significance as certain fears are dispelled.

The fact that the women's main objective was simply the delivery of a healthy child contrasts sharply with the ideals set out by Bergum (1989) with regard to the emotional expectations, aspirations and rewards of birth. She considers women's active participation in the process of

birth to be important for their transformation to mother, as well as for the development of a female reproductive consciousness. An aspect of this is the mother's acknowledgement of the strength and power of her reproductive body, which is realised in her ability to birth her own children.

THE EXPERIENCE OF HOSPITALISATION

The common assumption that the experience of hospitalisation is unpleasant meant that some of the women were surprised at the extent to which they enjoyed their stay, especially considering they were dreading it: "They were excellent. Obviously hospitals are not nice places, but this is a nice thing that happens in a hospital."; "Being in the maternity section is nice because it's a happy section. It's not depressing like the rest of the hospital where people are sick and dying."

Most of the women found their time in hospital pleasant and enjoyable, with the exception of a few who labelled themselves "not a hospital person." Over half of the women did, however, experience some problems with regard to being in hospital, though these were often minor and mainly concerned restrictive and annoying routines. Unavoidable problems relating to the occupation of general wards included the situation of recuperating women who are exhausted but unable to sleep because the others in the ward are chatting and watching television and the case where the baby is not permitted to room-in with the mother because of the disturbance it might cause to the other mothers.

Despite the general satisfaction with the hospital stay, the experience of hospitalisation is still highly subjective and depends on previous experience in hospitals, expectations and attitudes towards medical personnel and approach. This accounted for the fact that one woman gave a glowing report of her stay, while another attending the same private hospital at the same time, was highly critical of the functioning of the hospital. She commented that the hospital was having a lot of problems involving tension between the nursery, labour ward and maternity staff and an ambiguity as to what their roles were. This resulted in a reluctance to perform any functions they saw as outside of their department, which was interpreted by the woman as an unwillingness to help and an insensitive attitude. She stated: "I haven't said anything because I don't want to get involved in a whole big thing, but to me there were real issues that they weren't following up on." Other women appeared to be oblivious to these problems.

A prominent theme in terms of hospitalisation has been that of depersonalisation (Cockerham, 1992:221). This is not generally intentional, but rather the result of the organisation of the hospital which favours rules and regulations that are necessary for managing a large number of patients, but also serve to reduce patient autonomy. This is also a feature of institutionalisation in general, as described by Goffman (1961). He sees institutional confinement as entailing factors such as role dispossession, the loss of identity equipment and forced interpersonal contact. Hospitals are said to resemble total institutions in part through their rigid conformity with general rituals and routines, the removal of items necessary for maintaining an individual's self-concept and identity such as their name, clothing and personal possessions and the fact that they are cut off from the outside world.

These women's experiences of hospitalisation should differ markedly from those of others because they are not patients in the sense that they are not sick. However, since a Caesarean is a proper operation, the recovering woman does fit the mould of the patient dependent on the medical staff and subject to their supervision. In this connection, two women who had undergone Caesarean deliveries commented specifically on the feeling of being pulled in different directions by two roles, that of patient and mother. This ambivalence was the result of the different treatment by labour ward nurses and maternity nurses: "When I was in my bed I was being treated as the patient. I had just had a serious operation and a serious condition. They're monitoring you all the time. Then when I went down the corridor to the nursery I was suddenly a mom and the focus was all on learning to cope. The two roles didn't really fit together. The nurses telling me to get back to bed, but from the other side the assumption that you were going to be up all the time."

Changes in routine mean that several mechanisms of depersonalisation have been removed. The use of regulation night-gowns is no longer required in the private hospitals, but were required in the state hospital: "The clothing was awful. They insisted we wear their clothing." For those attending the private hospitals, being allowed to wear their own clothing and to be surrounded by their own possessions allowed them to maintain their individuality. Also of great value was the fact that the stress imposed by separation from their outside lives was removed to a certain extent because the strict visiting hours no longer existed with regard to the baby's father. Similarly, a number of the women had met the nurses before and were in hospital at the same time as others from their antenatal class.

A further way in which depersonalisation was avoided was through the personal attention granted to private patients. This meant that they were not treated as merely one of many patients in a large bureaucratic institution. Mention was made of this: "The people were so helpful and the sisters were caring. You didn't feel like just another bed in the hospital. They treated him like a person and looked after him. So it was actually a good experience." In fact, several women saw the hospital as providing a safe, contained environment, the importance of which was assumed or explicitly stated, "You need a nice environment or your nerves will be shot."

Another routine, extensively criticised in the past, that has been done away with in the private hospitals attended by the women was that of routine enemas. While enemas are no longer performed as a matter of course, a few women had them and experienced them as either "revolting" or as "good because it cleans the bowels completely." The difference the reforms made to the women's experiences of birth and hospitalisation makes one wonder what other reforms, not considered or resisted in the past, could be initiated to improve the women's experiences further.

While the success of the reforms that have been implemented and the removal of certain routines should be acknowledged, it was still the rules and regulations that marred the women's experiences of hospitalisation. The most common criticism of the hospital on the whole, concerned the routines. Raphael-Leff (1991:265) has pointed out the possibility that some hospital routines are dictated not by medical considerations but by other factors such as rules for patient management that have emerged in the hospital for the convenience and comfort of the staff. These routines are not necessarily suited to the physical and emotional needs of the recuperating mother. The sleep disturbing routine of coffee at five o'clock was mentioned by

many women: "The hospital routine carries on regardless of whether you've just given birth at 3 o'clock in the morning and you've just fallen asleep." Another woman complained of being woken up at four o'clock in the morning to prepare to be induced. Other routines were seen more as irritations: "There were questionnaires to fill in, a million bloody questions."

RELATIONSHIP WITH MEDICAL PROFESSIONALS

A common theme throughout the literature concerns the gap in communication between the doctor and patient. Dissatisfaction with the lack of explanation given by doctors has been frequently reported (McIntosh, 1989:204; Oakley, 1980). This creates anxiety and a lack of continuity with the staff who attend them. Furthermore, it has been reported that the amount and type of medical intervention, as well as the perceived adequacy of communication have been found to be particularly important in producing negative responses to birth (McIntosh, 1989:206).

A lack of communication was not found in the case of women attending private hospitals, but was found in those attending state hospitals who felt that the doctor was too busy to answer questions: "There are hundreds of people waiting and you know they're waiting. They want you in and out."

Research has shown that class differences are an important factor in doctor-patient communication. It has been reported that upper and middle class people tend to receive more personalised service from doctors and are more active in seeking and thus gaining further information. In comparison, poorly educated people are more likely to have their questions

ignored or not to ask questions at all (reported in Cockerham, 1992:163). Women in this study generally received the information they required and in many cases their doctors had been selected because they could be assured that all relevant information would be made known: "I chose my doctor specifically because he was very much into natural childbirth, which I was. I knew the reasons why I had to have a Caesar. They didn't treat me like an idiot."; "My doctor was great. He explained everything that was happening. He wasn't just in-out, bugger you, kind of thing."

An important source of security and confidence came in the form of the trusting relationship they had built with their doctors. One woman whose birth did not happen according to plan saw the main positive as her doctor, "She's the most wonderful person. She instils such confidence in you. You have such confidence in her." Another woman stated that, "I had complete faith in my doctor. She was wonderful. I heard her say to my husband, hang on, the cord's around her neck. That was something that freaked me out when I was pregnant. When I heard that I didn't even panic. She sorted it out. I was very calm."

Female gynaecologists and obstetricians have been received by some as imitation men, striving to emulate and even outdo men in their technological expertise and lust for power (Cosslett, 1994:63). While no generalisations can be made, the female doctors in this study were much appreciated and commented upon for their sensitivity to the women's needs and the special relationship that was made possible because of their ability to relate along gender lines: "My doctor was great, just having a woman there. Even afterwards when she came on her rounds my room-mates commented on her because their doctors would just pop in and chat for 5 minutes, the male gynaecologists. The one's gynie didn't even see her because he was away, so she felt

totally alone. One woman said my gynie took the time to talk to me and ask questions about personal things, other than my stitches and my uterus, not just examine me, okay, bye, rush off. It didn't strike me that the gynies are different. I thought that this was how they're supposed to be."

The extent to which these women relied on their doctors is revealed in this statement, "When she gave me her weekends off, I was dreading it. I thought, there's no way I'd like someone else to do the birth." This makes one consider those giving birth at state hospitals, who have not been treated through their pregnancies by one doctor but by whoever is on duty on the day they go for their check-up. These women are unable to attain the benefits of a trusting relationship with their doctors.

From the praises the women directed at the care they received from the general nursing staff, it is clear that what is valued most is being treated sensitively and intelligently and being fully informed. In some cases it was the care that made the experience pleasurable even though the actual birth was different to what they had expected and desired. A woman experiencing a difficult birth said, "It wasn't in itself a nice experience. It was hard and something I wouldn't like to go through again. But the way we were looked after was excellent. I think that made it worthwhile. They were extremely caring, kind, whatever your need was. They explained everything to you if you asked. That's the only real positive."; "The hospital was fantastic. It was the first time I've been in hospital. I was a little bit apprehensive, but the staff were wonderful. The whole set-up of the hospital was amazing. I was really impressed with the whole lot. The fathers could visit basically at any time, which is really nice."; "They don't make you feel inadequate even though you don't know what you're doing. They teach you and answer your

questions even if they need to show you things ten times over. They don't mind."

