Thesis 3484

THE SOCIAL ORGANISATION OF MOTHERHOOD

- Advice giving in maternity and child health care in Scotland and Finland

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Declaration

I declare that the thesis has been composed by myself, is the result of my own work and has not been included in any other thesis.

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ABSTRACT

This study is a qualitative, cross-cultural research on advice giving for mothers in maternity and child health services in Scotland and Finland. It has been accomplished through local case studies using ethnographic methods. The main objective is to analyse how in these service systems motherhood, women's daily life, and their responsibilities for children's welfare and health are defined and organised, and how these definitions vary across social and cultural contexts. Methodologically, referring to the feminist methodology by Dorothy E. Smith, it is emphasised that beginning from the local and particular, from the everyday practices of health professionals, can provide more general understanding of the social relations that organise motherhood in the two societies.

Empirical results of the study are presented under six substantial themes: The first theme discusses different professional groups as service providers and the relationships between them. Second theme concentrates on the clinic and the home as the physical settings of service provision and their professional and cultural meanings. Third section discusses the relationship and interaction between health professionals and their clients. Next two themes are related to the standards of motherhood: expectations for proper motherhood, child care, and family relations of the mothers. The last theme analyses possible conflicts between women's everyday experience and professional expertise in motherhood.

The general conclusions drawn from the research suggest that motherhood is socially organised at four different but interrelated levels, named in this study as interactional level, institutional level, welfare state level, and socio-cultural level. Advice giving for mothers in maternity and child health care is related to family policy measures, social class and gender systems, historical and cultural tradition, customs, and ways of thinking in a certain society. This complexity underlines the relevance of qualitative approach in comparative research.

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CHAPTER 1

INTRODUCTION

A personal history of the research project

This research focuses on maternity and child health care, health services for pregnant women and young children, in two countries, Finland and Scotland. The main questions are, how do maternity and child health services define and organise motherhood, women's daily lives and their responsibilities for children's welfare and health, and how do these definitions vary across social and cultural contexts?

The reasons that got me interested in studying motherhood and maternity and child health services, are actually very personal. The research project has a long history, which I find important to explicate, in order to locate myself in the field as a woman and as a feminist researcher. The first reason to choose the topic could be found in my experiences of working with mothers and new-born babies in a hospital maternity ward. Later on, I wanted to connect my experiences to academic work, and here feminist re-search seemed to give me permission to do that. In feminist research, in the last 10-15 years, motherhood has been a very central, but also a contradictory issue. At the same time motherhood seemed to be both a source of social oppression for women and a source of personal fulfilment and satisfaction. Also, in different societies motherhood

has different consequences for women, for example, to what extent they are able to combine mothering to other aspects of their life. In modern Western societies the welfare state has an important role in creating the social conditions for motherhood, and in organising women's everyday lives as mothers.

As do all women, I have had to consider my own personal relationship to motherhood: whether I want to have children and become a mother or not, and what that decision would mean to me. My generation of women is actually among the first for whom, at least for most of us, there actually is a real choice. The other side of the coin is that the freedom to choose also makes the decision more difficult and complex (see e.g. Nopola 1991). I do not have children of my own, but that has not actually been my choice. I do not therefore have personal experience of being a mother or using maternity and child health services. Instead, for some time, I was one of those health professionals giving women advice in mothering.

In the 1980s I was working, alongside my university studies, in my former occupation, as a nursery nurse in a hospital maternity ward undertaking basic care of new-born babies. I was helping and supporting mothers in a post-natal ward in caring and feeding their babies, and also teaching fathers some basic skills in baby care, which was a part of the then new 'family approach' in maternity care. I was one of the first child care 'experts' new mothers met, and even if our encounter lasted only for a couple of days, the advice they received from me and my colleagues in hospital certainly had some kind of an influence on their ways in taking care of their babies. I advised the mothers the way I was taught in the Nursing College, according to the most recent expert knowledge

in child care and child health. For a long time I took very much for granted that that's how it should be.

