

Thesis
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THE SOCIAL ORGANISATION OF MOTHERHOOD

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

Marjo Kuronen

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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.

Marjo Kuronen
Marjo Kuronen

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 research 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 societies¹.

¹It 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.

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 UK³ 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

³I 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 professionals⁴, 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.).

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 UK⁵, 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

⁵The 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 over 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.

Female actors in the welfare state

To find another perspective on maternity and child health services and on work of female health professionals within the system I will now turn to a feminist approach which concentrate on women as political and professional actors in the welfare state. This kind of perspective has been strong in Finnish feminist welfare state research since the 1980s (Anttonen 1994 and 1997).

In the Nordic feminist research the welfare state is often understood as a 'woman-friendly state' or as a 'women's ally' (see e.g. Julkunen 1992, 40-42, Anttonen 1994). In emphasising its woman-friendliness Finnish researchers have referred for example to the public social care services and financial support which women get as mothers. Financial support, such as maternity benefits, long paid maternity and parental leave, and social care services, especially public day care for children, has allowed mothers to take paid work, to combine motherhood and paid work, and thus given them more economic independence. The Nordic welfare state has promoted gender equality both in working life and in the family. It has also been an important employer of women. When the welfare state expanded, especially between the 1960s and 1980s, it gave women new opportunities in the labour market in the public sector, mainly in caring professions, as nurses, home helpers, kindergarten teachers, child minders, social workers and so on (e.g. Rauhala 1996). Feminist research has shown that without women's active involvement and action the Finnish welfare state would not have its woman-friendly elements (e.g. Anttonen, Henriksson & Nätkin 1994).

Finnish feminist researchers have often concentrated on the historical development of the welfare state and the role of women in it. Historical research has shown that Finnish women have a long history of working - first in philanthropy and in voluntary organisations and later on within the state, in politics, administration, health and welfare institutions. In these positions they have made women's questions visible and audible, and campaigned for political reforms. They have also negotiated and created their own space in the welfare state professions.

Women's interests have also differed, often according to social class. For example, at the turn of this century upper and middle class women campaigned for their rights to enter higher education and the professions, whereas working class women campaigned for right and protection for working mothers and their children, including poor single mothers. Upper and middle class women also often took the role as educators of working class women in 'proper' family life and motherhood. Often at the same time as women brought their interests and demands to public sphere, implicitly or explicitly, they strengthened and created ideologies of motherhood, which supported pronatalist politics of the state. 'Social motherhood' was the new ideal for the Finnish (upper and middle class) women at the first half of the 20th century and even beyond: Because of their 'maternal properties' women were given a highly valued role in the family, but also in the outside world in helping the sick and poor, first in philanthropy and later on in welfare professions and even in the national politics. (E.g. Sulkunen 1989; Kuusipalo 1993; Ollila 1993; Anttonen, Henrikson & Nätkin 1994; Nätkin 1997.) But also within female professions, like in nursing, hierarchies were created between women at the different levels of nursing and also between qualified and non-qualified health workers,

and these hierarchies were carefully protected. (Henriksson 1998; in Britain see e.g. Witz 1992.)

Historical studies have shown an active role of women in the development of the welfare state, but also contradictions and conflicts between needs, interests and demands of women in different social positions. While women have created their own space and position within the welfare state, it has also created or reproduced hierarchies between women as professionals and clients and between or even within different female professions.

Women's place in the welfare state has been made visible also in another way in feminist research: by analysing the everyday work of female professionals in the fields of health care and social services, using the concepts of care and reproduction. Finnish researchers have studied caring as paid work and the professionalisation of caring with its specific features, rationalities, and contradictions. (E.g. Simonen 1991; Rauhala 1991; Metteri & Rauhala 1993; Tedre 1995; Henriksson 1998.)⁶ Feminist research has given a voice to female carers, made their work visible, and analysed what has happened when caring has 'gone public', when it is done as paid work in different organisational settings. The political aim has been to give a new kind of value to women's

⁶In feminist research in the UK caring has also been an important concept, but the difference is that in the UK caring has most often been studied as unpaid, informal care provided by women in families and in the community. It has often been assumed that caring is not so much work but a specific, altruistic, personal relationship. According to some recent critiques this view has dominated both the everyday understanding, professional interpretations and feminist research on caring. (Ungerson 1990; Lee-Treweek 1996.) For example Anneli Anttonen (1997, 110-141) has analysed the concept of care in feminist research in different countries.

care work. Feminist research has also given female professionals new concepts to discuss, understand and describe their work.

In all care work, whether it is paid or unpaid, the relationship between carer and cared for has been seen as essential and meaningful (e.g. Wærness 1984; Ungerson 1990; Abbott & Wallace 1990; Tedre 1995). The situation where both the professional and her client are women, as is often the case in maternity and child health care, has been seen to have some specific features. First, women as clients and professionals are acting as mediators between family and the state, between public and private spheres (Simonen 1990, 115; Borshorst & Siim 1987, 137-138). Women, more often than men, become clients on behalf or because of their children, husbands, elderly parents, as mothers, wives and daughters. Professionals, on the other hand, are handling personal, often very intimate aspects of their clients' lives. They are working in the borders of private and public spheres, breaking, moving and crossing these boundaries, and often making private life public. (Eräsaari, Julkunen & Silius 1995.)

From the perspective of female actors it is difficult to define the welfare state and its professionals and institutions as control agents. State intervention in family life has more often been seen as positive rather than negative, where the state share women's family responsibilities in caring for children, old people and other dependent family members. Professionals representing the welfare state are often women themselves, whose work has been discussed in terms of caring, not in terms of control. Instead, welfare state has been seen as an arena where women have campaigned and struggled for their own interests and where public services are important for women in many ways. Still, as Raija Julkunen has reminded us "woman-friendliness of the Finnish welfare

state needs to be critically analysed. The 'best reforms for women in the whole world' might cause unintended consequences. Reforms, which at the ideological level sound good and advanced, might still produce new kinds of gendered practices" (Julkunen 1992, 47).

In Finland maternity and child health services have been studied much less by feminist researchers and social scientists than in the UK. Ritva Nätkin (1997) in her historical research of the politics of motherhood in Finland briefly mentions maternity and child health centres and women's demands for professional aid in child birth. Pirjo Markkola (1994) has also discussed issues of maternal and child welfare in her research on regulation of the working class family life in 1870-1910, showing the different interests of upper class and working class women. Sirpa Wrede (1991) has studied the history of maternity care, but her perspective is mainly in medicalisation and in the medical control of women's reproduction. Furthermore, Lea Henriksson (1998) has studied the professionalisation of nursing in Finland, including midwives and public health nurses, but without any specific interest in their role in maternity and child health services. Maternity and child health centres and the work of midwives and public health nurses have been more often studied in nursing research (e.g. Hyvönen & Lauri 1988; Vehviläinen-Julkunen 1990; Viljanen & Lauri 1990; Hakulinen 1998; Paavilainen 1998), but quite surprisingly, there has been no specific interest in gender issues.

A feminist approach where women are seen as political and professional actors shows that maternity and child health services could and should be analysed more widely not only in relation to the medical or social control of motherhood. It is important to recognise and analyse the role of female professionals in the field. However, studies that have

concentrated on female professionals and women's care work have not told very much about the clients, and the relationship between professionals and clients which is an important aspect in the work. The focus on control has tended to stress the consequences for woman clients and their actual needs for services. It is important to ask however, whether female professionals are control agents of the patriarchal state or co-producers of women's agency, or perhaps both in different contexts? In my research, I wanted to be aware of the two different perspectives, keeping my mind open to different interpretations and to contradictions.

The structure of the thesis

In the next chapter I will turn to history. I will look at how the current system of maternity and child health services has been created and developed in Finland and in Scotland. The chapter can also be read as an ideological narrative (Smith 1990a) of how maternal and child welfare became defined as a social problem and as a state responsibility, and how this field has professionalised, specialised, and institutionalised. What have been the arguments for different actions in different times and what has been the role of mothers as targets of these interventions.

In chapter three I will discuss the methodological issues of my research. I will first locate my research in the fields of cross-cultural and ethnographic research. I will also introduce the settings and accomplishment of the local case studies. Furthermore, I will discuss the specific problems in doing ethnographic research in institutional health care

settings, in two countries, using two different languages. I will also take up some ethical issues and discuss my position in relation to the organisations and people I have studied.

In the chapters from four to nine I will present the empirical results of my research under different substantive themes. In chapter four I will discuss the professional network where midwives, health visitors, and public health nurses are doing their work. I will analyse their position inside the organisation of maternity and child health care in relation to doctors and to each other. I will also discuss their role in a wider professional context, in relation to other professionals and organisations in the field of health and social services. The chapter concentrates on professionals relations, but I will also show the position of clients within this professional network.

In chapter five I will discuss the physical settings of service provision focusing on main difference between the two countries in whether the services are provided in an institutional setting - a 'clinic' that can be either a health centre, a doctor's surgery or a hospital, or in client's home. I will show how the physical environment creates different conditions for the meeting between mothers and professionals. I will also discuss home visiting in relation to the different cultural meanings of home in the two countries.

In chapter six I will concentrate on the characteristics of the relationship between professionals and clients in maternity and child health services. It is an arena where women meet each other in different positions. I will analyse their encounters in relation to feminist discussion where the relationship between women, in its ideal form, has been seen as an equal relationship, where women are able to share common experiences. I will

problematise this interpretation by analysing the power relations between health professionals and their clients.

In chapter seven I will turn to the content of professional advice giving to mothers. What are the standards and expectations for mothers and what are seen as problems needing professional intervention. In chapter eight I will discuss motherhood in the family context, different cultural understandings of family, and the ideal of shared parenthood. I will also analyse the role given to men as partners and fathers in maternity and child health services. I will go on to discuss lone motherhood: to what extent and why it is seen as a special problem by the health professionals.

In the last empirical chapter I will discuss the possible differences and conflicts between expert knowledge and women's everyday experiences as mothers: To what extent health professionals have managed to legitimate their expert role and what are the other, competitive or complementary sources of advice and information for mothers.

In the conclusion, I will draw the substantial themes together and discuss the differences and similarities in professional practices and in the relationship between health professionals and mothers in maternity and child health services in Finland and in Scotland. I will return to the issue, raised in the introduction, of how the relationship between health professionals and their clients should be understood. I will also connect the results to a wider social and cultural contexts. Following Dorothy E. Smith (1988, 151-154) I want to draw a map, or maps, that renders visible the social relations that coordinate and organise women's everyday world as mothers in the two countries. I will then

return to methodological issues and discuss and evaluate significance of qualitative cross-cultural research in the field of comparative research.

CHAPTER 2

A HISTORICAL OVERVIEW TO MATERNITY AND CHILD HEALTH SERVICES

For more than a hundred years in many Western societies maternal and child welfare has been a matter of public concern. It has been an issue that has been connected, depending on the time and context, for example with population policy, public health, changing ideas about children and childhood, the development of the welfare state, and professionalisation within medicine and health care. One of the concrete consequences both in Scotland¹ and in Finland was the development of health services for pregnant women and young children. In this chapter I will describe how maternity and child health services were created and developed in the two countries and also present an ideological narrative on the different debates over maternal and child welfare and health at different times. I will ask what have been defined as the main problems, what kind of concrete actions have been taken and by whom, and what has been the role of mothers

¹ In the case of Scotland, I have to rely to a large extent on historical research on England, or on Britain. There is very little research available on Scotland (Checkland 1982 as an exception), but there is a reason to assume that development has followed the same line as elsewhere in Britain. In legislation concerning maternity and child health care there has been some differences in timing and content in England and Scotland, which I have taken into consideration. With a more detailed historical analysis, more differences might be possible to find, but this kind of detailed historical study is not my intention here.

as targets of these actions and ideologies, but also, what have been women's own interests and demands.