Many complaints about hospitalisation did, however, centre around the behaviour or attitude of one of the nurses, such as the "sergeant major nurse" who made everyone nervous and tense because of her criticism and adherence to textbook ideas about baby care. This placed a damper on an otherwise positive experience of the staff. Otherwise, the most common complaint given concerning the staff was the ambiguity surrounding the issue of breastfeeding. Different nurses had different ideas as to the best approach and the women found the assortment of contradictory advice confusing and upsetting.

While there were a few complaints that nurses at private hospitals were insensitive and abrupt, such complaints were more consistently heard with regard to state hospitals. A woman considered the idea that, "I think the basic nursing staff get paid badly. They're sick of their jobs. They go through so many babies. They're not really interested. They just want to go home."

The gap between the experiences of women attending private and state hospitals is enormous. While it is clear that expenditure is a central issue, as well as the fact that state hospitals cater for a larger number and may suffer from problems of overcrowding and staff shortages, it was the attitude of some staff that was more frequently mentioned: "It's a state hospital, they're busy. You're not getting that one on one treatment you pay for. Some of the staff there were appalling, rude, really rude and some of them were nice. It's too impersonal and efficient to the point of being brutal. You can say things more gently and behave more gently. They were a bit insensitive."

The descriptions of the treatment in the state hospital such as the assembly line approach to birth, insufficient choice with regard to type of birth and insufficient attention from medical staff correspond with the situations described in much of the literature. These are the circumstances which the majority of childbearing women are likely to face, bearing in mind that only a privileged minority are able to attend private hospitals.

The financial aspect of birth is another point that was remarked upon and was relevant to some woman's experience of hospitalisation. (See Appendix B for examples of price lists from a private hospital.) Attending a private hospital, made possible because of medical aid, was greatly appreciated and some women acknowledged their fortunate situation. "I'm amazed at how the doctor would come and see you, he'd be with you for two minutes. He's done his job, but the costs involved! The paediatrician arrives and just looks at the baby and R80 or whatever. Being on medical aid though, it wasn't a problem at all. We were very fortunate." For others, financial problems placed an unnecessary strain on their early experience of motherhood, such as a woman who was left with a bill for R12 000 because her medical aid went bankrupt before settling their account.

The lack of medical aid determined the decision to attend a state hospital because the cost of a private birth made it an unfeasible option. This decision proved regrettable: "If I had to do it again I wouldn't go to a state hospital. I'd rather spend that money on a better quality beginning just for my psychological frame of mind more than his." Accounts of experiences in state hospitals were fraught with words such as "traumatic" and "nightmare". One woman remarked: "I think its the mothers that get traumatised that haven't had children before. I think if you had another child you'd take it with a pinch of salt."

It was pointed out that the improvement in approach and handling of birth in private hospitals is motivated by competition: "You pay for it but it's worth every cent. The thing is there's so much competition between the hospitals and they're aware of it so they do everything to keep one step ahead. So the meals are better, the security's better, the wards look better. The hospitals are constantly upgrading the levels of their service because there's so much competition. If they want the patients, they've got to make sure they've got a good name." This means that the gap between state and private hospitals is continuously widening.

CHAPTER 6

THE EXPERIENCE OF MOTHERHOOD

In the same way that the medical discourse of birth shapes women's expectations and experiences of birth, so the dominant ideologies of motherhood can be seen to shape experiences of early motherhood. Within feminism, mothering patterns have been regarded as contributing to the oppression and subordination of women by creating the sexual division of labour whereby women and men are thought to occupy different spheres of society (Everingham, 1994:3; Burton, 1985; Birke, 1986). To explain women's restriction to the domestic sphere, feminist writers have referred to the 'motherhood mandate' or the 'myth of motherhood'. The processes whereby motherhood is mandated vary, but have historically been based on ideas about biology, where women's position is determined by their biological capacity to give birth, and enforced by social and cultural institutions (Russo, 1976:143). An important aspect of the 'motherhood mandate' encompasses the idealisation of the mother role. Motherhood is portrayed as the supreme route to physical and emotional fulfilment, as well as a means by which women achieve full adult status and demonstrate their feminine identity. This is indicated in the fact that the validation of adult status and identity are listed as primary reasons given for having children (Woollett, 1991:47; Matlin, 1987:379).

Oakley (1976:187) argues further that the myth of motherhood owes its credibility to the early process of feminine gender-role socialisation, which stresses motherhood as all women's destiny, and psychoanalytic theory, which provides the "pseudo-scientific" backing for this cultural

emphasis on the importance of motherhood to women. Within psychoanalytic theory, maternity is a key theme in feminine psychosexual development. Motherhood is an essentially positive experience, providing them with the opportunity for final resolution of conflicts and integration of the ego (Oakley, 1976:18; Boulton, 1983:3).

The idea of a socially defined institution of motherhood has been supported by several feminist writers (such as Rich, 1976; Kaplan, 1992; Ruddick, 1982). Standing in contrast to the biological fact of giving birth and the experience of motherhood, which is potentially empowering and fulfilling, the notion of the institution of motherhood emphasises the ideological and structural situation of motherhood. Situated within patriarchal society, prescriptions and conditions of motherhood have been created within which choices are made or blocked. These social prescriptions are constantly reinforced and embellished by 'experts' who, with recourse to 'science', determine what constitutes good mothering practice.

These 'experts' have suggested a number of ways in which maternal behaviour can have potentially dire consequences for children. The development of the maternal deprivation theory and the accounts of a child's emotional development by writers such as Bowlby (1953) informed popular ideas about childcare. These theories imply that the child's slightest psychological problem may be attributed in some way to faulty mothering. Psychoanalysis has further increased the significance accorded the mother. In psychosexual development the mother is regarded as the child's primary love object and the purveyor of mental health or illness (Birns & Ben Ner, 1988:59).

EARLY RESPONSES TO MOTHERHOOD

Motherhood brings about qualitative life-style and emotional changes. Faced with a dependent child, the requirements of baby care need to be learned. This takes place while still recovering from the fatigue and general exhaustion resulting from the very physical and emotional nature of the birth experience, as well as healing from procedures such as episiotomies and Caesareans. In general, the descriptions offered of early motherhood ranged from demanding, exhausting and frustrating to rewarding, enjoyable and fulfilling. The commitment required and enormous responsibility of motherhood came as a shock: "Sometimes I get very scared. You look at the immense responsibility you've got and what lies ahead. Your old life is gone, over and done with. That little person is there all the time. That's it. Motherhood is a total commitment."

Oakley (1980:284) believes that the idealisation of motherhood constitutes the greatest problem for women in becoming and being mothers today. Furthermore, despite the prominence of motherhood as a social institution and the almost universal expectation that women will become mothers, the everyday reality of mothering is frequently invisible (Nicolson, 1993). The image of the joys of motherhood, that permeates popular culture (Marshall, 1991), did contribute to the difficulties the women experienced by the creation of glorified and unrealistic expectations. These were evident in the shock expressed at the day-to-day realities of baby care, despite their previous assessment of motherhood as anxiety-provoking: "She's a handful. It's quite stressful. Maybe I had wrong expectations, but I did imagine that a new baby would sleep for at least a couple of hours a day."

Where the reality diverges far from the idealised and romanticised image, the early days of motherhood can be a traumatic and frightening experience. Oakley (1980:253) adds that holding unrealistic expectations is especially inimical to self-esteem and may have an influence on the chances of depression after birth. Returning home from the safe environment of the hospital and assuming full responsibility for their babies for the first time was particularly stressful: "When I came home those first few days I kept checking in his room to see if he was breathing."; "I was too scared to go the post-box in case he started crying and I couldn't hear him. You don't forget for a minute that you've got this other responsibility."

All of the women, even those who described themselves as very maternal, struggled initially: "I had my doubts. The first couple of weeks I thought, God, what have I done? Am I going to cope? He's here now. I can't send him back."; "Some days I'll feel really good and then the next day I'll think, God, put him up for adoption."; "I'm starting to feel more positive about it. Initially I didn't know why I ever got involved in this." With time, as the shock of what is involved in baby care wore off and a routine was established, baby care did become more pleasant. It was agreed that the rewards of motherhood would come as the baby became more responsive and began sleeping through the night.

From the interviews, it would appear that the extent to which a mother copes with the experience of early motherhood depends to a large degree on her baby care experience and her expectations of and preparation for motherhood. Other important factors are the character of her baby, the amount of external support she receives and her social, economic and emotional circumstances. While all the women struggled initially, their general feelings regarding the ease or difficulty of mothering were divided in half. Very often a condition was added, such that baby care is easy if

you have support or if you have a well-behaved baby, as judged in terms of his/her sleeping and feeding patterns, the amount of crying and the ease with which s/he is able to be comforted.

In terms of experience, Oakley (1980:253) argues that contact with children before motherhood converts the assumption of responsibility of one's own children from a sudden shock to a continuous theme. The general lack of experience amongst the women in the study meant that they were unprepared for the time-consuming nature of babycare, which necessitated the development of a new concept of time and a complete change in routine. One version of a time schedule was relayed as follows: "To feed him takes an hour and a quarter. Then if you change him it's another 10/15 minutes. So that's an hour and a half gone and you feed him seven times a day. So you've taken nine hours just feeding. Then you're got to look after your husband, cook meals, shower, tidy the house. Before you know it, the hours are gone."