It was an advantage to have a double role: a nursery nurse and a university student. It helped me to distance myself from the hospital world and from my 'expert' role. My earlier experience made me think how we as health professionals defined motherhood: is there only one way that women should act and feel in order to fulfil our standards of motherhood. I also started to ask where did these standards come from. I wanted to unveil and question the standards and expectations set by myself and my colleagues, and all the other 'experts', in order to give women more alternatives, choice and freedom in motherhood. This has also been the feminist aim.

An important distinction that feminist research has made concerning motherhood is the division between motherhood as women's experience(s), as a 'real life' of mothers, and as a social institution and ideology (e.g. Dally 1982; Barrett 1985, 63; Richardson 1993). As historian Ann Dally has put it 'women have always been mothers but motherhood is invented' (Dally 1982,17). The main target of feminist research has been the 'invented' motherhood. It has denied motherhood and mothering as natural for women and asked, how and by whom it has been socially constructed in different times and societies[1].

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[1]It is important to notice, however, that there are different feminist perspectives to motherhood, not just one. As Tuula Gordon has written "The diversity of feminist debate is significant; there are no straightforward explanations, analyses or prescriptions about motherhood or mothering." (Gordon 1990, 48.) Some authors have even argued, referring mainly to the 'second wave of feminism' at the 60s and 70s,

For example Diane Richardson (1993,120) has written that "the feminist aim has been to try to change the conditions of motherhood which limit women's experiences and choices. ... It is the institution of motherhood which feminism has challenged, not mothers or mothering." Also Tuula Gordon (1990) in her book 'Feminist Mothers' has introduced a 'programme' for feminism regarding motherhood, where the aim is not to oppose or deny motherhood but to give women different alternatives:

"Feminism, then, is about the politics of transformation, about seeking the implications of the personal being political. In terms of mothering this means questioning politics of reproduction, motherhood as an institution, analysing the complex desires involved in mothering, considering the right of women not to be mothers, and how those who make a positive choice to have children can combine their parenting with other activities, including paid work." (Gordon 1990, 47-48.)

Historical studies discussing the practices, ideals and ideologies of motherhood and child care (e.g. Badinter 1981; Dally 1982; Hardyment 1983; Oakley 1984), have shown how motherhood and mothering has always been connected to certain historical and social conditions, and how it has been actively produced and reproduced in different arenas and by different actors, in medicine, psychology, education, politics, media, literature and so on.

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that feminism is actually hostile towards mothers and has ignored the problems mothers meet in their everyday life (e.g. Freely 1996).

To be able to understand and analyse my own professional role and my personal feelings and thoughts and also to learn more about feminist analysis of motherhood, I decided to study for my master's thesis how different child care experts in different times have defined normal motherhood. I accomplished the study by analysing articles written by different child care experts in one Finnish journal in 1952-84 (Kuronen 1989).

Some years later, in the early 90s, when I got the opportunity to carry out more research, I continued with the same theme, but I wanted to get closer to the everyday practices of professionals working with mothers. This also meant a turn in my methodological approach. Now I asked how definitions of normal motherhood were constructed and used in professional practices where mothers were met as clients. Instead of looking at the ideology of motherhood separate from the everyday life of actual mothers, I wanted to explore how these definitions are produced and negotiated in the concrete situations where professionals and mothers meet. The study I accomplished was an ethnographic analysis of the professional practises in maternity and child health centres which are the main providers of health services for pregnant women and young children in Finland (Kuronen 1994). I found these services important and influential because they are targeting all mothers and young children. I would argue that in Finland, it is seen as 'responsible parenthood' to use the services and follow the advice given by the health professionals.

When I had the opportunity to work, for two years, in Scotland, as a visiting research fellow at the University of Stirling, it gave me the opportunity to study the same questions in a cross-cultural context. I hoped that a cross-cultural approach would widen my perspective and show the 'blind spots' in my cultural understanding. Phil Strong (1988)

has discussed the value of comparisons by making a question "How does the fish get to notice that it is surrounded by water", and answering "Only when it is hooked out to dry land" (Strong 1988). In a foreign country a researcher is really hooked out to dry land. I had to investigate my new surroundings, but I also had to reconsider the 'water' where I had been swimming before.