Scotland

Keeping babies alive

Several British writers (Bland 1985; Dwork 1987; Lewis 1980) have located the invention of maternal and child welfare as a social problem and the beginning of maternity and child welfare work in Britain at the turn of the 20th century. This does not mean that previously no attention had been paid to the welfare of children and mothers (see e.g. Dick 1987). It was, however, the time when the first really meaningful concrete actions were taken and when maternal and child welfare became a major public issue. In Britain special importance has been given to the Boer War (1889-1902), during which alarm was raised about the poor physical condition of many men, assessed unfit for military service. This notion, together with recognition of high infant mortality rate and declining birth rate, raised concern and caused demands for action in order to keep more babies alive and in good physical condition. In terms of the population policy, children were now seen as future adults who were valuable for the nation's work force and the military. High infant mortality remained for a long time the key problem in maternal and child welfare work and different reasons were given to it and different solutions suggested.

Some efforts, however, had been made earlier mainly as part of the philanthropic work organised by upper class women. The main motive was to change working class family life which was seen as unhealthy and immoral. Causes and solutions for the problem were seen as individual rather than social. The first target was the hygienic conditions in the homes of the poor, and one of the earliest forms of action was home visiting. The intention was to advise the working class mother in looking after her home and her children. The origins of health visiting, which later became one of the corner stones of maternity and child health care, lie in the Manchester and Salford Sanitary Association Ladies Branch founded in the 1860s which employed working class 'mission women' to befriend the poor and be a model to them. This was the beginning of the process of professionalisation for female sanitary inspectors and later of health visitors. At the beginning their work was concentrated on sanitary inspection, but local authorities wanted them to become 'a mother's friend' and advisor rather than an inspector of sanitary conditions and their work was limited to advisory work in private homes.² (Davies 1988; Dingwall 1977.)

Another early action aimed at the protection of unwanted children. The high infant mortality rate among unwanted, illegitimate children was recognised by the 1870s. For example, in Glasgow the Medical Officer of Health J. B. Russell conducted an inquiry in 1876 about 'uncertified deaths' among children in Glasgow in 1872-74. He found a remarkable difference not only between wealthy and poor districts of the city, but also between legitimate and illegitimate children. The problem of high illegitimate death rate

²Celia Davies (1988) sees this as one of the struggles over women's professionalisation. Women were gradually excluded from sanitary inspection and placed into a professional sphere which was seen as more suitable for women because of their 'natural' skills.

was connected to 'baby farming'. Mothers or fathers of many illegitimate babies paid a sum of money to a baby minder to take complete charge of the baby, who often soon died because of neglect and inadequate food. (Checkland 1982.) In Britain the Infant Life Preservation Act was passed in 1872 in order to tackle the problem of baby farming. The Act required anyone caring for two or more children under one year of age for payment to register with the local authority. Some authorities also appointed inspectors to visit these baby minders. According to Dingwall et al. the Act had only a marginal practical importance, but it was still significant to the future child welfare work because it gave the authorities the right to inspect private homes, not only their sanitation but also child care practices. Inspection also gave evidence of the poor conditions where children were living, and ineffectiveness of the law demonstrated the need for further reforms. (Dingwall et al. 1993, 183.)

Concerns about the wellbeing of children gave the voluntary organisations and authorities a legitimate reason to intervene in the working class family life. Some of the working methods which were used later in maternal and child welfare work, such as the inspection of private homes and advice giving for mothers, already existed in the late 19th century. However, the most heated public debate over the high infant mortality rate took place at the turn of the 20th century. The main reasons were seen to be infant feeding practices, especially contaminated milk, and the ignorance of mothers. Different local actions were taken, first in the biggest industrial cities, to overcome the problem.

The milk question

At the turn of the century infant deaths were divided into non-preventable, like prematurity and congenital defects, and preventable causes, especially diarrhoea, which was the most obvious and dramatic cause of infant deaths. Much research was done in Britain, and also in Germany and the United States, on the causes and transmission of diarrhoea, but it was only in 1945 when the bacteria causing the problem was found. Very early on, however, the connection was found between diarrhoea and feeding methods. Statistics which were available showed that more bottle-fed than breast-fed babies died of a result of diarrhoea and other infant diseases. Although the exact reason was not known, a lot of attention was paid to the standard of milk supply and the conditions under which it was produced, transported, and delivered. These were, however, difficult to control. (Dwork 1987, 22-90.)

Other measures had to be found in order to provide pure milk for babies who were not breast fed. At the beginning of the century, in many cities around Britain, 'milk depots' were opened in order to provide pure, sterilised or pasteurised cow's milk specifically for babies. The model of the 'milk depot' was taken to England and Scotland from France where they had proved to be very effective in decreasing infant deaths. The first milk depot in France was established in 1890, the L'Ouvre de la Maternite at Nancy by Professor François-Joseph Herrgott. The object of this charitable organisation was to educate and aid the mothers delivered at his clinic and to encourage them to breastfeed. A small sum of money was also given to mothers who brought the baby back to the clinic for medical examination. Another similar scheme was started in Paris by Pierre Budin in 1892, and Dr Leon Dufour at Fecamp in Normandy in 1894 opened an inde-

pendent baby clinic 'Goutte de Lait' using very much the same methods. In all these clinics babies were medically examined, mothers were advised in baby care, and encouraged to breast feed. If breastfeeding wasn't possible babies were given sterilised cow's milk from the clinic. (Dwork 1987; 95-101.)

In Glasgow four milk depots were opened in 1904 (Checkland 1982), but there is no information available as to whether these were the first ones in Scotland³. It was seen as important to reach the mothers to advise them, not only to deliver milk for the babies and in some areas home visiting programmes were combined with milk depots. Mothers who used depots were visited at home in order to check the babies and give advice in infant feeding (Dwork 1987, 107-108; Oakley 1984, 39-42; Checkland 1982).

Education for mothers

The wellbeing of the baby was very much seen as depending on the mother, with special attention to her feeding practices. It was soon realised that not only babies need pure milk, but also their mothers need cheap, nourishing meals in order to feed and nurse their babies. Again, according to the French example, the first restaurants for nursing mothers were opened both in England and Scotland in 1906. In Scotland the first one was opened in Dundee and later the same year a similar kind of restaurant started in Glasgow (Checkland 1982). All these programmes were organised by voluntary women's associations, but supported financially by local health authorities.

³In England the first 'milk depot' was opened in 1899 and some others, either municipal or voluntary, were opened soon after (Dwork 1987; 103-104).

In spite of the programmes to offer women better nourishment, and thus tackle the social reasons of poor health, the main problem during the early decades of this century was seen to be 'maternal ignorance' and the solution for that was education (Lewis 1980, 61-113). Maternity and child welfare work was concentrated on keeping babies alive and on mothers' responsibilities to ensure their wellbeing and health, and to take the expert advice offered for them.

Several feminist researchers, for example Jane Lewis (1980), have argued that instead of grasping the real reasons of infant mortality and poor health, reasons like poverty and poor housing conditions, and of providing proper services and financial help, a cheaper solution, education, was chosen. The pressure and blame was put on individual mothers. According to Lewis (1980, 61-82) in several contemporary studies and statements by health authorities inadequate maternal care was named as the main reason for infant deaths. Working class mothers were the main concern. They were accused, for example, of having dirty houses, not breast feeding their babies, neglecting them, and of going to paid work outside home. Women were seen as being in need for education to be good mothers and blamed of ignorance. This kind of educational programme was directed not only to pregnant women and mothers of young children, but also to school girls, the future mothers.

Deborah Dwork (1987) only partly accepts the critical argument made by Jane Lewis (1980) that the efforts made to increase maternal and child welfare were mainly concentrated on ideological work, on controlling and educating women as mothers. According to her the action that was taken was 'conservative', but maternalism was not the only solution. Although she admits that physicians never radically addressed the prob-

lem of poverty, her opinion seems to be that they did their best under the contemporary circumstances. As she shows in her research the risks to babies of 'contaminated milk' were recognised and a number of social and medical services, in addition to instruction and education, were provided. Nor was the system which was developed as cheap a solution as has been claimed to be. (Dwork 1987, 216-228; also Robson 1986.)

Dwork (1987) and Lewis (1980) together with some other researchers (e.g. Jones 1994) still agree that, during the early 20th century, a lot of effort was made in order to educate mothers. Education programmes were first directed only at working class mothers. Middle class mothers were expected to seek advice themselves from child care literature which had been available already since the 18th century (Urwin & Sharland 1992). For example, only gradually, from the 1920s onwards health visitors became involved with middle class families. Only then motherhood among middle classes was made as much of a 'problem' as it was among working class. (Dingwall et al 1993, 192.) Education was given both individually by sending health visitors to working class homes and by organising 'schools for mothers', classes for women in child care.

According to Deborah Dwork (1987, 123) "it was the hygiene education given by health visitors which became the unique and lasting English contribution to infant welfare work." There had been several different visiting schemes, predecessors of health visiting and social work, arranged by charitable associations at least from the mid-19th century. Gradually health visiting became more professional, and more wide spread. By the end of 1905 about fifty towns in Britain employed paid health visitors, both working class women and women with higher education, including qualified doctors (Dingwall 1977). It has been estimated that by 1910 there were at least 3000 voluntary visitors,

and between 200 and 300 municipally employed health visitors in the UK (Oakley 1984, 42).

As professionals health visitors had an interesting position between nursing and social work. They had an advisory and educational role, they didn't do any nursing or give any treatment. At the beginning there was no obvious link between health visiting and nursing. A nursing and midwifery background became a requirement for health visitors only in the mid-1920. According to Dingwall et al., for decades health visitors played an important role for example in child protection, and they only started to loose this task to social workers in the 1940s. Confusion of the roles of health visitors and social workers continued at least till the 1960s. (ibid. 1993, 194-201.)

The 'image' given to health visitors was different from that of other visitors: "Instead of the rigorous investigation of the caseworker (social worker - mk), home visits would be occasions for the respectable poor to display their respectability and to be rewarded for it. Contradictory, to deny entry would be a token of their disreputability and a legitimate cause for corrective interventions." (Dingwall et al 1993,184). First of all health visitors were experts in hygiene and child care. They were expected to counter the influences of grandmothers and neighbours who were blamed to teach mothers old fashioned and unhygienic child care practices. According to Jane Lewis homes were divided in four categories: the poor but 'good' ones, which needed to be visited once every three months; the 'bad' which needed a visit more than once a month; the 'ordinary home' which needed a visit once or twice a year, and finally 'the better class houses', from which not even a card was filled. (Lewis 1980, 106.) In fact, it was just as much the mothers as their homes that were assessed and classified. At that time 'home' was actu-

ally the synonym to woman: the wife and mother who was held responsible for the wellbeing of the family, first of all the children.

Along with the health visiting schemes, child welfare centres were also founded. Health visitors had a role in encouraging mothers to bring their babies to child welfare centres to be examined by a doctor and to participate in mothers' groups, schools for mothers, where they were given lectures on health and hygiene, even taught sewing and cooking. The maternity and child welfare centres were very much educational institutions. Their role was limited to examinations and advice giving. Medical officers who ran the consultation clinics were not allowed to give any treatment. (Lewis 1980, 108.)

Again, different authors seem to have different opinions about, how women themselves perceived the services and especially the education that was directed at them (Oakley 1984; Lewis 1980, 1986; Dwork 1987). Some of them are more critical, pointing out women's opposition and demand for different kind of solutions, whereas others emphasise women's willingness to use the services that were offered. According to Jane Lewis women found some services more useful than others. For example, infant consultations where mothers could get individual help in concrete situations were more popular than mothercraft classes. The help and advice from health visitors was probably welcomed by most women, but sometimes they were also blamed for behaving in a very patronising way. What was also criticised was that women had no control over the timing of the visits.