When the pressure to succeed as a mother, the result of child development theories emphasising the primacy of the mother, accompanies a lack of experience and holding of unrealistic expectations, anxiety is added to the list of emotions felt. Oakley (1980:152) states that it seems that anxiety must be regarded as a usual accompaniment of first-time motherhood in a culture that assigns childrearing to women in a socially isolated nuclear family context. This anxiety is, however, only temporary and minimally disabling. All of the women in the sample expressed feelings of anxiety and frustration, with varying degrees and depending primarily on their amount of first-hand experience with newborns.

The reliance on 'how-to' books offering contradictory advice may further contribute to this anxiety. This is illustrated in the case of a woman who was frantic about being "not even able

to feed my baby properly": "They say I'm over-feeding her and I've read that you can't over-feed a breastfed baby. So I can tell Mirian Stoppard that I'm over-feeding my breastfed baby." This point was made by a few other mothers who were also informed that they were over-feeding their babies.

The assumption that women have a duty to take care of their children and the expectation that they will find motherhood naturally fulfilling has made it difficult for women to express openly feelings of dissatisfaction, disappointment and anger. However, feminist writers (such as Boulton, 1983; Rich, 1976; Badinter, 1981) have sought to expose motherhood's darker side, such as feelings of irritation, boredom, disillusionment and resentment. The women in the study did express more negative emotions, usually, however, with an additional "but he's wonderful" or "but I love him to bits." One woman commented that, "Being with a small baby all day and night is enough to drive anyone insane. Anger and frustration is unavoidable."

A very common confession made by the women was that: "It's exhausting. You have moments when you crack and you don't believe you can do it. Eventually you want to take that dummy and shove it down her throat. You get a fright when you feel that intensity. You're exhausted and you don't know what to do."; "There are times when she's crying and I can't take any more. You can sympathise with people who bash their children. You can see how you can get to that stage where you want to smash her head against the wall. You think about doing it sometimes."

While some of the mothers included 'guilt' in their descriptions of motherhood, others indicated the presence of guilt, but did not explicitly name it. One woman remarked: "I think it starts with guilt. When he's crying you're immediately blaming yourself for everything. It's quite hard to get

that into perspective. It's inclined to make one very neurotic and frantic. I'm much better with him now. If he cries a lot, I don't run and think he's dying." Similarly, another woman made reference to feelings of guilt: "I can see how there are lots of opportunities for feeling, it's my fault, I'm a failure. What have I eaten? Have I had the wrong feelings?" In view of the pressure on new mothers to fulfil the emotional, psychological and developmental needs of their children, along with their awareness of theories emphasising the mother's role in shaping the personality of the child, guilt is not an unexpected response.

Feelings of guilt have been revealed most clearly with regard to maternal employment. Though to a lesser degree than in the past and because of the increasing numbers and acceptance of working mothers, many women in the study felt the need to justify their decision to return to work.

It is important to note that the emotions reported are responses to the realities of baby care. The feelings a mother has for her child are very different to how she feels about motherhood as a set of maternal tasks. Separating the tasks involved in mothering from the feelings towards the baby, revealed a far more positive response: "It was just such joy, such an amazing bubbling out of your heart. It's an incredible experience."; "The minute she was born and the days afterwards and even now I sometimes look at her and feel tearful about how wonderful she is. It's difficult to put into words because its emotions that you feel, how precious she is, how dependent she is."; "It took a while to kick in, the feeling of love you have for this tiny thing that's dependent on you for everything. It took me by surprise. It's more of everything. You finally understand what your parents were talking about. It's quite something."

THE MATERNAL INSTINCT

The widespread belief that a maternal instinct qualifies women for childbearing and childrearing forms part of the ideology of the 'myth of motherhood'. The notion of a maternal instinct underpins the contemporary construction of motherhood through determining notions of femininity and required maternal behaviour (Nicolson, 1993:208). Feminist research has, however, exposed contradictions, pointing to a lack of historical or psychological evidence of an innate desire to bear and nurture children. Scheper-Hughes (1992) sees the maternal indifference displayed by Brazilian mothers in conditions of extreme poverty and violence, as the result of material circumstances and community attitudes, rather than natural maternal emotions. She argues that a high expectation of child death is a powerful shaper of maternal thinking and practice.

Similarly, Badinter (1981) and Shorter (1975) provide evidence of historical variations in maternal behaviour. They regard the maternal indifference displayed in earlier times by women of different classes, who were experiencing social conditions at opposite extremes, as disproving the original explanation of maternal indifference. This was based on the high probability of infant mortality within conditions of poverty. They argue, instead, that 'mother love' is a cultural invention of modern society and that the emphasis placed on good mothering today is the result of the high esteem bestowed on the maternal role.

The reliance of many women on the available literature would imply that they regard the skills and knowledge required to be a good mother as acquired. Despite this, however, it appears that the opinion that mothering is natural as opposed to learned is widely held. This was revealed by

the fact that most of the women in the study, to varying degrees, believed in the existence of a maternal instinct. These opinions, however, changed dramatically after the birth of their babies: "I thought part of this maternal instinct is that you know instinctively what to do, how to handle him and I actually didn't know."; "They tell you to follow your instincts, a mother has an instinct. But I'm sorry, I didn't feel that."

Women who were confident that motherhood would come naturally were shocked to find themselves incompetent at tasks such as changing nappies and bathing: "When I first bathed her, they showed me how and I had this vest in my hand and I said, how do I put this on? They said, just put it on. And I said, but how? How? I had to learn." Performing these tasks for the first time was often a nerve-wrecking affair: "Bathing! That was the pits. I think I shook for about half an hour after that." In general, motherhood involved a process of learning. The women were grateful for the easy access to guidance, a phone-call to the clinic, their assortment of baby-care books and magazines and the extended visitations from their own mothers.

MATERNAL IDENTITY

It was unilaterally agreed that life changes dramatically with the transition to motherhood. These changes take the form of losses and gains and it is the extent to which these are able to be balanced against each other that, in part, determines how a woman responds to her new status as mother (Oakley (1980:244). First and foremost, motherhood, as socially defined, represents primarily and essentially a loss of identity, the feeling of being a separate person in an equal community of other persons. This was expressed by one woman who saw herself as losing a part of herself in the transition to motherhood: "Life will never ever be the same. From a point of

view of what's left of me at the end of the day - very little. I'm trying to give myself a few hours a week to be me, but your own personality's in shreds for a while."

The feeling of loss of identity is not only a consequence of the restriction that motherhood places on other activities, but also of the very presence of the child. The women in Boulton's study (1983:99) found that the constant physical presence of their children intruded on their personal space, disrupting their sense of independent existence. Such feelings were also revealed in the present study: "I felt this overwhelming sense that this is it, my life is completely not my own any longer. This little thing depends on me for everything. I'm going to be responsible for her from now until she dies."

Oakley (1980:245) has pointed out that for a woman whose self-concept is already organised around a commitment to motherhood, its arrival brings a sense of reinforcement and confirmation instead of a need to reorder how the self is perceived and evaluated. Only two of the women in the study had chosen to become full-time mothers. For most of the women, maintaining their careers, as a source of independence, interaction and stimulation, was one way in which they were able to counteract the sense of motherhood consuming their lives and retain an identity outside of 'mother'. Many were looking forward to returning to work out of increasing frustration with the limitations of motherhood: "That's all your life is at the moment, what nappies you're using."; "It's a lonely feeling, when you're trying to rock a baby to sleep all day. It's mind-bogglingly boring." For some women, maintaining other aspects of their identity meant that undertaking the role of mother was experienced not so much a disruption of self-identity, but as "just a new part of me."

It was common for women to struggle initially to identify with the mothering role. 'Mother', as a social construction more than a biological fact, carries preconceived associations. From the women's accounts, it appears that a clear image was held of a 'mother' and the qualities or virtues she possesses. This reverberates back to constructions of the ever-loving, ever-forgiving mother. Furthermore, there was almost an expectation that these qualities would surface with the act of childbirth, as in the case of the often elusive maternal instinct. The sense of a 'mother' as a different sort of person is revealed by these women: "I still feel exactly the same. I still feel like I felt before. I can't believe I'm a mother. I think the same. I still find it strange being called mother. I don't know if I feel like a proper mother. I don't know what mothers feel like."; "It's still something that's going to grow on me. I don't think I'm 100% mommy yet."; "I don't feel I'm the mother by any means. I don't feel that mother-earth thing." The doubt expressed as to whether they were mothers in the 'true' sense further illustrates the extent to which ideologies of motherhood as women's purpose and ultimate fulfilment have been internalised.

Ruddick (1982) believes that being a mother stimulates particular ways of perceiving and explaining the world, termed 'maternal thinking'. Through the experience of being a mother, socially and psychologically women develop a distinctive way of seeing the world, which enables them to accomplish raising their children. Being a mother is then not only about performing maternal tasks. It is a way of thinking and reacting and involves a change in perspective and priorities.