The reason I have accomplished my research in these two particular countries is partly a coincidence. Finland was an obvious choice, because it is my home country, and I wanted to see what it looked like from the distance. Scotland, on the other hand, is an interesting, but also challenging country in which to do research, because it is a 'stateless nation'. Health services in Scotland are organised within the National Health Service system as elsewhere in the UK. However, there are also differences between Scotland and the rest of the UK socially, politically and economically. People in Scotland also have a strong sense of their own history, culture and even language. (See e.g. McCrone 1992.) Both countries, Scotland and Finland, have also been quite ignored in comparative research. Scotland has been ignored as part of the UK, Finland maybe, at least partly, because of the language barrier.[2]

There are also other, more theoretical reasons, which make it interesting to study motherhood and maternity and child health services in these two countries. In modern Western societies the welfare state is an institution which creates the conditions under which mothers and fathers act as parents (Björnberg 1992,12). Comparative research has

[2] The representative of the Nordic welfare state in comparative research has most often been Sweden.

shown, however, that the welfare state systems in the UK[3] and in Finland differ remarkably and have also different consequences for women as mothers. (E.g. Lewis & Ostner 1991; Anttonen & Sipilä 1996; Millar & Warman 1996.) For example Alan Siaroff has ranked 23 OECD countries according to their generosity in 'pro-family' policies. The criteria he has used are total social security spending, family policy benefits, public day care programmes and maternity and parental leave. In his list Finland is ranked as third after Sweden and France, while the UK is 14th. (Siaroff 1994.) In this sense, Finland and Scotland are different enough to provide interesting opportunities for comparison.

Several authors have also emphasised the ideological differences in the two countries; In the UK the state has adopted a policy emphasising privacy of the family and responsibilities of parents, where intervention in family life and child care practices of the parents is accepted mainly in problematic situations, whereas in Finland state intervention is seen to be more supportive, providing universal services for families with young children. (e.g. Millar & Warman 1996.) The role of maternity and child health services has been ignored in the discussions on the relationship between family and the state. That is why it is interesting to ask, what kind of a state intervention to parenthood and family life this system represents.

My main interest is not in the organisation of maternity and child health services as such. That is only the starting point, even if a very essential one. Instead, the main issue

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[3] I have to talk about the UK here because Scotland is not mentioned separately in international comparisons.

is how this system, and professionals working in it, organise and define motherhood and how these definitions are constructed at the everyday level of service provision. My main interest is in female professionals[4], midwives and health visitors in Scotland and midwives and public health nurses in Finland, as providers of maternity and child health services.

Mothers and health professionals - searching for a feminist perspective

The main purpose of maternity and child health services has often been described in terms of the health and safety of mothers and the healthy growth and development of children. The content of the services is usually described in terms of different tests, screening and measurements (Antenatal Care 1995; Lastenneuvolaopas 1990; Screening and Collaboration in Maternity Care 1996). The outcomes and effectiveness of the services have been measured mainly by medical standards, using statistics, for example, on maternal and infant mortality rates, birth weight of the children, numbers of normal deliveries and caesarean sections, and the incidence of different children's diseases (Neuvolatoiminnan kehittämistyöryhmän muistio 1984, 74-92; Having a baby in Europe 1985; Provision of Maternity Services in Scotland 1994, 1.).

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[4] Midwifery, health visiting and health nursing are not entirely female professions but a vast majority of professionals in this field are female. In sociology and in feminist research nursing has also often been analysed as an 'ideal type' of a female profession. (See more about these discussions in Chapters 4 and 6.)

In this discourse the development of health services for mothers and children has been described in terms of progress, as a 'success story'. For example, the policy review of provision of maternity services in Scotland begins with a chapter titled 'Evolution of Maternal Health in Scotland', telling us that:

"Over the last 70 years there has been a significant change in maternal mortality in Scotland and maternal deaths are now very rare indeed. More premature babies survive than ever before. ... The last 70 years have also seen the development of obstetric training for general practitioners as well as for doctors working in obstetric hospitals. There has also been a significant development in the education of the midwife and recognition of midwifery as a discipline separate from, but complementary to, nursing. Such educational and training improvements have played an important part in the provision of a higher standard of maternity care." (Provision of maternity services ... 1994, 1.)