Women, especially some organisations of working class women, also demanded other services and economic support for mothers, like home help, maternity benefits and

family allowance. The government and local authorities were much less willing to fulfil these demands than they were to provide education. Home help, if it was available, was often too expensive to use for working class women. In the National Insurance Scheme introduced in 1911 wives of insured men, and working women who were insured themselves, received a maternity benefit, but for a long time this remained the only economic support, except for those programmes which provided free or cheap meals for mothers. (Lewis 1980, 165-180.)

The rise of public health services

In the early 20th century voluntary organisations and local health authorities co-operated in the field of maternal and child welfare. Concrete action was usually taken by voluntary, philanthropic organisations, but it was supported by local authorities. For example, in Glasgow as early as 1906 The Health Department had appointed a woman doctor to co-ordinate the voluntary schemes and to undertake infant consultation sessions at the clinics run by voluntary associations⁴ (Checkland 1982). Still according to Olive Checkland (*ibid.*) 'there can be few fields where public authorities originally relied more heavily on voluntary initiatives than in that of maternal and child welfare.' The situation changed during the first half of the 20th century.

⁴First female doctors who graduated around the turn of the 20th century, often made their career in the growing field of maternity and child health care. This was partly because they were denied the access to more male dominated areas in medicine, but many of them had also entered medicine to have opportunity to treat other women (Alexander 1990).

At the beginning of the century then a wide range of philanthropic programmes were directed at mothers and their babies. They provided both advice and material help, 'schools for mothers', infant welfare centres, dinners for expectant and nursing mothers, fresh air fortnights, holiday homes, milk for babies, day nurseries, or crèches and nursery schools. There were, however, two main forms of activity which gradually became governed by the local authorities and the state, namely maternity and child health centres and home visiting. The Notification of Births Act 1907 was one of the reasons which made the work more effective and widespread, because it required that every child born should be notified to the local authorities. Although the law was optional, it was widely adopted by the local authorities. The Act made it possible to gather information on birth and mortality rates in the area. It also allowed mothers and babies to be visited earlier and more effectively than before. The Act was made mandatory in 1915. (Dwork 1987, 139-155; Dingwall et al 1993, 185.) This meant that more mothers than before came under home visiting schemes, under the surveillance and supervision of health professionals or voluntary visitors.

In Scotland, unlike in England, the extension of the Act in 1915 also required local authorities to make provision for expectant and nursing mothers and for children under five years of age, for example to pay part of the costs of voluntary schemes. This meant a major shift from voluntary to obligatory, municipal work in the welfare and health of mothers and children. It also meant that child health services were gradually widened to cover all children under school age, in addition to infants under one year of age.

By 1917 32 schemes for maternal and infant welfare had already been founded in Scotland by various small burgh and county authorities in addition to those in largest cities,

Dundee, Aberdeen, Edinburgh and Glasgow. In Glasgow, in the programme developed by local health authorities in 1917, the main measures adopted were the same as elsewhere in Britain, namely 'infant and child consultation' at the child welfare centres and 'home visitation of expectant mothers, nursing mothers and children up to age five'. Home visitors were administered from the infant and child welfare clinics, run by medical officers. According to the programme there were to be 14 'infant and child consultation centres' in Glasgow. At that time there were 12 health visitors. Only mothers and children from poorer districts were on their lists. (Checkland 1982.)

Elsewhere in Britain a similar kind of legislation came only three years later, in 1918, when the Maternity and Child Welfare Act was passed. According to Deborah Dwork this was a turning point in maternity and child welfare work and actually the first landmark in the establishment of the modern welfare system: "It signified the explicit recognition of the responsibility of the State to protect the health of its citizens regardless of socio-economic status, albeit for one age group only. The assistance offered was made available as a right or privilege, and not a charitable donation or eleemosynary relief, to all who wished to make use of it." (Dwork 1987, 214.) Her interpretation is interesting, because it emphasises the public provision in maternal and child welfare as a beginning of the modern welfare state providing universal services for all its citizens⁵.

The system created, based on municipal maternity and child health centres and health visiting, remained unchanged until the creation of National Health Service in 1948. Within the NHS child health care was very much organised according to the same

⁵ A more widespread interpretation is that a modern welfare state was only created in Britain after the Second World war.

model as it had been before. More changes, and more rapidly, happened in maternity care.

Child health - not a problem anymore?

In the second half of the 20th century there has been much less public concern over the issues of child health compared with the early decades of the century. This might be partly because the immediate danger of high infant mortality had been overcome, and partly because context of the debate had changed. Within the health services the earlier definition of 'child welfare', including both social and health problems, gradually changed to a more narrow definition of 'child health' (Dingwall 1977). This also reflects specialisation in the field of child welfare, where new professionals and institutions have taken their place and defined their area of expertise. Child welfare is now often discussed as a social work issue. Only in recent years the issue of multiprofessional co-operation has been raised up emphasising a need for a broader understanding of child welfare. It has been seen as very important for example in prevention and recognition of child abuse (Cloke & Naish 1992; David 1994). If the concern in child welfare has turned elsewhere what is then the role left for the child health care?

Child health clinics run by doctors and health visitors employed by the local health authorities still remained the main model of primary child health care under the NHS. It was only the National Health Service and Community Care Act 1990 that brought sig-

nificant changes in the provision of child health services⁶. Since then general practitioners have been expected to provide a full range of primary health care services for their patients. As a result, many services previously provided by the local health authorities, like child health clinics, are now provided by GPs. The system of health visiting has remained, even if health visitors now work in closer contact with GPs. (Blackburn 1994.)

The current primary child health care system in the UK includes a child health surveillance programme and health visiting. In 1986 the Joint Working Party on Child Health Surveillance was established with representatives from the British Paediatric Association and the Royal College of General Practitioners, the General Medical Services Committee of the British Medical Association, the Health Visitors' Association and the Royal College of Nursing. After deliberating two years it gave recommendations for development of child health surveillance. Because of the changes in the NHS soon after the report was published, a new working party was established only in few years later, in order to review the content of district programme for child health surveillance. The second report was published in 1990. (Hall 1991.)

These official reports on child health care seem to concentrate on the organisation rather than the content of the services or on the main problems in child health. The reports only include recommendations and emphasise that child health surveillance should be arranged according to local circumstances and needs. The Joint Working Party proposed a minimum core programme for child health surveillance which contains one antenatal

⁶I am not going here to the details of organisational changes happened in the NHS. I am only looking at them as far as they have effected in the organisation and content of child health care.

visit and at least eight visits or contacts before school age (Hall 1991; Turton et al 1993, 40). Medical checks should be done by GPs, while general growth and developmental screening and health education or health promotion were named as the main responsibilities of health visitors. The second working party expressed the role of health promotion in child health services and the role of health visitors as providers of health promotion: "Their programme of home visiting and community development makes an important contribution to many areas of health education, including prevention of accidents and child abuse, early detection of abnormality, provision of guidance to parents on child development and child rearing, and encouraging uptake of immunisation." (Hall 1991, 120.)

The main emphasis in child health care has remained in educational work as it was in early decades of the century, even if the target is now expressed in different terms. The rhetoric of education has been modernised. The concepts used in the 1990s are 'health promotion', 'prevention' and 'support'. "Early parenthood and childhood are perceived as periods when families need increased support and time for promoting health and preventing disease." (Blackburn 1994). Different programmes for parent education are now very popular and are offered not only by health professionals, but also by schools, social work and voluntary organisations (Pugh et al. 1994). The difference with the early 20th century is that instead of the exact rules in hygienic conditions of the home or in practical skills of mothers in physical care of young children, what is now discussed is 'support' parents need from the professionals. Language used today is more abstract: It is often difficult to specify what this support is expected to include. It is often also gender neutral: Families or parents have replaced mothers as targets of professional action, at least in professional rhetoric.

Medicalisation of motherhood

While in child health services the main emphasis has remained on education, maternity care has developed in another direction. From the late 1940s onwards, under the NHS, maternal health became defined as a medical problem to a greater extent than before. It was not only because of the new organisation of maternity care, but also because of the development of medicine and medical technology that took place at the same time. This development had, however, started before the late 1940s. As early as at the 1920s two major changes had occurred in maternal and child welfare work in Britain. First, there was a shift from the emphasis on educating mothers to take care of themselves and their babies to an emphasis on the professional supervision of expectant mothers. Second, more attention was paid to maternal mortality in addition to infant mortality (Hall et al 1985, 5-6.) At the same time, the deaths of youngest children got more attention. Neonatal mortality⁷, the causes of which had earlier been seen as unavoidable, now came under new consideration. In the 1920s the reasons of neonatal deaths became connected to antenatal causes and this, in turn, raised more interest in the medical surveillance and treatment of pregnant women. (Lewis 1980, 62.) Maternity care began to be developed separately from child health care and in more medicalised direction.

In maternity care the main aim was to encourage women to use the services and to seek professional surveillance and advice. It has been very common, until the present days, to blame women for not using the services and thus putting their own and the child's health in danger (Lewis 1980 117-118; Porter & Macintyre 1991). This is not to say that

⁷Neonatal period is a medical term referring to the first month of child's life.

educational aspects did not exist in maternity care. If nothing else women were educated to turn to medical experts.

Even if there had been some early social programmes, like restaurants for nursing mothers and pregnant women, the history of maternity care can very much be described as a development of a medical model of care. According to Marjorie Tew (1990, 87) “The first efforts to reduce infant mortality around 1900 in Britain and other countries had been to improve the nutrition of expectant and nursing mothers. But faith that this kind of social intervention would be enough was weak and was soon overtaken by the conviction that surer salvation would lie in taking steps to improve the quantity and quality of medical care in pregnancy and labour.” Only during the Second World War, under the exceptional war conditions, the importance of ‘social interventions’ was temporarily recognised again.

Childbirth has gone through a dramatic change during this century. Before the 20th century the only form of maternity care was assistance for women in childbirth which was often given by self taught midwives, so called ‘handywomen’. During the first decades of the 20th century qualified midwives and doctors replaced, to a large extent, unqualified handywomen in childbirth. (e.g. Leap & Hunter 1993.) Their ignorance was seen as a major cause of maternal deaths, and their exclusion from practice was the main aim at the time. In Scotland The Midwives Act in 1915 eliminated unqualified midwives.⁸ The welfare of pregnant women was not the only or, perhaps, even the main reason, but the fight over professional monopoly in midwifery. It is important to

⁸ In England already 1902 (Bent 1982).

note that the services women get and the way they are treated during pregnancy and childbirth has been, to a large extent, a consequence of professional competition and power relations⁹.

The beginning of antenatal care in Britain has been traced back to Edinburgh in 1915.¹⁰ Ann Oakley (1984, 46) has named Dr John William Ballantyne (1861-1923) 'the founding father of antenatal care'. The first antenatal clinic was, however, opened by another doctor, Haig Ferguson, also in Edinburgh. In 1899 he had co-founded a refuge for young unmarried women in the late stages of pregnancy. He was so impressed with the findings that rest, good food, healthy surroundings, and medical supervision resulted in lower pre-term delivery rates, higher birth weights, and lower neonatal mortality that he advocated the provision of medical supervision for expectant married women as well. (Tew 1990, 75.) It is interesting however that only medical examinations and supervision was introduced as a way to better 'pregnancy outcomes' and the social aspects of his findings disappeared.

It was in the 1930s and 1940s when pregnancy as a specific period came under wider medical scrutiny. Before, neither midwives nor doctors had very much to do with any-

⁹There was not only a competition between handywomen and midwives, but also between midwives and doctors. At that time doctors often worked in more affluent city areas and midwives in rural areas and among the poor in industrial cities (Dingwall et al 1993, 152-153). After child birth was moved from home to hospital, it placed midwives more under control and supervision of doctors. (About the professional battle over the midwifery training and qualifications see also Witz 1992).