An ambivalence was evident in the fact that many women questioned their identity as 'mother', while at the same time acknowledging a change in perspective and perception similar to that suggested by Ruddick: "Everything changes overnight. You do silly things that you take for

granted, but the way you speak to each other can have an influence on how he's feeling. If you're angry he's going to feel it. Everything you do has a direct or indirect affect on him so you're aware of how you behave and how you're feeling."; "People say you'll never be the same again and I can understand that because the depth of love that I feel towards her now is just the beginning and its going to grow. That changes you. It changes the decisions you make, your priorities. What's important to you suddenly wanes into insignificance."

THE DEVELOPING RELATIONSHIP

For most (14) of the women, the relationship with their babies developed over time as they got to know his/her individual character. Initially the baby was a stranger: "At first I'd look at her and think, goodness, am I going to feel something for this creature?" The women were, however, aware of the fact that love is not always felt immediately: "At the moment I don't see myself as mom. I don't think it will come straight away. It'll take me time to bond with the child. Everyone says you don't fall in love straight away."

A recent British study found that women who delivered by Caesarean took significantly longer than those who delivered vaginally to feel close to their infants and these differences persisted several months after the births (Hillan, 1992). In this study, however, there was no clear association between the immediacy of the bond between the mothers and their babies and the type of birth or even the amount of time allowed with their babies immediately after delivery. A more important factor appeared to be the ability of the women to establish a solid relationship with her baby in the womb. Where this had occurred, albeit infrequently, a sense of continuity between pregnancy and birth was experienced: "You have a relationship with that child for nine

months. I think if you've worked on that relationship then when they're born its an extension.";

"I'd communicated with her in the womb, playing with her little feet. So it was basically seeing what she looks like and holding her."

THE ART OF BREASTFEEDING

Attitudes towards breastfeeding have been ambivalent, the debate surrounding the issue of bottle versus breastfeeding swinging back and forth. Breastfeeding has been seen by some feminists (such as Firestone, 1972; deBeauvoir, 1960) as another tie to women's traditional role. Artificial feeding was thus seen as part of women's liberation (Renfrew & McCandlish, 1992). The most common opinion today, and encouraged in the Antenatal classes attended by the women, is that the benefits of breastfeeding are numerous, making it the best option. The colostrum expressed initially provides immunisation against disease and infection and breastmilk contains nutrients necessary for development. Breastmilk is also free, immediately available, the correct temperature and requires no time consuming sterilisation. Furthermore, breastfeeding enhances bonding between mother and child and increases a baby's sense of security. It helps mothers lose weight after birth and the hormone oxytocin, secreted during breastfeeding, helps the womb contract more quickly (The South African Women's Health Book, 1996:377).

With the exception of two women who did not feel it was something they wanted to do, all the women in the sample breastfed with varying degrees of success. Only four women found breastfeeding easy, the remaining 14 experiencing great difficulty. The most basic of all mothering tasks is to feed a baby. As such, the unanticipated difficulty experienced had an effect on some women's confidence in the mothering role. Women whose babies were unable to

establish breastfeeding shortly after birth, owing to incubation or neonatal problems, tended to encounter problems with latching, so much so that one woman was forced to abandon her hopes of breastfeeding. A further problem involved not having enough milk, which necessitated supplementing with formula. Several women also struggled with painful nipples, as one woman elaborated: "My nipples cracked and you bleed. It's sore and then you're still feeding so you can't say, OK, hold on for a day. You get blocked ducts as well, so you have these rock hard breasts. You're dealing with all that and still trying to recover. It's no wonder you want to sit and sob. It's totally overwhelming."

The women were generally of the opinion that, "Breastfeeding is a job, a skill. You don't just breastfeed. You've got to learn how." Women were shocked to find that the seemingly most natural aspect of motherhood was not natural at all: "You think it's going to come naturally, but it doesn't. There's a lot they don't explain. Unless somebody's told you about it, it comes as a bit of a nightmare. People were crying about it." The assortment of contradictory advice and opinion from the nurses did not help the matter.

PARENTAL RELATIONSHIPS

The bulk of the literature on marriage and the family conceptualises childbirth as a disruption and the accompanying adjustment process as a threat to marital harmony and stability (Oakley, 1980:76). All but five women acknowledged a change in the nature of their relationship with their partners. Only two viewed this change as primarily negative. For the most part things were "just different" and adjustments needed to be made.

It has been argued that the reasons why children do not, on the whole, appear to enhance the personal relationship between spouses is that energy and time, previously devoted to each other, is channelled away and that parents are often ill-prepared for the demanding nature of parenthood (Thorne & Collard, 1979). This was experienced by the couples in the present study. However, the arrival of the child also had the effect of strengthening the relationship because of the addition of a shared dimension which introduced a new way of relating. This is illustrated by one woman who, on seeing her husband in the role of father, remarked: "I've seen a whole other side to him. I love her so much and because he's her father, it's like loving that part of him."

It has been suggested that a couple's egalitarian ideals are severely tested after childbirth. While couples can easily conform to all the egalitarian ideals - equal job status, equal distribution of household tasks - prior to the arrival of a child, the major social reorganisation in the family occurring after the event, makes this difficult to maintain (Entwisle & Doering, 1980:260). Five couples, who shared egalitarian relationships, achieved a sense of equality in terms of baby care, but this was only made possible by flexible working hours and the joint nature of their working arrangements.

Having to work a full day places heavy constraints on the extent of the father's participation. A far different picture of parenthood emerges if the father sees the baby only for a few hours each evening, especially where the night-feeds are handled solely by the mother. It is only in caring for the child over an extended period that the fathers are able to realise the full implications of parenting. One woman described how on one occasion her husband came home from work after a rough day and complained, "What do you mean dinner's not ready? What have you been doing all day?" Restraining her anger, she allowed him to discover for himself. The following Saturday

she told her husband she needed to get out of the house and left him to look after their baby for the whole day. On her return he, amid chaos, sheepishly admitted, "It's quite hectic, isn't it!"

Rothman (1989:223) suggests that looking at the role of 'mother' as a discipline and a way of thinking, shifts the focus from who she is to what she is doing, which is responding to the needs and demands of a child. The fact that these actions are not gender-based means that the person engaged in 'motherhood' need not be a mother or even a woman. In the study, half the partners fitted the category of 'helper', many of them needing encouragement to participate. However, the remainder were as involved as work would permit and there was a clear sense of parenting being a joint venture. This is apparent in the case of a few women whose partners initially woke up for late night breastfeeds, until the women told them it was not necessary because they had to go to work in the morning. Despite this, there still remains the perception that parenting is the main responsibility of the mother. The extent of this is revealed in the statement: "Sometimes I think he's too involved. I said to him the other day, she's going to think she's got two moms."

All except two of the women were happy with the father's contribution, even where this was limited. Those women who regarded the main parental responsibility as resting with the mother were not resentful of their partner's sporadic and partial involvement. A common situation for these women is seen in the case where a woman reported that her husband was very involved and yet it was revealed later that, "he isn't yet confident enough to bath him," and "he doesn't do nappies." It was, however, the perceived amount of support that was important, as opposed to the actual support. Emotional support was also vital, but where a mother is struggling with the physical demands of baby care, it is active participation that is most appreciated: "If I didn't have the support that I do, I'd probably still be in my pyjamas now, the house quite chaotic. There have

been times when I've done nothing, just feed her and clean myself all day and he's done everything."

PHYSICAL AND EMOTIONAL STATE AFTER BIRTH

Physically, the women in the study had recovered from their birth experiences. For half the women, the need to return to their pre-pregnancy figure was their primary physical concern. None of the women had suffered from postnatal depression at the time of the last interview, though some had not dismissed the possibility. Many knew of others who had struggled with postnatal depression.

Nearly half of the women (9) experienced what they described as third day blues, lasting a few days to a week. A typical description was: "I got them good and proper. It was uncontrollable. You want to sit and sob. I don't remember thinking, this is wrong, that is wrong. I just remember feeling that all I wanted to do was cry for no particular reason." All but two of the women complained of what they termed weepiness, the symptoms of which have been described as 'blues' by Oakley (1980). The descriptions offered varied, but generally entailed a feeling of not coping, doubting themselves, swiftly changing moods and crying for no definable reason.

Evidence exists that high technology births and the management of medical care have an important effect on the adjustment process and may exacerbate the problems most women face during the early weeks of motherhood (Doyal, 1995:139; Ball, 1989; Raphael-Leff, 1991:302; Brook, 1976:234; Oakley, 1980). Out of the eight women who delivered their babies by Caesarean, six suffered from the blues, whereas out of 12 who delivered naturally, only three

suffered from the blues. This would appear to support the view that high technology deliveries are detrimental to a woman's emotional state after birth. However, despite the fact that those experiencing the blues after birth were more often those who had high technology births, it would appear that the extent of medical intervention in a birth is only one factor. Of equal importance is the perceived success of the birth, in terms of feeling safe, secure and in control. It was found that a low intervention delivery that amounted to a disappointing or traumatic birth experience was more likely to constitute a hazardous start to motherhood than a successful high intervention birth taking place within supportive and relaxing surroundings. This accounts for inconsistencies such as the fact that a woman who delivered her baby naturally reacted negatively to early motherhood, feeling weepy, restricted and resentful, while another woman who had an unplanned Caesarean bonded immediately with her child and painted a glowing report of her first moments of motherhood.