Instead of the 'good old days' the story tells us about the 'bad old days', when having a baby was a dangerous business, when women and children died and suffered due to the missing professional aid, but also because of the ignorance of mothers, and their traditional, misleading and even dangerous lay knowledge in pregnancy, child birth and child care. The history of motherhood has been constructed as a horror story, as opposed to the modern, advanced and safe motherhood and childhood that is firmly in the hands of different experts. The quotation above is connected with maternity services in Scotland, but the same kind of 'success stories' are told also in Finland, and in relation to child health services, where we are told about successful scientific and professional battles against infant deaths and children's diseases (e.g. Heydemann 1980; Korppi-Tommola 1990; Tuuteri 1993).

Simultaneously, however, becoming a mother or growing up in modern society has become a 'risky business'. In the same discourse, which tells about great progress in the fields of maternal and child health, it is often reminded that in a changing society the health care system meets new kinds of challenges. We should not assume that all the problems have been solved. In maternity and child health care various things are defined as risks in pregnancy and child birth or in the normal development of a child. The role of the health professionals is to identify these risks and dangers in order to intervene and correct them. It is seen as part of the same 'success story' that there are now more sophisticated classifications and ways of identifying these risks and problems. (See also Scott et al 1992.)

The 'success story' is difficult to question: who would want to go back to times when women and children suffered and died. Still, I find this as a narrow, medical understanding of maternity and child health services. I am looking for an alternative, feminist way of understanding health services for mothers and children, which would question the 'success story' and ask about the position of women in maternity and child health services both as providers and users of the services. I want to ask, how maternity and child health services define and organise women's motherhood and their ways of taking care of their children. But I also want to recognise the role of female professionals in the fields of maternal and child health care, which has often been ignored in medical discourse, but also in its feminist critique.

Within feminist research there are different perspectives and discussions relevant to my research. First, maternity and child health care has often been discussed in terms of medicalisation and social control of motherhood. It has been argued that scientific

knowledge and different experts, especially in the field of medicine, have taken over women's experiences and expertise in motherhood and reproduction. Another perspective emphasises the role of women as agents and active participants, who have created their own arenas within the welfare state, and expressed their own interests. From this perspective maternity and child health services could be seen as services for women where female professionals also have an important role as providers of services.

The control perspective has been more dominant in the UK[5], whereas in Finland women as active agents have received more attention. The two different perspectives or interpretations are related to differences in feminist welfare state discussion. In the UK the welfare state has often been understood as a patriarchal state which controls women and enforces their role as unpaid carers, financially dependant on men. In Finland the welfare state is more often understood in a recent feminist discussion as a 'woman-friendly state' and a women's ally where women have had an active role in creating and developing social policy which has recognised women's needs and interests. The dichotomy between the two perspectives is, of course, too simplified and the situation is actually more complex than this, but it does reflect some fundamental differences between the two systems in the relationship between women and the welfare state. (About

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[5]The control argument in the UK goes back to the Marxist feminist discussion in the 1970s. For example Carol and Barry Smart wrote in the late 70s about social control of women, which takes various forms going through the whole society: "The social control of women assumes many forms, it may be internal or external, implicit or explicit, private or public, ideological or repressive." According to them both women and men are subject of material, repressive and ideological forms of social control in a class-divided society, but they identify four dimensions of social control which women alone experience. These are related to the reproductive cycle, a double standard of morality, a subordinate social and legal status in the family, and the separation of 'home' and 'work' and the ideology of woman's place. (Smart & Smart 1978.)

the feminist welfare state discussion see e.g. Wilson 1977; Dale & Foster 1986; Showstack-Sassoon 1987; Leira 1989; Simonen 1990; Ungerson 1990; Julkunen 1992; Lewis 1992; Sainsbury 1994; Anttonen, Henriksson & Nätkin 1994; Eräsaari, Julkunen & Silius 1995; Anttonen 1997.) I will now look at the two discussions more closely in relation to my own topic.