¹⁰ Edinburgh medical school was also the first one in Britain to teach midwifery already in the 18th century and later the University of Edinburgh appointed the first Professor of Midwifery. Initially he taught female midwives but he also opened a voluntary class for medical students and a small maternity ward in

thing that could have been called antenatal care, care during the pregnancy. Care when available, had been concentrated on childbirth. The proportion of women receiving some sort of antenatal care in Britain was 40% in 1932 and it rose to 54% by 1937 (Hall et al 1985, 5-6).

The first clinics were hospital based antenatal clinics, but it was municipal antenatal clinics that were the most common providers of maternity care until the 1940s. (Oakley 1984, 55). In Scotland, the Maternity Services Act 1937 made maternity care more universal and systematic. First of all, it made midwives employees of the local authorities¹¹. From then on they practised under a closer control of local authorities and doctors. It might have been a loss for midwives as a profession, but from the clients' point of view it meant that midwifery services were now more easily available for all women. The service was not, however, free of charge. Women had to pay for the services to the local authorities if they could afford it. The work of midwives enlarged to participation in municipal antenatal clinics, run before by doctors with involvement of health visitors (Tew 1990, 150.) In the 1937 Maternity Services (Scotland) Act also three antenatal medical examinations were introduced.

The National Health Service introduced in 1948 changed the situation in maternity care dramatically producing a system which has continued very much unchanged until the present day. It separated maternity care and child health care from each other to their own systems and made maternity care more medicalised and hospitalised.

the Royal Infirmary. (Tew 1990, 43-45.) Midwifery became a mandatory part of basic medical education in 1879 (Dingwall et al 1993, 149).

¹¹ In England Midwives Act 1936 (Dingwall et al 1993, 166).

The NHS made different options in maternity care free of charge and thus more competitive with each other. Responsibility for maternity care became divided between hospitals, general practitioners and local health authorities. Within a few years the NHS had effectively taken over the municipal maternity clinics replacing them with GPs and hospitals as main providers of maternity care. (Oakley 1984, 135-136.) It is difficult to say whether it was women's demand for new kind of care and services or active advertising for 'safer childbirth' by medical profession which caused such a rapid shift. Ann Oakley has suggested that hospitalisation of child birth also led to hospitalisation of antenatal care (ibid. 131). The weakness of municipal clinics was also that they couldn't provide any treatment, but the function of medical officers was limited to advice giving (Tew 1990, 151).

The organisational changes also weakened the role of the midwives in maternity care. According to Marjorie Tew (1990) in partial compensation for the attenuation of midwives' former antenatal role, their training was extended in mothercraft, nutrition, family planning, psychology, breastfeeding, and the importance of mother and baby bonding. Maybe this was not only a compensation but also a part of a wider approach to childbirth adopted by the midwives, in contrast to the narrow medical approach. Many of these were new issues of the late 1940s and 1950s expressing contemporary ideals of motherhood. At that time, there was a strong emphasis on psychological and psychoanalytical theories of child development and the mother-child relationship. It was in the early 1950s when, for example, John Bowlby introduced his theory of 'maternal deprivation' which claimed that young children need constant care by their mothers to develop normally. For a long time his theory, and popularisation of it, were very influential among child care experts, and were also spread to the wide public. (Riley 1983.) A

more popularised, and positive, version of 'new motherhood' was introduced by Benjamin Spock in his widespread advice books. "Mothers were told to form close, warm and loving relationships with their babies. The motto was 'enjoy your baby' and 'have fun'." (Humphries & Gordon 1993, 57.) In maternity care the emphasis on psychology, breastfeeding and the importance of mother and baby bonding could be seen as an exemplification of the new ideology. As female professionals midwives were perhaps seen as suitable to introduce these issues to mothers while doctors concentrated on 'pure' medicine.

In spite of the attention to the psychological aspects of motherhood since the 1950s, the more recent history of maternity care has mainly been a history of new medical inventions and interventions. New medical technology has made it possible to monitor and intervene in pregnancy much earlier than before. In the 1960s a period began when both doctors and mothers focused on the foetus from very early stages of pregnancy. In the early 20th century even many reasons of infant deaths were still seen as non-preventable and unavoidable, but now a foetus could be monitored and diagnosed in the early weeks of pregnancy. A woman's pregnant body has become an object of medical intervention.

The development of obstetrics has not removed the responsibility of the mother. It could be argued that a mother's responsibility has even widened from her child care practices to her life style and behaviour during the pregnancy and even beyond. For example, when the ultrasound scan was developed in the 1960s and became more widely used during the 1970s, the ideological consequence was that it made the foetus as an individual of its own right and the mother responsible for the wellbeing of that individual. It

was assumed that one of the advantages of ultrasound scanning, along with finding and diagnosing early developmental disorders of the foetus, was to make women more aware of the foetus, and at the same time of the importance of their own healthy lifestyle during the pregnancy, especially of the risks of smoking and alcohol intake. It gave women 'the possibility to meet the baby' and to develop 'prenatal bonding'. (Oakley 1984, 185.) According to Hilary Graham (1979) also the idea of prevention which was very much launched in British health care, especially in health education programmes, during the 1970s, emphasised the responsibility of individuals for their own health, and in the case of women, for their children's health right from the beginning of the pregnancy.

Back to 'nature'

Several women's groups in the UK, for example the Association for Improvements in the Maternity Services (AIMS) and National Childbirth Trust (NCT), have for a long time campaigned for changing the practices in maternity care. Also in feminist research (e.g. Garcia et al 1990; Oakley 1992) maternity care has often been criticised of being too medically oriented and interventionist ignoring women's own needs and not allowing their active participation. In recent years the critique seem to have reached the service providers, at least some of them, and they have started to search for new alternatives in maternity care. The key question is whether medical surveillance of pregnant women and medical intervention in childbirth is needed to the extent that it is currently offered and used.

Maternity care in Scotland is at the moment very much in a process of change. There is a lot of evaluation and development going on in maternity services both nationally and locally (Provision of ... 1994; MSP 1/94 and 2/94). Maternity services have been identified as an area where wide variation exists in clinical care and in the provision of services. This is a reason why, in 1992, the Framework for Action Working Group on Maternity Services was set up under the auspices of the Clinical Resource and Audit Group (CRAG) and the Scottish Health Management Efficiency Group (SCOTMEG) in order to examine the provision of maternity services and to develop strategies for raising standards (CRAG/SCOTMEG 1995, 1). In the Working group there are representatives of national and local health authorities, and different professional and consumer groups.

In Scotland, the main questions in maternity care at the moment seem to be connected to customer choice, continuity of care and carer, and cost effectiveness. A theme, which has also been very much discussed, is the role of different professional groups in maternity care: general practitioners, obstetricians and midwives. The increased involvement of midwives has been much discussed and new models of care have been developed and tested. For example, In Glasgow Royal Maternity Hospital there was a separate Midwifery Development Unit, the first one in the UK, which was set up in 1992 in order to develop and study midwife care. The arguments for more independent midwife care have been expressed both in relation to allowing midwives to use their skills more widely and to the provision of better services for the clients (e.g. McGinley & Turnbull 1994). The final report of the trial was published in 1995 (The establishment of a Midwifery Development Unit based at Glasgow Royal Maternity Hospital 1995).

There has been criticism of unnecessary antenatal visits and duplication of care. It has also been argued that the number of visits is not tailored according to women's individual needs. In 1991 the average number of visits was 15, but it has now been widely agreed that no more than 8-10 visits are necessary for healthy pregnant women. (CRAG/SCOTMEG 1995, 36; McGinley & Turnbull 1994, 259.) The critique has been mainly directed towards the medical aspects of care. The aim is to improve continuity of care and integration of services between professionals and to prevent unnecessary visits. It has been argued that what women need is less medical surveillance and interventions and more individual choice, more information, advice and support. However, the new models of care are not only suggested and offered in order to better meet women's needs, but also because they could reduce the costs of services (e.g. Provision of Maternity Services in Scotland 1993). Arguments about meeting 'women's needs' are also used to legitimate the roles of different professional groups in the field of maternity care. It is still very much the professionals who are defining women's needs.

Finland

First steps in maternal and child welfare

In Finland, as in Britain, the beginning of maternal and child welfare work can be traced back to the first decades of the 20th century. However, public interest in children's welfare and mothers' way of taking care of their children is a much older phenomenon. As early as the mid-18th century a new kind of interest arose in Finland, then a part of Sweden, as well as in many other countries, in the welfare of children. Children were no

longer seen as a short term economic burden. Instead, according to the new way of thinking, the growth of the population became a new national target because it was seen to increase the work force and the political power and economic wealth of the nation. In this context high infant mortality was seen as a central problem and this made child welfare as an important national question (Turpeinen 1987, 280).

In order to decrease infant mortality, attention was paid first to mothers and their child rearing practices. During the 18th century in official reports descriptions and complaints about mothers' careless and loveless child care practices became an issue. Traditional practices were seen as superstitious and harmful and in need of replacement with more modern ones. Such practices as keeping the baby tightly swaddled, refusing to breastfeed or giving the baby to a wet nurse were seen especially harmful. The main reason for high infant mortality was seen to be that mothers did not breastfeed their babies. This concern led to the first 'breastfeeding campaigns', publication of the first child care manuals and circulation of child care guidance. (Pulma 1987, 4.)¹² In the 18th century there were no specialised child care experts or professionals to educate the mothers, but the 'enlightenment programme' was run by the 'educated class' of that time, mainly by priests and local authorities. (Turpeinen 1987, 294-297.)

There were also some plans in Finland already in the 18th century to increase the standards of health care by educating doctors and midwives in order to tackle the problem of infant mortality. The most urgent need was seen to be to educate midwives to assist in childbirth. Already in 1723 a Royal letter was sent to all regional governors around

¹²An extreme example worth mentioning is that in the 1750s the Governor of Ostrobothnia, one of the regions, suggested that mothers who refused to breastfeed their babies should be fined (Pulma 1987, 4).

Sweden and Finland asking them to send suitable women to be trained in midwifery in Stockholm (Viisaista vaimoista nykyajan kättilöiksi 1991, 18). This had, however, very little effect and the first concrete measures which had some practical importance were taken more than one hundred years later, in the mid 19th century.¹³

Women and children were also the main target of charitable work started by local upper class women's associations in 1840s. It was seen as the responsibility of upper class women to help the poor because of their privileged position. The associations founded and maintained schools and children's homes for poor children. They also did home visiting to working class homes, giving advice in homemaking. (Åström 1961.) The intention was to give supervision in child care and child rearing, in homemaking and to support woman's role as a moral guardian in the home.

In Finland upper class women's participation in charitable work was also connected to women's emancipation. The same women were often active both in early women's movement and in charitable organisations. According to historian Irma Sulkunen these women were building up a new ideal of womanhood, an ideal which was based on women's moral superiority and maternity (Sulkunen 1987, 164). It was an ideal for all women, but in practice women from different social classes were expected to fulfil their

¹³ In 1859 a new Rule for Midwives was given which brought along the beginning of training for midwives in Finnish. This was a major step for the professional midwifery. The first Finnish midwife was trained already in the mid-18th century, but even a hundred years later there were less than one hundred qualified midwives in Finland. That was partly because there was no School for Midwives in Finland until 1816 and until 1859 teaching was given in Swedish which meant that it was difficult for Finnish speaking women to attend. The other reason was that municipalities were not very willing to employ midwives. (Viisaista vaimoista nykyajan kättilöiksi 1991, 33.) In Finland, unlike in Britain, qualified midwives never

maternal role in different ways and in different arenas: working class women within their homes but upper and middle class women also in outside world.

Save the children ...

Public concern over working class family life and child care practices in the late 19th and early 20th centuries was a part of a wider 'working class issue' in the early stages of industrialisation when society was rapidly changing. For example, in the city of Tampere both philanthropic women's organisations, labour movement, and local authorities paid attention to the health and welfare of working class children, and especially to high infant mortality. (Markkola 1994.)