Kitzinger (1992:67) states, in this regard, that where a woman is isolated from sympathetic human contact or processed through a hospital system as if on a factory production line, the experience and its aftermath may be distressing even if there are few obstetric interventions. This is further testified to by the fact that regardless of the type of birth, all the women in the study who expressed direct disappointment with their birth experiences struggled emotionally and found the experience of motherhood difficult. One woman saw her difficult birth experience as effecting her initial relationship with her son: "It was a nightmare in the beginning. It took a while. He was freaked out. I was freaked out. I didn't want him in a way. I wanted him, but I didn't want to have to put up with all that howling."

A reason why more of the mothers who delivered their babies by Caesarean appeared to suffer from the blues than those who delivered naturally may be related, in part, to the aftermath of the Caesarean rather than the operation itself. These women found the extended recovery period very frustrating as it inhibited their ability to care for their demanding newborn. The delay in seeing their baby after delivery, because of the required incubation period, was also upsetting.

The fact that no simple association can be drawn between the extent of medical intervention in birth and a mother's subsequent emotion state lends support to a suggestion put forward by Jordan (1993). She argues, specifically in relation to American women, that the technologicalisation of birth in combination with childbirth education have dramatically reduced the fear and dread of birth experienced by earlier generations. Women who are well-educated for birth, who receive support in labour and who feel they are active participants in decision-making during labour do express satisfaction with even highly technological births. While the women in the present study did not anticipate the extent of intervention in their own birth experiences, they were educated in the procedures available and were aware of the possibility of their use.

In relation to this, Cunningham (1993:489) found in his study of Australian childbearing women, that women's experiences are consistent with the expectations and beliefs they hold about childbirth in relation to the specific ideology they have chosen either actively or by default. In this way, the women's choice to give birth in a hospital setting and make use of medical procedures indicates the predominance of and acceptance of the medical ideology of birth. A further point, in relation to several women in the study, is that their emphasis on the product of birth, the baby, and downplaying of the value of the experience in itself meant that few expectations could be disappointed.

POSTNATAL DEPRESSION

All the women agreed that the emotional disturbances they had experienced were the result of fluctuations in hormonal levels. This is the drop in oestrogen and progesterone output occurring after birth. Many women supplied the explanation of the 'third day blues' coinciding with the hormonal imbalances caused by the production of milk in the breasts. It has been pointed out, however, that while hormonal changes may be a factor, explanations pointing solely to hormonal or psychological causes focus on the supposed faulty functioning of the woman to the neglect of the real social and medical roots of the problem. Kitzinger (1992:65) argues, in this regard, that labelling a woman who has been helpless in a situation of overwhelming stress as suffering from postnatal depression turns it into a problem that is located in her disturbed mind, rather than in reality. This deflects attention away from what is wrong with the hospital system and the way in which care is given, as well as other social factors that lead to mother's unhappiness.

Acknowledging the hormonal changes occurring, postnatal depression or the blues may thus alternatively be associated with the social environment and changes in women's lives as a consequence of having children. In terms of social environment, certain kinds of vulnerabilities have been shown to increase the risk of depression. These include not being employed, a segregated marital relationship, a lack of support from family and friends, economic disadvantage, having no previous experience, holding unrealistic expectations and social or emotional isolation (Oakley, 1980:279; Llewellyn-Jones, 1993:259). Relevant aspects directly related to mothering include the pressures and demands of motherhood and the several losses involved such as the loss of life-style, free time and independent identity (Marshall, 1991:82;

Dix, 1987:75).

In the present study, the relationship between the blues and the demands of motherhood may be clearly demonstrated. Symptoms such as weepiness, irritability and over-sensitivity, associated with the blues, are also a consequence of sleep deprivation, a common problem experienced by new mothers. In the study, 15 women found lack of sleep to be a serious problem. As one woman elaborated: "I'm coping. You get weepy days just because you're so tired. When you're tired you lose all perspective. Everything's wrong. The whole world's a disaster."

The blues are also an obvious and understandable outcome of the shattering of idealised expectations of the joys of motherhood: "I was totally unprepared for it because I'd always wanted children. I thought it would never happen to me. At antenatal when they talked about it I didn't really listen. I was trying to think of all the things that were said."; "I had a feeling of flatness when I came home, feeling I ought to feel overwhelmed with love. Why am I not feeling that? Am I getting depressed? I think there's soup of emotions." The very nature of baby care as time-consuming and repetitive can be depressing: "Everyday the same thing - feed the baby, change the baby. That depressed me. Here I thought I'd be going shopping, visiting. You don't do that. It takes four hours to get out of the house and by that time the traffic's started." The blues, or weepiness, experienced by many of the mothers may then be understood as not simply the result of hormonal imbalances, but as an obvious response to the shock and stress of first-time motherhood.

CHAPTER 7

CONCLUSION

THE MEDICAL DISCOURSE OF BIRTH

The women's accounts of their experiences of pregnancy and their anticipation of and experience of childbirth were shaped to a large extent by the dominant discourses within which the process of childbearing has been constructed. Throughout their accounts, the cultural specificity of pregnancy and childbirth is demonstrated, telling as much about the women's experiences as the ideologies that shape them.

Throughout the interviews it was clear that the medical discourse of birth was thoroughly incorporated into the women's perceptions of their childbearing experiences. Pregnancy entails acquiring a new identity, undertaking a new social role and a complete disruption of life-style. However, the experience of pregnancy was relayed more in terms of a list of physical symptoms. Similarly when asked to describe broadly their experience of childbirth, the women all chose to focus on the medical aspect of the event, supplying a list of medical procedures and accompanying medical opinion.

In terms of medical intervention in the birth process, in the study, there was a 100% intervention rate ranging from the use of pain relieving medication to the performing of Caesareans. The rate of intervention was higher than anticipated. While only four out of the 20 women intended to

request an epidural, 16 women made use of analgesia, either epidurals or spinal blocks. This was despite adamant objections to the procedures, expressed during the pre-birth interviews. Most of the eight Caesarean deliveries were also unanticipated, as no medical risk was foreseen. The medical intervention was generally accepted as a necessary part of birth, with few women resisting it or even commenting on the high rate of intervention. The evident preoccupation with medical procedures during the women's accounts, to the exclusion of other aspects, attests to the fact that pregnancy and birth were responded to primarily in terms of the medical paradigm. They were experienced as physical conditions to be handled within a medical context.

The medical discourse shapes expectations and limits perceived options, in part, because the only birth portrayed as acceptable is medicalised birth. Within the hospital setting there is no visible alternative. The women's stay in hospital brought them into contact with other women, all of whom had undergone high intervention births, which were then widely portrayed and accepted as the norm.

The head of an organisation of midwives reports that women seek out their services either because they have a special interest in home birth or because of the desire to avoid a repeat of an unpleasant hospital birth experience. Home deliveries or midwife attended deliveries have to be actively sought and are generally not suggested or encouraged by doctors. Furthermore, those seeking home deliveries are often labelled 'irresponsible' (Lilian, 1996).

The main criticism directed against the medical discourse has been that thinking in medical, technical dimensions neglects the consideration of social and personal implications involved in childbirth management. This narrows the scope of perception. An example of the way in which

a medical focus results in the disregard of other significant factors is seen in the case of the relationship between the fetus and mother, which was found to be lacking. With the exception of a few cases, the women did not strongly relate to the fetus as a developing baby and consequently struggled to identify with the role of mother. The pathological view of pregnancy contributed to a sense of pregnancy as an 'illness' culminating in a baby, as opposed to an ongoing, developing relationship. In addition to this, a sense of continuity between birthing and mothering was missing because of the fact that birth was the first maternal task the women performed and yet few women participated actively in the delivery.

Many women, through fear or pain, wanted their experience of birth to be over and done with as soon as possible. Birth was seldom regarded as an experience to be savoured and reflected upon. The perception of birth as a medical procedure is not consistent with the idea of birth as an enriching experience, having transformative value (as proposed by Bergum, 1989).

Where a healthy baby was seen as the only significant indicator of the success of a birth, as judged in terms of the apgar score received, the emotional and physical state of the mother was not awarded a high value. The presence of a healthy baby further meant that many negative aspects of the birth were overlooked and thus not criticised. Birth was not significant as an emotional experience, but rather viewed, in some sense, as a hurdle to be gotten through on the way to motherhood. The quality of the experience was thus lost or jeopardised because of the narrow medical perspective through which birth was viewed.

Another aspect of birth that is lost through the medicalisation process is the possibility of birthing pain being experienced as positive and valuable. The idea that pain is negative and

needs to be controlled or relieved detracts from the fact that pain may be accompanied by an enormous sense of achievement and enrichment, as attested to by the four women who declined an epidural. An awareness of the loss of this aspect of the birth experience is revealed in the regret expressed, in retrospect, by many women who had unplanned epidurals. In the study, pain relief was actively encouraged and continually offered to the women, the perceived implication being that they were not expected to be able to endure the pain. The lack of confidence displayed by the women is not surprising in view of this continued suggestion of their inability to cope.

Medicinal pain relief was the first option offered or sought to the neglect of other less severe methods of alleviating pain. One woman insisted that additional support or encouragement would have been sufficient for her to cope with her labour pain, but as this was not forthcoming, being alone and unattended, she felt she needed the help of an epidural.