Controlling mothers

Ann Oakley makes a strong statement that "...'control' rather than 'care' has become the motif of maternity services. ... any informed reading of both sides of the case suggests that antenatal care has increasingly lost its 'care' component and become a package of other things - surveillance, monitoring, social control." (Oakley 1992, 13.)

Feminist research has introduced an alternative, critical perspective to maternity and child health services. It has argued that different experts, especially in the field of medicine, have taken over women's experiences and expertise in motherhood, and also taken the power to define risks, dangers and problems in mothering and in normal development of a child. In this respect maternity and child health care has actually constructed motherhood as a 'risky business' and made mothers targets of its intervention. Furthermore, it has been argued that medicine and 'medical men' are not only controlling mothers, but have also replaced female professionals, like midwives, and left them a marginal, subordinate position as providers of health services. (E.g. Ehrenreich & English 1978; Oakley 1984; 1992; Wrede 1991; Eräsaari 1997). Medicalisation of maternity care has been the main target of feminist critique.

In the late 1980s and in the 1990s one of the new issues that has been raised in feminist discussion is the increased use of medical technology which allows more effective surveillance, monitoring and intervention in pregnancy and child birth. There has also been much critical discussion of the consequences of the new reproductive technology and medical intervention in the treatment of childlessness. Feminists have asked what are the consequences of the new inventions for individual women as well as for the whole concept of motherhood. They have argued that the use of medical technology has changed our understanding of motherhood and reproduction, from a normal to a pathological phenomenon. It has turned women into the 'physiological environment of the foetus' and into guinea pigs for medicine where the main interest is in the foetus and not in women's needs. Feminist critique has raised important ethical and moral questions in relation to the development and use of the new technology from the women's point of view. (E.g. Corea 1985; Stanworth 1987; Turunen 1996.) It has often ignored, however, that there are women who are actively seeking and demanding these medical interventions. How should we understand their demands? This is a question that should be discussed more widely and something feminist analysis has not paid much attention to.

The main emphasis in feminist critique has been on the medical and technological control of woman's body during pregnancy and child birth. Another form of the control discussion is related to social control of motherhood, to the notion of professionals 'policing the family' and mothering. Here the emphasis is not only on professionals, but also on the role of the (welfare) state. In this respect health professionals, or more widely professionals and institutions of the welfare state, are discussed in terms of 'public surveillance of private behaviour' (e.g. Dingwall & Robinson 1990). This is not only a feminist notion (e.g. Donzelot 1980; Rose 1989; Rodger 1995), but what feminist

research has added to it is that public surveillance of family life actually means surveillance of women and their family responsibilities. For example Jennifer Dale and Peggy Foster (1986, 81) have argued that welfare professionals exercise social control over women in two ways: First, by giving them advice and sometimes treatment that is intended to reinforce women's willingness to perform the roles of submissive wives, lovers, unpaid homemakers, child minders and carers of other dependants, and second, by exercising control oven women's access to certain material resources and benefits.

Especially health visitors in the British discussion are often seen as control agents of the state, controlling mothers' ways of taking care of their children. For example, Pamela Abbott and Roger Sapsford have written: "In their mode of intervention they (health visitors) can be seen as targeting the mother, working with definitions of 'good' and 'bad' mothering and attempting to shape mothers in particular directions. Their training generally leads them to work with a particular view of what the family should be like, how mothers should behave and the likely causes of poor health or lack of cognitive development in children. In general they work with a set of ideas about the family and child development which are patriarchal and middle-class. In this way health visitors can be said to 'police the family'." (Abbott & Sapsford 1990, 120.)