Very early on there were also demands that local authorities should take responsibility of child welfare. The labour movement and especially women active in it were in favour of public services instead of the philanthropy of upper class ladies. In 1906 the City council of Tampere set up a committee whose members were representatives of philanthropic organisations, women's organisations, and labour movement, and which also included a female doctor. The committee suggested that city council should found two 'milk depots'¹⁴ and also kindergartens and nurseries for children whose mothers were

actually practised privately, but they were employed, and at the beginning also suitable candidates chosen and sent to school, by municipalities.

¹⁴What happened elsewhere in Europe seemed to be very well known in Finland. The child welfare organisation Maitopisara (Goutte de Lait) that run milk depots was founded in Finland in 1904 according to the French model which was brought to Finland via Sweden by Miss Greta Kläring (Korppi-Tommola 1987; about Goutte de Lait association in France see Dwork 1987, 94-104 and earlier in this chapter). The

in paid work. The only member of the committee who objected to the public provision of services, was the female doctor who promised to set up a milk depot herself, an offer which the city council accepted. At that stage public provision of services was an idea that was still too modern and voluntary organisations continued as the main actors in the field of child welfare for some time.(Markkola 1994, 193-218.) The programme of the child welfare organisations founded at the beginning of the century was a combination of concrete measures to improve the living conditions of children and families, the introduction of medical expertise, and education for mothers. Aura Korppi-Tommola describes that time as a transition in voluntary work from 'charity' to 'enlightenment' (Korppi-Tommola 1990, 18).

Women had a central role in voluntary organisations, but male doctors also became more active. They soon took a leading role in developing child health projects. In Finland the development of child health and welfare has been very much personified in one man, Arvo Ylppö. He was a paediatrician, who for almost one century was the leading figure in child health care in Finland¹⁵. He studied medicine first in Finland and then in Germany. His main scientific interest was in premature babies. After returning to Finland in 1920 he worked first as a lecturer in paediatrics, then a year later he was nominated as a professor of paediatrics at the University of Helsinki, a post he only left in 1957 at the age of 70. He was also one of the founding members of the Mannerheim League for Child Welfare, which continues to be one of the biggest and most powerful child welfare organisations in Finland today. He played an active role in planning its

Maitopisara organisation opened the first 'guidance centres' (milk depots), where babies were given tested milk, mothers were taught child care, and also health checks for children were done.

programme. Along with his scientific and clinical work he also published several books and articles about child care and child health directed at mothers. (Korppi-Tommola 1990, 25-26 and 58-65; Ylppö 1964; Heydemann 1980; Numminen 1987.) For example, his guidance book for mothers, 'The mother as a nurse of her baby' (Äiti pikkulapsensa hoitajana ja ruokkijana), which was published for the first time in 1918, spread in several new editions during the next decades and was very influential among Finnish mothers. According to Ylppö (1964, 113-115) education, 'propaganda', was the key issue to influence the mothers. His influence in both official and voluntary child health and welfare sector in Finland has been remarkable. He was also a mediator between the two sectors and a promoter of child welfare work because of his status as a university professor and because of his close personal links to the leading figures of the Finnish politics and economy.

The active development of child welfare work in Finland in the 1920s was, at least partly, connected to the political situation of the time. Finland had just become an independent country in 1917 and had lived through a very bitter civil war in 1918 between the 'Reds', the left wing socialists, and the 'Whites', the Government forces. In that situation there was a strong nationalist effort to develop the young independent country. After the civil war which was, after heavy losses on both sides, won by the 'Whites', there was a need to 'heal the wounds of the war', but also to control working class family life. Working class mothers, the 'Red mothers', were seen as immoral, dangerous models for their children, teaching revolutionary, 'anti-social' values to the next gen-

¹⁵ He was over 100 years old when he died in the early 1990s. He was very active both in public and voluntary child welfare sectors until his death.

erations. State intervention was needed to avoid their bad influence to the children. (Nätkin 1991; Satka 1995, 81-91.)

The Mannerheim League of Child Welfare was founded in 1920. It was named after General Mannerheim who was the commander of the white army during the Civil War and after the war the head of state until the first President was elected in 1919. Actually it was his sister Sophie Mannerheim, a qualified nurse, together with Arvo Ylppö, who had the leading role in founding the organisation. The name and support of General Mannerheim gave the organisation more authority and public recognition. Although it was a voluntary organisation, it had close connections to the state right from the beginning.

The role of General Mannerheim in connection with child welfare work was however contradictory. It caused suspicion and opposition among the working class both at an organisational and individual level. Working class organisations saw child welfare work as important, but for a long time they did not want to support or to participate in the work of the Mannerheim League because of its political connections (Korppi-Tommola 1990). At the individual level, it has been said that working class mothers sometimes brought their babies to child welfare centres without their husband's knowledge (Korppi-Tommola 1987). It might have been that even if they opposed the ideological base of the Mannerheim League, in their everyday life child welfare centres were the only places where they could get free health care for their children. For working class mothers, it was first of all a place to get concrete help, whereas the providers of the services emphasised the educational and ideological role of the centres. Arvo Ylppö, in his memoirs, has praised Finnish women for their willingness to take advice and to change

their child care practices with the right education (Heydeman 1980,26). Still, very little is actually known about how women really responded to the services and to the advice giving.

Working class women's organisations and members of parliament¹⁶ campaigned for maternal and child welfare as a wider issue which would need social rather than individual solutions. They took up such issues as, for example, women's rights as working mothers and protection for unmarried mothers and children (Sulkunen 1989; Markkola 1994). Their demands met quite a lot of opposition, but some reforms occurred in the early 20th century.

Most women in manual work obtained the right to unpaid maternity leave in 1918-19. However, this had very little significance to the everyday lives of working mothers, because the leave was unpaid and there was no guarantee that they would be able to return back to work after having the baby. Only in 1963 along with the National Insurance Act, women got universal subsidised maternity leave. (Wrede 1994.) The first law concerning unmarried mothers and illegitimate children, which gave the child the right to receive maintenance from the biological father, was given in 1922 (Ala-Nikkola 1992).

Voluntary child welfare work got much wider acceptance and support than the legislative measures to improve the conditions of mothers and children. The means to solve the problem of poor child health were very much the same as elsewhere: to arrange medical examinations for babies and child care advice to mothers. When the Manner-

¹⁶ In Finland women got the right to vote in 1906, and at the same time the right to become elected as members of parliament. Until very recently women MPs and ministers have concentrated on social policy, health, and education in Finnish politics (Kuusipalo 1989 and 1993; Sulkunen 1989).

heim League for Child Welfare with the active influence and participation of Arvo Ylppö opened its first child welfare centre in 1922, in Helsinki, the capital city of Finland, in a working class area of Kallio, and soon after several others, the model for the Finnish child health care work was established¹⁷.

Aura Korppi-Tommola (1990, 65) emphasises the universalist idea of the services right from the beginning "the child health centres provided the first free social services which were open to all and were not in any way stigmatising. The personnel at the child health centre gave advice on preventive health care, they distributed cod liver oil and sometimes also gave vaccinations." It was still clear that the main priorities were working class mothers and children. In the 1920s and 1930s child welfare was seen more as a social problem among working class families than purely as a health problem. Along with health checks for the babies and advice for mothers, they were offered means-tested material aid. Services were free of charge, and in addition, packages of baby clothes and baby care products were distributed to poor families. The primary reason for giving material aid was, however, to encourage mothers to come to the centres rather than to seek solutions to poverty (Wrede 1994). In child health centres child health checks, material aid and guidance for mothers were integrated with each other.

¹⁷ It is interesting that very little has been written about child welfare work in Finland before the foundation of the Mannerheim League for Child Welfare, for example about the Goutte de Lait -association and its work. It seems to me that the Mannerheim League as a powerful and extensive organisation and Arvo Ylppö as its leading figure have very much written their own history of maternal and child welfare work in Finland (e.g. Ylppö 1964; Heydemann 1980; Numminen 1987; Korppi-Tommola 1990). This has, even if not intentionally, hidden the role of other organisations and individuals in the history of maternal and child welfare.

The areas where child welfare work was first directed were both urban working class areas and remote rural districts. The original intention had been to open health centres only in urban areas. In the rural districts health sisters (later called public health nurses), employed either by local authorities or voluntary organisations, went round people's homes checking on children's health and advising mothers in child care. (Korppi-Tommola 1990, 64). There is no clear explanation why health centres began to be founded also in more rural areas and they started to replace home visiting.

Till the 1940s child health care was organised and funded by voluntary organisations and local authorities together, some of which were more willing than the others to participate and share the costs. When new centres were opened, they were more and more directed to all mothers and babies, not only to specific groups.

... and mothers too

In the early 20th century, as since the 18th century, the main issue in maternity care was to increase standards of child birth and the way to achieve the target was to train more midwives. This was also very much a women's issue. In 1907 five women members of parliament suggested that every municipality should be required to employ a midwife. Their argument was based on both the high maternal and neonatal mortality. According to them, with proper care many lives could be saved and unnecessary suffering and permanent harm could be avoided. Their suggestion was discussed in parliament, but the law was only passed more than ten years later, in 1920. (Viisaista vaimoista nykyajan kätilöihin 1991, 38-39.) The new law required rural municipalities to employ mid-

wives with the state subsidising two thirds of the salary. In 1934 the law was broadened to city municipalities. In the Midwives Act in 1920 it was also directed that only trained midwives were allowed to practice midwifery. Still, in 1939 one third of all deliveries were assisted by untrained 'handywomen', 45 per cent were assisted by midwives at home, and 27 per cent took place in hospitals. (Malin & Hemminki 1992.)

During the 1920s and 1930s care during the pregnancy began to get more recognition. Soon after the first child health centres were founded, the first maternity health centres were opened in 1926 in two cities, Helsinki and Viipuri, by the same organisation, the Mannerheim League for Child Welfare. (Korppi-Tommola 1987, 1990, 63-65.) Both child health centres and maternity health centres were organised very much according to the same model. It was the obstetricians who first paid attention to antenatal care (Wrede 1994). However, it was the midwives who became the main providers of care in the municipalities. In 1934 'maternity guidance' was included in midwifery training and in 1937 provision of antenatal care became a statutory responsibility of municipal midwives (Viisaista vaimoista nykyajan kätilöihin 1991,55).

As in child health care, voluntary organisations, local authorities and the state acted together in providing services. In many cases local authorities were either persuaded by the voluntary organisations to share the costs or at least to provide the premises, or they were required or encouraged to do so by the state¹⁸. In 1935, the state had already started to grant municipalities monetary aid to recruit 'maternity advisors', midwives,

¹⁸ The relationship between the state and local authorities (municipalities) is interesting. Pirkko-Liisa Rauhala (1996) in her research about historical development of social services in Finland shows that the

who should monitor the progress of the pregnancy and "give individual advice on child care and nutrition, emphasise particularly the importance of breast feeding, and provide the people's homes with the appropriate literature on health care and child care" (Vauhkonen 1978, 57). Gradually maternity and child health care became more and more a municipal responsibility supported and regulated by the state. The development was completed in the 1940s.

Municipal maternity and child health centres

In 1944, three laws were passed simultaneously changing maternity and child health work to public, municipal services: the acts on municipal maternity and child health centres (Laki kunnallisista äitiys- ja lastenneuvoloista 224/1944), municipal midwives (Laki kunnallisista kättilöistä 223/1944) and municipal health sisters (Laki kunnallisista terveyssisarista 220/1944). The fact that the laws were all passed at the same time showed that maternity care and child health care were very much seen as related issues and they were both organisationally based in primary health care in the community. From then on every municipality was required to found maternity and child health centres and to employ a necessary amount of health sisters and midwives. Through the 1950s centres run by voluntary organisations still operated along with the developing municipal system before they gradually disappeared (Korppi-Tommola 1987).

state has been more modern and radical in its actions than the local authorities. This seem to be the case also in the development of maternity and child health services.