CONTROL WITHIN THE BIRTH PROCESS

A central issue throughout the interviews was that of control. The women did exercise an element of control in specifically selecting the doctor they wanted to deliver their child and discussing their intended birth plans. Despite this, however, many women demonstrated a passive acceptance of medical authority, some actively preferring a passive role.

The dominance of the medical model of birth was found to have consequences in terms of the decisions reached by the women. Medical ideology and terminology moulded the way in which the women conceptualised birth. As a result, decisions were made based on the medical definition of the situation. Here it is necessary to reiterate that medicalisation is essentially

conceptual. Childbirth is medicalised because its definition as a medical event is justified and accepted and not because childbirth is primarily a medical event. Medicine's construction of reality is the result of the power of doctors to establish and reinforce a particular definition of birth and monopolise its management. Within the context of the hospital, boundaries were set in terms of what was acceptable and possible and judgements were made in terms of the doctors' opinions. The doctors' advice to induce or to perform a Caesarean was seen as the, as opposed to a, solution.

The women felt confident that they had made the important decisions, but it was demonstrated that the control remained in the hands of the doctors either through subtle domination or through the women voluntarily handing over control. This was the result of the fear and anxiety expressed by the women about the birth and the fact that the doctor had access to the necessary knowledge, that judged to be scientific and valid, and was thus regarded as in a better position to make the important decisions. Where the women displayed little confidence in their ability to cope, giving over control to the medical staff provided a sense of security and reassurance. The willingness of the women to allow the doctor a considerable amount of latitude with regard to the management of their births further illustrates the extent to which the process was accepted as needing to be performed by a specialist.

The continuation of the exertion of control by the medical establishment over the process of birth was disguised by this willingness to place the control in the doctors' hands, as well as by the offering of 'choices'. For example, a woman was informed that her baby was in distress at some point in the womb, as evident from the presence of meconium in the amniotic fluid. At the present time, however, the fetal heart-rate was consistently stable and there were no signs of

more recent distress. It was recommended that although the baby was in no present danger and natural delivery was possible, it would be safer to perform a Caesarean. Where a woman is made to feel she is doing her baby harm by persisting with a natural delivery where a Caesarean has been suggested or by having her baby at home, it is understandable that she will go along with the advice. A woman being advised as to the best course of action by a qualified and experienced doctor, does not always feel in the position to contradict his/her opinion or suggest an alternative.

The power relations at play in the present situation differ from those reported in earlier research. Several writers (such as Arms, 1975 and Oakley, 1980) illustrate the lack of control afforded women within the hospital system, where they are treated with assembly line efficiency and allowed no choice with regard to type of birth. In the present study, control was not forcibly taken from the women, leaving them powerless and distraught, but rather they were under the influence of more subtle control while, at the same time, feeling secure and in charge. With regard to medicalisation in general, it has been remarked that medicalisation does not act on people coercively, but rather through a subtle transformation of everyday knowledge and practices concerning the body (Scheper-Hughes, 1992:199).

INTERACTION WITH NATURAL PARADIGM

For many women a conflict existed between wanting the birth to be as natural an experience as possible and making use of the available technology. It has been pointed out that the ideology of natural birth is as much a construct as that of medical birth, especially considering the essentialist and prescriptive notions of motherhood implicit in the accounts and imagery of natural birth presented by writers such as Dick-Read (1933). The consequence of this has been

the assumption that there is a correct way to give birth in terms of specific relaxation and breathing techniques needing to be mastered prior to delivery. Pressure is also exerted to avoid any form of assistance, making guilt a common response where assistance is required.

While the medical discourse predominates by far, the two discourses are interlinked. The success of the natural discourse in encouraging women to go the natural route is revealed in the fact that most women's birth plans were "as natural as possible". By 'natural birth', it appears that the women were referring to intervention-free birth, based on the assumption that the female body is equipped to deal with natural delivery. The medical discourse, in opposition to this, portrays medical intervention as necessary and acceptable. Occurring within the medical context, at the critical moment, medical birth was perceived as an easier, more readily available and acceptable option. Owing to the authority of medical knowledge and the internalisation of the medical definition of birth, the women did not appear to be willing or able to avoid a highly medical birth.

In examining the notion of 'natural birth', it is clear that it has many different interpretations. Natural birth may conjure up images presented by Dick-Read (1933) among others, of 'primitive' women giving birth in the thicket. Alternatively, natural birth may mean birth without anaesthetic, birth outside the hospital or vaginal delivery as opposed to Caesarean Section. Natural birth, in the midwifery model, refers to the understanding of birth as a normal, natural physiological process which, in the majority of cases, should require little intervention. Here, birth is thought about as a normal human experience, rather than a risky medical procedure. In relation to this assortment of meanings of natural birth, Jordan (1993:132) quotes a more thorough and realistic version: "Natural childbirth does not mean that you deliver in a cornfield,

unattended, while out rounding up the cattle, but rather that you are awake, alert and able to participate in and enjoy the birth of your baby. It does not mean that you can't use analgesics or anaesthetics, but that the selection of such is done wisely to minimise the effects on you and your baby."

In examining the interconnection between discourses of birth, the medical and natural approaches have been presented in opposition to each other. However, for practical purposes too clear a dichotomy between these approaches should not be drawn where they are treated as mutually exclusive categories. Discourses of birth are constructs and not objective representations and as such should be regarded as flexible and shifting and not rigid and dogmatic. It is perhaps more helpful to regard natural and medical birth in degrees, especially in view of the fact that within private hospitals in South Africa, 'natural' birth, where it has been understood as intervention-free birth, appears to be rare.

INTERACTION WITH FEMININE PARADIGM

In the discussion of childbirth, the medical paradigm intersects with the feminine paradigm where motherhood is regarded as synonymous with womanhood and childbirth as a transition to full adult status. The feminine paradigm influences the experience of reproduction on the whole through determining the value and status of motherhood and the responsibilities entailed in the role. Furthermore, in presenting motherhood as the natural function of women and as part of women's biological make-up, it holds up the culturally conditioned role of mother as 'natural' and unchangeable.

A consequence of this has been that women have been left with the bulk of childrearing responsibilities and a double load where motherhood is combined with a career. Prior to the arrival of the child, many of the women in the study were fortunate in enjoying relatively equal relationships with their partners in terms of similar employment status and a shared division of labour within the household. However, despite active participation in baby care, the mother was still regarded as having the primary parenting responsibility. Several partners fitted the category of 'helper' as opposed to co-parent.

Despite the opinion that motherhood is more an option than a given, it did appear that the women adhered to the portrayal, within the feminine paradigm, of motherhood as a marker of femininity and the ultimate fulfilment for women. They anticipated that baby care would come naturally and most supported the notion of a maternal instinct. A consequence of this was shock, anxiety and dissatisfaction where the idealised image of motherhood did not fit the reality. Despite being informed through antenatal classes and general reading, with regard to both childbirth and motherhood, the gap between expectations and reality was large. The women appeared ill-prepared for the realities of motherhood.

Contrary to expectations, baby care did not come naturally. Many women struggled with the most basic, seemingly natural, maternal tasks. In particular, breastfeeding needed to be learned and proved to be very difficult, frustrating and sometimes painful. The situation was exacerbated by the fact that, in the context of the isolated nuclear family, the women generally had very little first-hand baby care experience.

On the whole, the construction of women as primarily childbearers has resulted in the analysis of motherhood in terms of the adherence to certain standards of feminine personality and behaviour. It has been shown, however, that childbirth and motherhood are better understood as involving a social transition with important physical, social, emotional and psychological implications. It follows that postnatal depression and the 'blues' are normal, obvious responses to the powerful disturbance motherhood brings about to established life-styles, routines and identities, particularly within the conditions and prescriptions of the institution of motherhood. As such, accounting for hormonal changes, understanding why postnatal depression occurs should not be a separate question from why depression occurs in general.

SCIENTIFIC MEDICAL KNOWLEDGE

Within the medical discourse of pregnancy and birth, legitimated by its scientific base, it has been shown that scientific medical knowledge is not considered just one outlook, but rather to be the truth. In the case of childbirth, the 'facts' constituting this 'truth' may include the beginning of labour, the timing of each stage of labour, the rate of dilation, the intensity of contractions and assessments of fetal distress. What comes to be perceived as a legitimate definition of reality determines the course of action taken. The judgement of the beginning of labour, for example, may determine the stage at which the woman is admitted to hospital, the amount of time allowed for full dilation and whether an induction is judged as necessary where this dilation is not occurring at the accepted rate. Similarly, judgements of the presence or extent of fetal distress, as based on a fetal monitor reading or the presence of meconium, may influence the decision whether or not to induce labour or perform a Caesarean. These judgements, based on scientific medical knowledge, are, however, not the 'truth', but rather varied interpretations

of a situation, which may result in different courses of action being taken, each with diverse sets of consequences. The extent of variation in childbirth management is demonstrated by Jordan (1993) in her cross-cultural study of childbirth.

THE USE OF UNNECESSARY INTERVENTIONS

It was clear from the interviews that the use of many of the interventions was precautionary, motivated by the desire to avoid any potential problems. Many other interventions were the result of the knock-on effect, where the use of one intervention necessitates the use of another. For example, all of the women whose labour was induced also required an epidural because of the painful and rapid induced contractions. Similarly, all the women making use of epidurals, required the use of forceps or vacuum extraction to aid delivery because of their inability or reduced ability to push.