'Control' and 'support' or 'control' and 'care' are often presented as opposite to each other. Instead of this kind of strict dichotomy what is needed is a more detailed analysis of the work of health professionals. Health professionals have no means to force the mothers, instead, the power of these occupations tends to rest on their occupational position, its legitimacy, and claims to knowledge. "They not only aim to change and control behaviour, but also help to structure the context of social and cultural life in a more

general sense - through their power to command definitions of reality by which the lives of their clients are shaped" (Abbott & Wallace 1990, 6; see also Smith 1988). This means that at the same time as professional intervention has increased, mothers are held responsible for the health and well-being of their children. Health professionals have taken the role to educate the mothers, 'to make them more informed and responsible about their children's development by pointing out the hazards to child health which they can prevent or control themselves'. (Graham 1979, 172)).

Also Miriam David (1984) has used the term education to describe the relationship between 'caring' professionals and mothers. She understands education as an attempt to change mothers' behaviour: "I shall explore the way 'education' in the broadest possible sense is used to inculcate and maintain standards of motherhood. By education I mean not only the work of teachers, but also the work of other 'carers'... Although 'carers' as distinct from teachers do not define their work as 'educational', they base their work on the assumption that it is possible for them to change others' behaviour. I take this to be education." (David 1984, 29.) She has argued that in the 1980's in the UK courses in family life education and parent education became increasingly common in schools and also in family centres, day nurseries and health centres. Hidden in such gender neutral terms as family, parenthood or child care the aim of this education is to teach women to be better mothers. She is criticising these education programmes because, according to her, they are directed only at poor and/or working class women instead of noticing the need for general kind of support and services for all families, and both women and men as parents. (See also Edwards 1995.)

Nikolas Rose (1989) has argued that in the modern state direct control has been minimised and replaced by self-governing. Only the households of the troubled and the troublesome are subject to more direct intervention. Instead of direct engagement by the state parents are encouraged to seek help from professionals. The ideal is 'the modern private family' or 'autonomous, responsible family'. "The family is simultaneously allotted its responsibilities, assured of its natural capacities, and educated in the fact that it needs to be educated by experts in order to have confidence in its own capacities." (Ibid. 203.) Thus, professional intervention is actually possible and effective only if parents, or mothers, accept it and are willing to cooperate with health professionals. This makes the notion of professional control more complex.

The control perspective provides an alternative, critical view to maternity and child health services, but, for several reasons, I also find it too narrow and one-sided to provide a full analysis of the relationship between mothers and health professionals. First, it is often based on a strong male-female dichotomy. This is the case especially in the feminist critique of medicine where maternity care is understood as male control over women's reproduction. At the same time, implicitly or explicitly, it is argued that if the services were provided by female midwives, or female doctors, they would be more supportive and better meet women's needs (e.g. Oakley 1992, 325-331). Elianne Riska (1993), however, has criticised what she calls the two basic assumptions about women in health work: the superior social and emotional competence of women, and their homogeneity. This has been the argument concerning the female professions in nursing but also within medical profession. As more women enter into medicine it has been seen to change the professional practice to a more patient oriented approach. Riska ar-

gues that this cannot be verified and more emphasis should be paid to specific settings where women and men work within health care. (See also Porter & Macintyre 1991.)

Second, the control discussion has paid very little attention to the role of female professionals. It has ignored the fact that professionals who are working with mothers on a daily basis are often women, and mothers, themselves. It denies women a role as actors and active participants and transforms them either into silenced victims of (male) professional control, or as control agents themselves. What is needed in order to fully explore these questions is a more detailed analysis of the role of women in health care. It is important to ask not only are services provided by women sensitive to women's needs, but also to what extent and in what ways female professionals are judging and controlling other women through their professional status. As Jennifer Dale and Peggy Foster (1986, 38) have noted, the role of women in judging other women has remained an important, but neglected area of feminist criticism of the welfare state.

The control perspective also emphasises that there is a fundamental conflict between health professionals and mothers, in their ways of understanding and defining motherhood, standards and methods of child care, and also women's and children's needs for services (e.g. Graham & Oakley 1981; Mayall & Foster 1989; Heritage & Sefi 1992; Carter 1995). If this is the case, why do women still demand and use the services? This is also an issue which should be problematised and analysed more closely.