In the act on municipal maternity and child health centres they were given very broad and demanding aims:

“It is the task of municipal maternity and child health centre to decrease the health risks related to pregnancy, child birth and post natal period, to promote physical and mental health of future mothers, and the birth of babies as healthy and strong as possible by spreading education and giving help, and if necessary, by guiding mothers in appropriate use of maternity and family benefits. Parents should also be given guidance in child rearing in order to allow children to remain healthy and develop normally.” (Laki kunnallisista äitiys- ja lastenneuvoloista 1944, 2§.)

The main role was given to education, advice giving, guidance, and health promotion. The emphasis on social problems and the definition of maternity and child health care as social services, which dominated in early years, started to disappear. The services were now directed to all pregnant women and young children instead of poor families. It was still an interesting detail in the law that health professionals were expected to supervise their clients in the use of social benefits. The use of health services and the entitlement to social benefits were also combined in other ways. In 1949 it became a condition of the maternity benefit that the woman visited the doctor or midwife before the end of the 16th week of pregnancy. (Neuvolatoiminnan kehittämistyöryhmän muistio 1984, 9-10.)¹⁹

¹⁹ Maternity Benefit was first introduced in 1938 as a means tested benefit for poor mothers and it was made universal in 1941. This condition has remained in the law until the present day, but in practice a woman can still receive the benefit even if she hasn't used antenatal services.

The war had its effects on maternity and child welfare work and on the new legislation. During the war (1939-45), and especially after it, there was a strong pronatalist ethos in Finland both in national politics and in the work of voluntary organisations. A concrete example was the foundation of The Family Federation of Finland (Väestöliitto) in 1941. It was a voluntary association, which unlike in the case of the Mannerheim League, united different political groups. Its main aims were to encourage an increase in the birth rate and to emphasise the importance of the family as a social institution. At that time motherhood was very much glorified. (Nätkin 1994 and 1997.) For example, the Family Federation launched the Mother's Day celebration in Finland after the war. Every year the Federation rewarded a group of mothers, usually mothers with large families, as a symbol of respect.

After the war a new term of 'protection of mothers' was introduced which meaning was broader than that of maternity care. It covered widely the protection of women's 'reproductive capacity'. A part of it was the development of maternity and child health services, but it also covered issues like protection of women at work and education in mothercraft for school girls. New social benefits were also introduced for mothers and families in the 1940s: tax reductions for families with young children, maternity benefits, and child benefits. Maternity and child health services actually became integrated to family policy. (Wrede 1994.)

As a result of the new laws and the enlargement of the services to all municipalities which accompanied them, the number of clients in both maternity and child health centres grew significantly. Between 1940 and 1945 the percentage of pregnant women on the books of the centres grew from 21 to 86%, and to 92% by 1950. The number of cli-

ents in the child health centres also grew during the 1940s. In 1950 the child health centres had on their books 71 per cent of children under one year old. (Neuvolatoiminnan kehittämistyöryhmän muistio 1984, 9-10; Suomen virallinen tilasto XI:78). However, the rapid growth in client numbers shown in the statistics for the 1940s is somewhat misleading. Still in the 1950s, and even in the 1960s, many pregnant women only attended the maternity centre on one occasion during their pregnancy in order to qualify for the maternity benefit (Luoto 1991, 220). It has been argued that by the 1960s the maternity and child health centres finally confirmed their position, and the number of users rose to the high level at which it stands today (Korppi-Tommola 1990, 148-149).

The municipal maternity and child health centres have retained their position as primary health services for pregnant women and young children. Even after the hospitalisation of child birth took place, most rapidly during the 1950s and 1960s, first as a shift from home to small local hospital maternity units, and from there to central hospital maternity units, municipal maternity centres remained as the main provider of antenatal care.

The Public Health Care Act in 1972 reorganised the whole primary health care system in Finland, and revoked the 1944 maternity and child health care legislation. In the new legislation, maternity and child health centres were not mentioned. Only a brief instruction was given to the municipalities "to organise health education, including pregnancy counselling, and to arrange general health checks for its residents." (Kansanterveyslaki 1972, 14§). Still, maternity and child health care continued to be provided according to the same model which had been created in the 1920s and confirmed in 1944 legislation.

One major change occurred in the 1970s in the maternity and child health care in the professional position of midwives and health sisters. The former posts of municipal midwives and health sisters were changed to those of public health nurses, which was a new title with new kind of training for public health work. After that, midwife training was no longer a prerequisite for municipal maternity care. It was assumed that because women did not give birth at home anymore, public health nurses could provide antenatal and postnatal care, along with child health care and other health guidance work. (Viisaista vaimoista nykyajan kättilöiksi 1991, 70-71.) Since then smaller municipalities have preferred to employ health nurses who can be given a wider variety of tasks, whereas cities have more often continued to employ midwives to provide specialised maternity care. There has been a heated debate, which has continued until the present day, whether or not there should be qualified midwives in maternity health centres and if the lack of them has decreased the quality of care, and even the safety of pregnant women.

The professional position of midwives in community based maternity care has certainly been weakened, but from the clients point of view, it might have meant less medicalised and specialised maternity services during the pregnancy and more continuity between maternity care and child health care. There is also a more pessimistic opinion, according to which the responsibility for antenatal care has increasingly transferred from municipal maternity centres to hospital antenatal clinics, partly because there is often no qualified midwives in community centres, and at the same time, it has become more medicalised. Another reason is, as in many other countries, the development of medical technology in maternity care which is rarely available outside the hospitals. (Malin &

Hemminki 1992.) Whatever is the case, the changes during the last few decades have affected maternity care more than child health services.

Education in parenthood

From the beginning, education for mothers had been an important aspect in maternity and child health care in Finland and maybe even more so in recent decades. In the period from the 1940s to 1960s municipal maternity and child health centres confirmed their position as a system which has been ever since widely used by pregnant women and parents with young children. Since the 1960s more attention has been paid to the content of the services with increasing interest in education and social support for parents.

Pregnancy and childbirth have started to be seen as 'a turning point in woman's life' (Niemi, Heino & Kinnunen 1981) which has its effect on the woman's whole life and her relationship to the child. The role of maternity and child health centres in the process has been seen to support women in 'becoming mothers'. Besides, gradually since the 1960s, childbirth has started to be seen not only as 'women's business' but as 'a family event' (Valvanne 1986, 205-44), where men also should be able to take part. Because of this parent education is now increasingly directed also to men as fathers. Education is mainly provided during the pregnancy, but also in child health centres where attention is paid to information and advice giving and social support both individually and in parents' groups.

In maternity centres pregnant women, and their partners, are given guidance and advice in pregnancy, childbirth, child care, and family life. In the most recent national guidelines for maternity care, given in 1995, the purpose of maternity care is defined as follows:

“In the broad sense, maternity care strives to promote the health and well-being of future parents, and to help them to take a positive view to family life and the role of the family in society. The expectant mother, the father and the whole family should be able to perceive pregnancy, birth and care for the infant as a safe and enriching experience. Preparation for parenthood and for child rearing creates the base for a lasting maturation process. In addition to medical and nursing care, the expectant parents want maternity care to provide them with social, emotional and psychological support and assistance in their new life situation, especially when their first child is being planned, expected, and born.” (Screening and collaboration in maternity care 1996, 7.)

There is a strong emphasis on the psychological aspects of parenthood in maternity and child health care today. Becoming a parent is described in terms of attitudes, experiences and emotions. Medical care is only briefly mentioned in the quotation above. Educational and psychosocial aspects of maternity services have been much discussed but also criticised. It has been argued, for example, that information is given routinely and without recognising the needs, circumstances, and former knowledge of individual women (Rautava 1989).

Parenthood classes have also been a target of critique, and in recent years there has been different local development programmes and research projects to develop the classes to meet better parents' needs (Vehviläinen-Julkunen 1987; Leinonen, Sjögren &

Vehviläinen-Julkunen 1992; Vakkilainen & Järvinen 1994). For example, the National Board for Health started a development project in 1989 for maternity and child health care and for school health services where personnel was searching for new approaches to service provision. In the final report of the project (Vakkilainen & Järvinen 1994) all the local projects are briefly introduced. Most of the projects in maternity care were concentrated in the development of parent education. The main interest has been to improve the teaching and group leading skills of health nurses, to get the couples themselves to participate more actively, and to recognise the role of the fathers in a new way. During the last few years in some local maternity centres special groups for fathers have been set up to give men a possibility to discuss with each other and to get information about the new situation of becoming a father. Also the Mannerheim League has paid a lot of attention on fathers in recent years. (e.g. Neuvola-lehti 3-4/1994; Isät esiin 1998.)

In child health centres more attention has been paid in the content and methods of advice giving for parents. There has been a great deal of recent research, mainly in nursing studies, about the health nurses' work in child health care (e.g. Lauri 1982, Hyvönen & Lauri 1988; Vehviläinen-Julkunen 1990; Viljanen & Lauri 1990; Kaila & Lauri 1992). In many of these studies it has been noticed that in the monitoring of physical health and in the recognition of possible problems in physical development is successfully undertaken. There are, however, weaknesses in relation to the recognition and handling of psychological and social needs and problems. Parents, according to several studies, expect more discussion and advice on child development and child rearing. How to develop the psychosocial aspects of the work, has very much been a key issue in discussions of the future of maternity and child health centres.

Conclusions

In many respects the debates around maternal and child health have been quite similar and emerged simultaneously in the two countries, even if the concrete actions taken have been slightly different. Both in Scotland and in Finland public concern over the high infant mortality rate rose in the late 19th and early 20th centuries. The issue was closely linked to population policy, to the need to get more healthy citizens for the nation, but also to the moral concern over working class family life. Ironically, wars have been important historical landmarks in recognising the importance of mothers and children, causing a pronatalist ethos and glorification of motherhood, but also an introduction of concrete action to improve the health and welfare of mothers and children.

Both the concept and content of maternity and child health care have changed during the last hundred years. Maternity and child health care is a modern focus centred strongly to a certain institution for service provision, located in both countries within public health care. Around the turn of the 20th century the term 'maternal and child welfare' was used which referred to a recently invented social problem as well as to a wide range of actions taken to solve it.

Since the early 20th century the field of maternal and child welfare has specialised, professionalised and institutionalised. It has also become divided between different expert systems: health care, medicine, social work, psychology and so on, which have all defined their special areas of expertise in the field. This has meant first, that maternal and child welfare has become a health issue, and in the case of maternity care also a medical issue, rather than a social issue as it was at the turn of the 20th century. An aspect of

this specialisation is that professionals in health and medicine have taken the expert position in maternal and child health. The term 'child welfare' is now used mainly in social work, and to a large extent, it has been separated from the issues of maternal and child health both substantially and organisationally. In addition, the central issues of child health and maternal health have also been separated from each other to a greater extent than they were in the early 20th century. This has happened mainly because of the medical specialisation of maternity care.

In both countries provision of health services for pregnant women and young children has become a state responsibility, and a part of their welfare state systems²⁰. At a very early stage professional interest turned from the working class mothers and babies to all pregnant women and young children. The state and the local authorities took responsibility for service provision earlier than was the case in the other sectors of health and social care services. Some authors have even emphasised that this was the beginning of the modern welfare state providing universal services for all its citizens (Dwork 1987, 214; Korppi-Tommola 1990, 65). In Scotland this happened as early as in 1915 along with the extension of the Notification of Births Act and was completed in 1948 along with creation of the NHS. In Finland the major shift from voluntary to public services in maternity and child health took place in 1944 when municipalities were obliged to establish maternity and child health centres.

Women have had an active role in the field of maternal and child welfare in many ways even if different women have had different interests. Upper class women participating

²⁰ See also Appendix 1.

in philanthropic work were in both countries the pioneers of maternity and child welfare work. The main emphasis was on the practical and moral education of working class mothers, but these voluntary organisations also provided some concrete help for mothers and children. Working class women's organisations, on the other hand, demanded social rather than individual solutions to the problems of women and children, not only health services but, first of all, financial support and protection for mothers and also opportunities for combining motherhood with paid work. Especially in Finland where women have been active in parliamentary politics since the early 20th century, they have had an important political role in creating the welfare state which recognises women's needs and interests as mothers. Women have also played an important role as health professionals and providers of health services for mothers and children, even if male doctors have usually been presented as 'founding fathers' of maternity and child health care and have influenced the organisation of services.