Apart from the obvious financial cost, the high rate of medical intervention has physical and emotional costs. Inductions were often accompanied by painful and intrusive internal examinations. The experience of being induced is generally not pleasant and in several cases the induction did not work. In the presence of unexpectedly intense labour pain, epidurals were welcomed. There are, however, negative aspects to their use, other than physical symptoms such as a rise in blood pressure and severe headaches. As a result of the epidural, the women were confined to bed and thus unable to continue walking which was found to help alleviate the pain of the contractions. The administration of the epidurals was also frightening, as the women were well aware of the risks involved. The women delivering their babies by Caesarean struggled with the extended recovery period combined with having to care for a demanding newborn.

Physically, recovering from a Caesarean and other procedures such as episiotomies, was a painful process.

Nearly half the women felt drowsy after delivery as a result of medication and in some cases over-medication. This affected their first moments with their babies, several women having only vague recollections of what occurred. The babies delivered by Caesarean needed additional medical attention as a result of the operation. Where this was unanticipated, the women were left frantic, not knowing in what state their babies were. The removal of their babies for testing and observation a few moments after delivery was also a source of anxiety and frustration for the women.

While not in relation to themselves or the medical care they personally received, several women did allude to motives for the high Caesarean rate relating to the time saved in the performance of Caesareans and, most importantly, the inflated cost. It is clear that interventions add considerably to the bill. Of relevance here is a point made by Birke et. al. (1990:54) with regard to reproductive technologies and technologies for managing birth. They state that considering that technology is a social product, it should not be surprising that a combination of personal ambition, the profit motive and patriarchal control is evident in technological development.

Lilian (1996:151), a medical professional and journalist, refers to a profit incentive in no uncertain terms, stating that in South Africa the owners of private maternity clinics are usually a group of gynaecologists and obstetricians who practice their professions there. In terms of financial cost, it is the medical aid companies that bear the brunt, which has motivated these companies to investigate further. According to a recent survey, 24% of all hospital admissions

in America are unnecessary, as is 62% of the time patients spend in hospital and 49% of doctors' visits (Focus, 1995b). In South Africa specifically, a study undertaken by a medical adviser for a medical aid company revealed that 77% of all hospital accounts are inaccurate. By scrutinising 870 accounts, massive savings were able to be made. Furthermore, the extent of some of the mistakes was found to be astonishing. One hospital claimed to have administered sufficient ampoules of a particular medicine in one day to "kill an elephant" (Focus, 1995a & 1995b).

Foster (1995) adds to this by arguing that the information women health care consumers receive is strongly biased towards an overly optimistic view of the efficacy and safety of modern medicine. She questions the extent to which ineffective and unnecessary medical interventions are promoted and perpetuated because of many vested interests involved in their continued expansion. Ironically, while the general public is still being fed a predominantly optimistic view of the triumphs of modern medicine, a relatively superficial review of a range of serious medical journals reveals a significant body of medical doubt and questioning in relation to a wide range of drugs and procedures, which remains almost totally hidden from most layperson's eyes. In relation to childbirth, enthusiastic supporters of fetal monitoring have notably failed to provide any clear evidence of benefits from its ever-increasing use. Research has rather demonstrated a number of significant costs, such as a significant increase in the Caesarean rate due to a high rate of detection of apparent fetal distress (Foster, 1995:38-40).

It should be noted that another possible reason for the high Caesarean rate is that some women, though none in the study, may choose to book themselves for a Caesarean because they regard it as quicker, easier and less painful at first assessment. A further reason may be that Caesareans do not damage or weaken the vaginal muscles and so allow women to retain their pre-birth

characteristics. These reasons emphasize the way in which medicalised birth has been thoroughly internalised. Birth is viewed as a technical process and the field of a medical specialist. Subsequently any emotional or transformative value that birth, as a natural process, may provide, is disregarded.

HOSPITAL REFORMS

The women were generally happy with the medical care they received and though they voiced complaints, most found their time at hospital a positive experience. Some reforms within the hospital have visibly improved the experiences of women. In private hospitals, an element of depersonalisation is removed where regulation hospital night-gowns are no longer required to be worn. Hospital visiting hours have become more flexible, fathers are allowed to be present in the delivery room, women are not confined to bed immediately on admission to the hospital and different positions for delivery are permitted where this is not impeded by the use of epidurals or monitoring equipment. Some of the practices that used to be performed routinely without the support of research findings or the consideration of individual wishes, such as shaving and enemas, have been done away with.

In terms of the call for demedicalisation, Riessman (1992:130) points out that as in many reform movements, larger issues have been silenced. Challenges to the medical domination of pregnancy and demands for demedicalisation have been co-opted by an exclusive focus on the birth environment. Even though the setting of birth is improved, and restrictive, unnecessary routines are removed, birth is still medically defined. It is still under the control of doctors and still occurs in hospital.

THE SCIENCE - NATURE DICHOTOMY

Within the birth process, obstetrical science and technology are thought to be more reliable and predictable than the natural process. As a result, the risk-taking of vaginal birth is being replaced by the risk-taking of surgical birth. In general, the scientific enterprise has been seen in opposition to nature, as attempting to control and gain ascendancy over nature. This has implications in the light of the nature - culture dichotomy, where women have been associated with nature and seen as nurturant, co-operative and suited to domesticity, while men have been associated with civilisation and culture. This socially constructed dichotomy has been challenged because it has brought about the creation of different spheres for men and women through the division between public and private realms. This has served to legitimate women's lower status in society and their restricted position within the home. In terms of this dichotomy, the power of male obstetrics over women's bodies has been likened to the power scientific discourse has claimed over a passive 'female' nature (Cosslett, 1994).

This is seen most clearly in the fact that specialised scientific knowledge has been shown to dominate over a woman's own subjective experience. Biomedical knowledge, seen as both legitimate and authoritative, is often judged as superior to a woman's knowledge and judgement of her own body. Within the medical context, attention is not focused on the woman's judgement or feelings, but on the messages coming from machines. With the use of the fetal monitor, for example, women come to depend on others to give them information about themselves. They come to rely less on what they themselves think and experience and in the process they are robbed of confidence and the feeling that they can manage by themselves.

In relation to this, Oakley (1980:98) argues that the medicalisation of reproduction has changed the subjective experience of reproduction, making dependence on others instead of dependence on self a condition of the achievement of motherhood. Dependence on others is also a consequence of the professionalisation of motherhood and the resultant industry of books offering advice about every aspect of childcare. This explicitly encourages the readers to distrust their own expertise or that of friends and family and to seek instead advice and expertise from medical professionals. The situation is aggravated where advice is contradictory or simply does not have the desired effect, as seen particularly in the case of breastfeeding.

Bergum (1989:91) gives another example of the way in which specialised medical knowledge dominates over other forms of knowledge. She states that although women wanted their babies with them after delivery, it was not until there was scientific 'proof' of the value of those initial hours that the 'natural' was supported by the 'scientific' and so the practices were changed. In the present study, the women were initially allowed only limited time with their babies and this was the only area in which the women resisted the advice of medical personnel, some repeatedly demanding to see their babies.

DOMINANT DISCOURSES

It would appear then that the experience of pregnancy and childbirth is portrayed not so much as a subjective experience shaped by the women's own frame of reference, but as a response to the paradigms or discourses available to them. The medical discourse, the natural birth discourse and discourses of femininity and motherhood interact to shape the experience of childbearing. Martin (1989) has commented, in this regard, that the more a woman is exposed to various

institutions and their discourses, the more dense the mediating screen becomes so that she becomes increasingly distanced from her own subjectivity.

The complexity surrounding the interpretation and experience of childbirth reiterates the fact that pregnancy and childbirth are not only physical, but cultural processes with many different representations. No consistent, unified point of view can thus be presented from which to define the experience. Furthermore, the social construction of the dominant discourses means that they are not without underlying motivations and repercussions. Ultimately the dominance of the medical model of birth marks the further encroachment of scientific thinking into everyday social life.

APPENDIX A

INTERVIEW SCHEDULE: BEFORE BIRTH

Age, marital status, religion, language, occupation, partner's occupation, education, residential area, living arrangements.

1. When you found out you were pregnant, how did you feel about it?
2. Tell me about your pregnancy so far.
3. Are you enjoying being pregnant?
4. Is the pregnancy anything like you expected it would be?
5. How have you felt emotionally and physically during the pregnancy?

6. How would you describe your partner's reaction to your pregnancy?
7. How has your pregnancy affected your relationship?
8. Have you noticed anyone treating you differently since you became pregnant?

9. What kind of medical consultations/ facilities do you use?
10. How do you feel about the medical care you are receiving?
11. How are you feeling about the birth?
12. What do you expect from the experience?
13. Do you have any worries or concerns?
14. Are you undergoing preparation for childbirth by way of classes or reading relevant material?
15. What sort of birth are you planning to have in terms of drugs and technology used?
16. What options have been made available to you?

17. Was your pregnancy planned?
18. Why did you decide to have a baby?
19. How much do you think you know about looking after babies?
20. Have you had any experience with babies?
21. Do you think of yourself as a mother?
22. Is there anything you're particularly looking forward to about having a baby to look after?
23. How do you expect you'll feel when you first become a mother?
24. Do you feel that you're doing what you always wanted to do in having a baby?
25. Do you plan to work after the baby is born?
26. How do you feel about giving up work and taking on the role of mother?