In maternity and child health care there has always been a strong emphasis on the responsibilities of individual mothers in health and welfare of their children. The role of voluntary actors, and later on health professionals has very much been educational. Women have been educated to use health services and to take professional advice. At the turn of the 20th century mothers' child rearing practices was seen as a matter of 'life and death': old fashioned and even dangerous. Especially working class women were seen as ignorant or careless causing 'unnecessary' deaths of young children. Such issues as hygienic conditions of the home, baby feeding, and physical care were the key issues in educational work in the first decades of the 20th century.

By the 1950s or 1960s new issues emerged. First, more attention was now paid not only to the physical well-being of babies but also to child development. Child rearing and psychological aspects of motherhood became more important along with the growing importance and new theories in child psychology. This has widened the sphere of education.

Second, in the same period, medical, technological monitoring of pregnancy developed as a specialised field. Medical intervention to pregnancy and child birth has become more widespread and a 'normal' procedure in maternity care. But as a consequence education for mothers has also extended to the health and lifestyle during the pregnancy. Women have been made responsible not only for their children but also for their pregnant bodies in order to have healthy babies. The medical turn in maternity care has been somehow stronger in Scotland than in Finland. In Scotland along with the NHS the role of doctors and hospital based services in maternity care became more important, whereas in Finland the main responsibility in maternity services has remained in primary health care, in maternity health centres, and midwives or public health nurses have remained as key providers of services.

Psychologicalisation and medicalisation of motherhood have increased both the involvement of health professionals and responsibilities of mothers. It is now taken very much for granted that pregnant women and young children need regular surveillance, and mothers, or parents, need advice and support from the health professionals. Only quite recently critical questions have been asked as to whether the services as they are currently organised and provided meet women's needs and expectations.

CHAPTER 3

THE PROFESSIONAL STRANGER - METHODOLOGY AND METHODS

The main focus of my research is on the current organisation and professional practices in maternity and child health services in the two countries. I wanted to find out what is going on within the health services offered for pregnant women and families with young children. I wanted to get inside the process rather than looking at the system from outside. In order to do that I have undertaken local case studies in both Finland and Scotland. Methodologically my research is ethnographic and cross-cultural. I wanted to begin from the local and particular (Smith 1988), from the everyday practices of maternity and child health services. I also wanted to be sensitive to cultural and social realities in a wider sense in order to understand what it means to be a mother in a particular social and cultural context.

The title of this chapter comes from Michael Agar's book with the same title 'The Professional Stranger' (Agar 1980). He refers to the position of a researcher in ethnographic research, but it also describes well the position of a researcher in cross-cultural research. According to Agar, in ethnographic research the researcher has to get close to the people or communities she is studying, she has to get into their lives, into their ways of thinking and behaving. However, she shouldn't go 'native' and become one of them, but should be able to question and problematise what they see as ordinary and famil-

iar. This means that closeness and distance to the 'field' vary in different stages of the research process. In cross-cultural research it is also important to get to know the countries and cultures where the inquiry takes place, but it also entails creating distance to one's own cultural environment and understanding.

In this chapter I will discuss my position from different angles. I will first locate my work methodologically in the field of comparative, cross-cultural research. Second, I will locate it in the field of ethnographic research. My research is ethnographic in two senses: It has been accomplished through local case studies in the two countries using ethnographic methods, mainly observations and interviews. It is ethnographic also in terms of Canadian feminist sociologist Dorothy E. Smith's (1988) definition of institutional ethnography: as a methodological device for feminist research rather than as a specific method for data collection. In the second part of the chapter I will concentrate on Dorothy E. Smith's ideas on feminist methodology. Finally, I will turn to the decisions I have made in my own research process, in data collection, analysis and in writing up the findings. I will discuss my position in relation to the people and organisations I have got to know during the data collection, in relation to my data, and in relation to my text.

Cross-cultural research

In recent years there has been a growing interest within social sciences in comparative research¹, but there has actually been very little discussion about the methodology. It is not clear how to define comparative research², and indeed whether it has its own, specific methods. According to Linda Hantrais (1996; also Hantrais and Mangen 1996) a study could be held to be cross-national and comparative "when individuals or teams set out to examine particular issues or phenomena in two or more countries with the express intention of comparing their manifestations in different socio-cultural settings (institutions, customs, traditions, value systems, lifestyles, language, thought patterns), using the same research instruments either to carry out secondary analysis of national data or to conduct new empirical work. The aim may be to seek explanations for similarities and differences, to generalise from them or to gain a greater awareness and a deeper understanding of social reality in different national contexts." This is a broad definition which actually covers all social research done in more than one country.

Several authors have stressed the need for more discussion about distinctive methodological issues in comparative research, but such questions have rarely been raised, and

¹ Comparative social policy research has very much concentrated on identifying and classifying different welfare state regimes or models (e.g. Esping-Andersen 1990; Lewis & Ostner 1991; Lewis 1992, Sainsbury 1994; Anttonen & Sipilä 1996). On the other hand, there are comparative studies, which concentrate on the social circumstances and social policy concerning different groups of people, e.g. families with young children, old people, or unemployed people (e.g. Clasen 1994; Hantrais 1995; Hantrais & Letablier 1996; Millar & Warman 1996; Tester 1996).

² Different authors use different terms, like comparative research, cross-national or cross-cultural research. These have been used very much as synonyms, but it would be important to discuss if they are only alternative terms or are they actually different approaches in comparative research.

even less, any clear answers given. Else Øyen (1990) argues that making comparisons is actually a basic element in all sociological research. Sociologists are making comparisons all the time, either explicitly or implicitly, even when doing research within one country. But there is no agreement about whether there are some specific methodological questions when doing research in more than one country, whatever the methods used. Øyen divides researchers in to four categories according to their methodological position in the field of cross-national comparative research. The first group she calls purists who argue that cross-national research is no different from any other kind of sociological research. Second, there are ignorants who use data and ideas across national boundaries without paying any attention to how it might effect their interpretation of the results. The third group is totalists who, according to Øyen, are even too well aware of the many problems of doing cross-national research, but who are ready to make compromises. The last group she names as comparativists who acknowledge the points of views held by both the purists and totalists, but argue that to advance our knowledge about cross-national research it is necessary to raise questions about the distinctive characteristics of comparative research. (Ibid 5.)

Linda Hantrais (1996) seems to agree with Øyen. According to her, in many respects, the methods adopted in cross-national comparative research are no different from those used for within-nation comparisons or for other areas of sociological research. There seems to be, however, a strong assumption that there is something that could be defined as 'real' comparative research and researchers situate their own work in relation of that assumption. For example Tuula Gordon (1994), who has studied single women in three different countries, in the US, UK, and in Finland, defines her research as "a cross-

cultural study, not a systematic comparative study in a traditional sociological sense" (ibid. 2).

What is often seen as 'real' comparative research in a 'traditional sense' is large-scale multi-national studies often using analysis of secondary data. There is, however, another method of doing comparative research, which Linda Hantrais (1996) has named the 'safari' approach, where a single researcher or a small group of researchers carry out studies in more than one country, using replication of the experimental design, generally to collect and analyse new data. The method is often adopted when a smaller number of countries are involved and for more qualitative studies where researchers are looking at a well-defined issue in two or more national contexts and are required to have intimate knowledge of all the countries under study.

I have decided to call my research cross-cultural rather than cross-national or comparative, in order to take distance from large-scale multinational comparisons. I am looking for answers to different questions. Instead of making comparisons at the system level, I am interested in processes and practices. In many respects my research comes closer to the ethnographic tradition in anthropology and social sciences (see e.g. Van Maanen 1988) than to comparative social policy research. However, according to Linda Hantrais (1996), a shift is occurring in emphasis, in comparative research, away from descriptive, universalist and 'culture-free' approaches to social phenomena, towards a more interpretative, culture-bound approach where it is understood that linguistic and

cultural factors cannot be ignored.³ In this sense, the ethnographic approach is one answer to the demands of cultural sensitivity.

Standpoint in the everyday world

My main methodological device has been institutional ethnography introduced by Canadian feminist sociologist Dorothy E. Smith in her book 'The Everyday World as Problematic' (1988). For Smith, institutional ethnography is, first of all, a methodological commitment about how to do feminist research. It is related to her wider project to develop feminist sociology and cannot be separated from it (Smith 1988: 1990a and b)⁴. In Dorothy Smith's conceptual framework there are two 'worlds' which are, however, firmly related to and dependant upon each other. First, there is the 'ruling apparatus', a concept which comes from the Marxist tradition. The 'ruling apparatus' is a "complex of management, government, administration, professions, and intelligentsia, as well as the textually mediated discourses that coordinate and interpenetrate it" (Smith 1988, 108). Second, there is the 'everyday world', or as she calls it in her more recent texts

³ Only very recently there has been some discussion on qualitative cross-national research methods, but they are still very much in their infancy and every researcher, more or less, has to find her own solutions to methodological problems in qualitative, comparative research (Ungerson 1996; Hantrais & Mangan 1996).

⁴ All her three books are actually collections of articles written in different times and only later published as books (1988; 1990a and b). In different texts she returns to the same themes but from a different angle and sometimes also using slightly different concepts. It is actually quite ironic that even if she is criticising the 'malestream' sociology of being abstract and isolated from the everyday world, her own texts are often very complex and abstract and difficult to follow, and do not give direct guidelines for empirical research

‘everyday/everynight world’, which is the world “we experience directly, and in which we are located physically and socially” (Smith 1988, 89).

She also identifies two different narratives or discourses which are related to the two ‘worlds’: the primary narrative, and the ideological, or sometimes she uses the concept professional, narrative or discourse. By primary narrative she refers to a narrative that uses the lived experience as its resource. It is a narrative related to the everyday world, to the local and particular. It can be, for example, a sort of an eye witness story or an autobiography. Ideological discourse, on the other hand, refers to professional or scientific discourse which transforms people’s lived experiences into general, abstract descriptions, and uses scientific concepts and theories in describing them.

She uses the concept ‘ideological circle’ to describe relations between the two worlds and discourses, where primary narratives are used as material of ideological discourse and, on the other hand, where the ideological discourse has its effect on how we describe and define our everyday experience. (Smith 1990a and b, especially 1990a, 141-173.) In her texts she gives several examples of different situations and practices where primary narrative is transformed to ideological narrative, for example, how an individual gets diagnosed as mentally ill (Smith 1990a, 107-138; 1990b, 12-52), or how the concept of a ‘single mother’ is used at school as an interpretative procedure in explaining children’s behaviour and problems, ignoring the actual situation of individual mothers and children (Smith 1988, 167-178). The relations between the ruling apparatus and the everyday world is actually the main focus in all her texts.

Relationship between the two worlds or discourses is also an important question in feminist methodology. According to Smith, feminist research should be done from the standpoint in the everyday world, “preserving the presence of active and experiencing subjects” (Smith 1988, 105). Because of her methodological ideas Dorothy Smith has often been named as one of the feminist ‘standpoint theorists’ (Harding 1986). She herself denies this and argues that her way of using the concept a ‘standpoint of women’ is different from the one used by so called standpoint theorists (and that she used the concept first). For her the standpoint of women is not the same as women’s perspective or women’s point of view, but very concretely, a place where people, both women and men, are physically and socially located and where the inquiry should start. Her notion of standpoint “doesn’t privilege the knower. It does something rather different. It shifts the ground of knowing, the place where inquiry begins.” (Smith 1992)⁵.