27. Have you been told anything about childbirth and the experience of motherhood? By whom?
28. Did your mother work?
29. Do you know what her attitudes were towards employment and motherhood?
30. Do your peers work? What type of jobs do they have?
31. When you were a child, what were your favourite toys and games?
32. Do you remember as a child if you wanted to be like your mother and get married and have children?
33. As an adolescent what were your plans for the future in terms of career ambitions?

34. How important do you think motherhood is to women?
35. Do you think that all women have a maternal instinct?
36. How do you feel about the women's liberation movement?
37. Would you consider yourself to be a feminist?

INTERVIEW SCHEDULE: AFTER BIRTH

1. Can you describe your experience of childbirth.
2. Where did the birth take place, within what surroundings?
3. Who was present at the birth?
4. How involved was the father?
5. Do you feel that he was sufficiently involved?
6. What type of delivery did you undergo?
7. What medical procedures and drugs were used?
8. What were your reasons for choosing this type of delivery?
9. What reasons were given by your doctor?
10. What choices and information was made available to you?
11. Do you know what was done with the baby immediately after birth?
12. How much time had elapsed before you held your baby?
13. How long did it take before the first breastfeed?

14. How do you feel the birth went?
15. Did you have any particular worries or anxieties during the birth?
16. What were the best and worst aspects of labour and birth?
17. Is there anything that you would have liked to be done differently?
18. Do you feel that you were in control of the way in which the birth was handled?
19. Was having a baby anything like you'd expected it to be?
20. How did you feel immediately after delivery?

21. How would you describe your experience of hospitalisation?
22. Describe the hospital routine.
23. Did you experience any problems with regard to being in hospital?
24. How do you feel about the medical care you received during the birth?
25. How do you feel about male and female doctors?
26. How would you describe your relationship with your doctor/s?
27. Have you been able to ask him or her any questions you may have and have the answers been explained adequately?
28. Do you feel that you understand the relevant medical terms?
29. Were you involved in making the decisions about what was going to happen to you?

30. Do you feel that the baby has affected your relationship with your partner?
31. How does your partner feel about becoming a father?
32. How much does your partner participate in baby care?
33. What do you feel about the amount he does for the baby?
34. Can you describe the division of labour within your home.

35. What does motherhood mean to you?
36. How would you describe your first moments of motherhood?
37. How do you feel you are coping?
38. Has becoming a mother been an easy or difficult experience?
39. Do you feel you have a relationship with your baby?
40. What sort of person is s/he?
41. Are you aware of being a mother?
42. Are you breastfeeding?
43. Did you feel at all anxious about looking after your baby?
44. How would you assess your satisfaction with motherhood?
45. Do you ever feel angry with your baby?
46. How much difference do you think having a baby has made to your life?

47. How would you describe your physical and emotional state?
48. Did you feel depressed at any time during your stay at hospital?
49. Did you expect to get depressed?
50. Why do you think you were depressed?

APPENDIX B

1997 MATERNITY RATES 2

RATES FOR NON MEDICAL AID PATIENTS

Hospital charges are according to Representative Association of Medical Schemes.
These rates also apply to those with insurance cover.

ACCOMMODATION:

Private ward (A) (Maternity only)	R709.10
Private ward (B)	R659.10
Semi-private ward (without bathroom)	R559.10
Semi-private ward (with bathroom)	R584.10
General ward	R459.10
Out patient facility fee	R148.70

NORMAL DELIVERY:

Labour ward	R.962.70
Epidural (including pack)	R347.00
Vacuum extraction	R55.00
Forceps	R55.00
Entonox	R47.69 per 30 minutes

OTHER CHARGES:

Nursery Fee	R199.80
Stress Test - in patient	R75.00
- out patient	R75.00
Incubator	R20.00 per day
Phototherapy	R55.00 per day
Observation (Infant)	R568.90 per day
High care (Infant intensive nursing)	R1266.00 per day
High care (Infant standard nursing)	R824.50 per day
I.C.U. (Adult)	R1823.60 per day
Neonatal I.C.U. (Infant)	R2272.80 per day
Baby pack	R70.00
Mother items	R50.00
All pharmacy consumables used in Theatre, wards and nursery	

CAESARIAN:

Epidural (including pack)	R347.00
Theatre	R18.84 per minute
Oxygen	R13.92 per hour
Oxygen & Nitrous oxide	R1.95 per minute (theatre)
*After hours fee	R129.40

CIRCUMCISION:

Nursery (in patient)	R6.06 per minute in theatre
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*(7PM - 7AM SAT 1PM - MON 7AM & PUBLIC HOLIDAYS)

(01/01/97) Please note, that prices are subject to change without prior notice.

Ref: kmatarif.sam

FIXED FEE
(ALL MEDICAL AIDS)

NORMAL CONFINEMENT

Code 58009	R2134.40 for the first day
Code 58010	R727.70 for each consecutive day thereafter
Code 58017	R527.90 for each consecutive day (excluding nursery fees)
Code 58011	R347.00 for an epidural (includes epidural pack)

These amounts do not cover pharmacy consumables.

CAESARIAN SECTION

Code 58012	R3169.00 for the first day
Code 58013	R713.00 for subsequent days
Code 58018	R513.30 for subsequent days (excluding nursery fees)

PRIVATE WARD DIFFERENCE

R250.00 extra per day on the above amounts, for private ward (A)
 R200.00 extra per day on the above amounts, for private ward (B)
 R100.00 extra per day on the above amounts, for semi-private ward without bathroom.
 R125.00 extra per day on the above amounts, for semi-private ward with bathroom
 This difference is not included in the fixed fee and will not be covered by your Medical Aid.

EXCEPTIONS:

If your baby requires a circumcision, or has to use High-Care, Neonatal Intensive Care Unit or needs special observation, he / she would then become a patient in their own right and the fees will be charged outside the fixed fee procedure. The same applies when the mother needs specialised care in the form of High care or Intensive Care.

NOT COVERED BY MEDICAL AID

Baby pack of R70.00
 Mother items of R50.00

Please note, that prices are subject to change without prior notice. 01/01/97

APPENDIX C

COST ANALYSIS OF A TYPICAL NATURAL DELIVERY (1997 RATES)

The most common type of delivery for those women within the study who gave birth naturally was an epidural, instrumental delivery. The costs listed below are in terms of the average confinement for a natural delivery, which was five days, and the most common accommodation, a semi-private ward. The information was attained from an examination of one woman's medical accounts.

Normal Confinement:	R2134,40 (the first day) R2910,80 (four consecutive days thereafter, at R727,70 a day) R625,00 (extra cost for semi-private ward, at R125,00 per day)
Use of labour ward:	R962,70
Pre-op assessment:	R165,92
Time - 65 minutes:	R454,50
Epidural:	R347,00
Forceps:	R55,00
Epidural top up for perineal tear repair:	R303,00
Time - 32 minutes:	R227,25
Nursery fee:	R799,20 (at R199,80 for each of four days)
Stress test:	R75,00
Total:	<hr/> R9059,77

APPENDIX D

GLOSSARY

Amniotic fluid - The fluid surrounding the fetus in the uterus. It provides freedom of movement, a constant temperature and protection from trauma and infection.

Apgar score - The rating of weight, heart-rate, respiration, muscle tone and reflexes given to the baby at one and five minutes of age. The scores range from one to ten.

Catheter - A tube inserted into the bladder before surgery.

Caesarean Section - The birth of a baby through a surgical incision made through the abdominal and uterine wall.

Colostrum - The yellowish fluid secreted from the breast during pregnancy and during the first few days after childbirth until milk flow is established. It contains antibodies to protect the baby against infection.

Elective Caesarean - A Caesarean that is planned in advance.

Enema - The injection of liquid into the rectum to clean out the bowels.

Entonox - A pain relief administered in gas form. It reduces rather than removes pain and has a drowsy effect on the woman.

Epidural Analgesia - An anaesthetic injected around the spinal nerves, leaving the mental consciousness of the mother unclouded, while dulling the sensation of contractions.

Episiotomy - A surgical incision in the perineal tissues to widen the vaginal opening and facilitate delivery.

Forceps - Two curved blades that interlock and fit closely around the baby's head to aid extraction.

Induced labour - Labour that begins artificially, usually using pitocin, before it begins on its own.

Meconium - A black tar-like substance in the large intestines of the fetus and newborn. Its presence is an indication of fetal distress.

Pethidine - A pain relief administered by injection. It lessens pain, but has a drowsy effect.

Placenta - The oval, spongy organ in the uterus through which the fetus obtains oxygen and nouris

Show - A blood-tinged mucous discharged from the cervix, often just prior to the onset of labour.

Spinal Block - An anaesthetic injected into spinal nerves, leaving the lower body completely numb. It is more invasive than an epidural, but has a quicker effect.

Ultrasound - A test performed to check for fetal maturity using ultrasound waves to produce an outline of the baby's head. It is also used to determine the position of the placenta or multiple births.

Umbilical cord - The cord connecting the navel of the fetus with the placenta.

Vacuum Extractor - A metal cup attached to suction equipment that is attached to the scalp of the baby. This creates a vacuum thereby aiding extraction.

Vermix - The thick, white substance which covers the skin of the fetus to protect it while in the amniotic fluid and immediately after birth.

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