Dorothy Smith understands people as competent and active practitioners in their everyday worlds, but at the same time she is looking for a methodology which would go beyond individual experience. She emphasises the importance of women’s/people’s experience and everyday world, but argues that feminist sociology should not be concerned exclusively with the world of women’s experience. Everyday world and lived experience should be the beginning but not the end result of an inquiry. She is, implicitly, criticising some forms of feminist research, where the aim has been ‘to describe women’s experience’ or ‘to give women a voice’. According to her this is not enough because it only tells what the subjects of research know already. It does not increase

⁵ I am not going to participate here to the, maybe endless and unsolved, debate on what ‘standpoint theory’ really is and who should be named as standpoint theorists. Instead, I am trying to clarify Smith’s thinking.

their understanding of how the world they are living in is organised. (Smith 1988, 151-154.) Instead, sociological feminist research should 'draw maps' and to make visible the social relations which coordinate and organise women's/people's everyday world.

What Dorothy Smith proposes is that we should undertake case studies of local practices. She argues, however, that beginning from the local and particular can also provide more a general understanding of the organisation of social relations. The everyday world is 'a point of entry' into larger social and economic processes. In this sense studying the local and particular is not only revealing of the local and particular. What she actually wants to unveil are the processes by which the 'ruling apparatus' with its textually mediated discourses enters into people's everyday world organising it and hiding some aspects of it. It could be argued that Dorothy Smith bypasses too easily the question of how to generalise from the local and particular. According to her "it is not a conceptual or methodological issue, it is a property of social organization. ... The problematic of the everyday world arises precisely at the juncture of particular experience, with generalizing and abstracted forms of social relations organizing a division of labor in society at large." (Smith 1988, 157.)

Even if Dorothy Smith emphasises the importance of the local, concrete, and particular, she is not very concrete in telling how to do empirical research using her methodological ideas, except by giving examples from everyday life and from her own and her colleagues' studies. She is not demanding her readers to use her ideas as an orthodoxy. Instead, she gives us the freedom to use her ideas for our own purposes: "The technical practices are not an orthodoxy; they are not required, nor is the concept of ideology. There could be no irony greater than an ideological practice of the concept of ideology

as I've used it here. The techniques of analysis and the concepts are there for your use. Feel free." (Smith 1990a, 206.)

There are two main methods she has used in her empirical studies: textual analysis and institutional ethnography. In the method of institutional ethnography she crystallises her theoretical and methodological ideas for feminist sociology. It is a research strategy rather than a method which, instead of beginning from abstract, scientific concepts, begins from a standpoint in the everyday world, from the local and particular. The method contains two parts: it is institutional and it is ethnographic. The term 'institutional' refers to the subject of an inquiry, and 'ethnography' refers to methods to study it. According to Smith: "I am using the term 'institutional' and 'institution' to identify a complex of relations forming part of the ruling apparatus, organized around a distinctive function - education, health care, law and the like. ... The notion of ethnography is introduced to commit us to an exploration, description, and analysis of such a complex of relations, not conceived in the abstract but from the entry point of some particular person or persons whose everyday world of working is organized thereby. Ethnography does not here mean, as it sometimes does in sociology, restriction to methods of observation and interviewing. It is rather a commitment to an investigation and explication of how 'it' actually is, of how 'it' actually works, of actual practices and relations." (Smith 1988, 160-61; see also Griffith & Smith 1990, 7.)

Dorothy Smith does not offer a complete and final recipe but instead gives an example of an institutional ethnography as a research strategy. She introduces a research project which she was undertaking, at the time of writing her book (Smith 1988), together with Allison Griffith. The project focused on the work mothers do in relation to their chil-

dren's schooling. Instead of beginning from the school as an institution and from its official and professional discourse they began by interviewing mothers about their everyday activities related to children's schooling, understanding mothering as practical work. Only then did they connect mother's accounts to the world of schooling, to what is actually going on in class rooms, and in school administration, and finally, in the national organisation of education. In this process women's interviews directed their attention to certain aspects of schooling. They showed how much schooling is dependant on the invisible work of mothers and how a mother's life is organised by their children's schooling. (Smith 1988, 167-175; also Griffith & Smith 1990.) Dorothy Smith gives the study as an example of testing her methodological ideas in empirical research. According to her it is important but also difficult to be aware through the whole research process not to take the institutional, 'outsider's standpoint', but to keep the standpoint in everyday world. There is no other way to do this but to be reflective in all stages of the process. (Smith 1988, 181-205.)

The accomplishment of the local case studies

I chose an ethnographic approach because I wanted to begin from the everyday practices of health professionals and from the situations where health professionals and their clients meet each other (Smith 1988). I have observed the work of health professionals, mainly midwives and health visitors in Scotland and midwives and public health nurses

in Finland⁶, interviewed them, and collected relevant additional documentary material: leaflets for the clients on different topics, forms used by the professionals, local and national reports and guidelines on maternity and child health care, and so on. In data collection I used a very practical guideline offered by Martyn Hammersley and Paul Atkinson (1983, 2): “The ethnographer participates, overtly or covertly, in people’s daily lives for an extended period of time, watching what happens, listening to what is said, asking questions; in fact collecting whatever data are available to throw light on the issues with which he or she is concerned.”

There are no concrete guidelines to follow in doing cross-cultural research using qualitative, ethnographic methods. Neither the methodological discussions on comparative research nor Dorothy Smith’s methodological ideas give direct answers about how to accomplish an empirical ethnographic research and how to solve problems a researcher comes across in different stages of a research process. These are the issues I will now turn to. I will discuss the process and problems of data collection, analysis and writing up the findings. Some of the issues are related to ethnographic research in an organisational context, others are problems of cross-cultural research, or connected to my commitment to feminist research. I will also take up some ethical issues which rose up in different stages of the research process.

⁶ In Finland nursing professionals working in maternity and child health centres are all called public health nurses no matter their professional qualifications. In my study all the health nurses working in maternity centres were qualified midwives. For the sake of clarity, I will call them midwives, as they often called themselves. Public health nurses working in child health centres I will call health nurses.

Research settings

Simply because the organisation of maternity and child health services is different in Finland and in Scotland, it was impossible to find identical settings to study in the two countries. Instead, the main criteria I used in choosing the settings was that I wanted to find the health services which pregnant women and parents of young children usually use. For example, when a woman gets pregnant, where does she go, who are the professionals she meets, how is her 'pregnancy career' scheduled. Another criteria was that I wanted to concentrate on advice giving for parents and the psychosocial aspects of care, paying less attention to 'purely' medical care. This distinction is, of course, somehow artificial, because in practice the two are mixed and related to each other. It is also very much a matter of definitions⁷. Even so, that was the reason to concentrate on work done by midwives, health visitors and public health nurses rather than on doctors as providers of maternity and child health care. That was also the reason to concentrate more on community based rather than hospital based services.

⁷For example Julia Twigg (1997) has made an interesting analysis of definitions of social and medical in help with bathing for old and disabled people. According to her the same activity, helping people with bath, can be defined in different ways. In medical context it is seen as part of the 'treatment', in social context as necessity in everyday life and something that gives people pleasure. Different definitions also have different consequences. Medical reasons to provide services are seen as more important and legitimate than social reasons. According to Twigg the power of medicine to define people's needs ignores their need for social care services and limits the number of people entitled to services. Thus, it is also important to look at how different things are defined within the service system itself. Based on Twigg's argument, it could be said that I am also looking for those aspects in maternity and child health care which have been seen as less important and marginal in relation to medical care.

⁸ The role of hospital based antenatal clinics has increased in Finland during the 1990s. In 1996 83% of all pregnant women visited in antenatal clinic during the pregnancy (Perälä et al. 1998). Still the main responsibility of maternity services is seen to be in maternity centres.

In Finland community based maternity and child health centres are the basic organisation providing maternity and child health services, other services, like hospital based antenatal clinics being an additional system⁸. Maternity and child health centres are run by the municipal health authorities as part of the primary health care services. The professionals who have the main responsibility in running the centres, and who clients most regularly meet, are midwives and health nurses, with doctors visiting the centres maybe once a week doing the medical examinations. For a pregnant woman or a mother of a new born baby her local maternity and child health centre is the first place to contact and the place where she will visit regularly for months or even for years, usually meeting the same professionals. This is why maternity and child health centres were a self-evident choice for the research setting in Finland.

In Scotland the choice was less obvious. The system is more complex providing no such clear physical context or boundaries for fieldwork. Instead, I had to concentrate on certain professional groups and their work wherever it took place. At the beginning, this was quite confusing. The provision of maternity services is shared between general practitioners, midwives, either community or hospital staff midwives, and obstetricians. Child health services are provided by GPs and health visitors. At the local level, general practitioners are the key professionals to decide what kind of services are available for their clients. There is local variation and differences from one GP practice or a hospital to another in service provision and in the role of different professionals both in maternity and child health care. What I found, however, was that (community) midwives and health visitors were the closest counterparts for the public health nurses in the Finnish maternity and child health care and they were also the professionals clients usually most often met. Although I wanted to look at the system of service provision as a whole, I

chose the work of midwives and health visitors as the main focus of my research. They offered me access to different settings and to the work of other professionals.

In Finland I concentrated on maternity and child health centres which provide community based services, but in Scotland it was impossible to ignore the hospital based services for several reasons: hospital antenatal clinic visits are routine for pregnant women, community midwives are based in the hospitals, and also parent education classes are mainly arranged in the hospitals.⁹ The distinction between community and hospital based services, especially in maternity care, is less clear in Scotland than in Finland. That is one reason why in Scotland the settings of research were more varied than in Finland including hospital maternity units, health centres, GP surgeries and clients' homes. In Scotland health professionals also actually worked more outside than inside the physical environment where they were based. I soon realised that community midwives and health visitors in Scotland are much more 'mobile' than their colleagues in Finland. Instead of sitting in their offices and meeting the clients there, they were driving around a wide area visiting their clients at home or meeting them in different health centres or GP surgeries.¹⁰ That was, of course, what I also had to do.

In Finland I collected my data between 1990 and 1992¹¹ in one city I call Tehtaala, one of the biggest cities in Finland. In Scotland I collected my data in 1995 in two cities and

⁹In both countries the vast majority of women give birth in hospitals.

¹⁰I will describe the different physical environments more carefully in Chapter 5.

¹¹Because the Finnish data was collected already in the early 1990s, I have collected some additional data later on. In 1995-96 I interviewed three local nursing managers in Tehtaala. I have also followed the discussion on maternity and child health care in professional journals.

their surroundings, in two different Health Board areas. I will call the Scottish cities Lochend and Strathdee¹². Lochend is quite a small town, whereas Strathdee is one of the biggest cities in Scotland. In all these three areas the locations and individual professionals' participation was negotiated with medical or nursing managers.

In Finland I only chose one city because maternity and child health care was organised very much the same way all over the country. Until the late 1980s the National Board of Health directed and regulated the health services provided at the local level, in municipalities. Today municipalities have more freedom to organise the services according to local needs, but there has not been any dramatic changes in provision of maternity and child health services. In Scotland, because of the local variation in service provision, I decided to take two areas instead of only one to make sure that the setting I chose was not an exceptional one. In both countries the research was accomplished in urban areas which certainly causes some differences compared with rural areas for example in the availability of services. It is important to emphasise that even if I wanted to find services and settings that are 'ordinary', the study is first of all about local practices in maternity and child health services. In institutional ethnography generalisations from the local practices are not based on the statistical representativeness of the cases, but are theoretically argued.

¹²All the names of the places and people have been changed because I wanted to protect the individual clients and professionals from being identified.

Data collection

My data collection was based on intensive involvement in the daily practices of the organisations and professionals in the settings I had chosen. In the Finnish city, Tehtaala, I spent in three different health centres, about three months altogether, mainly with midwives and health nurses. During that time I also observed doctor's clinics, and professional meetings held in the centres, participated in a couple of parenthood classes, and met other professionals, such as a psychologist and physiotherapists who occasionally visited in the centres. Afterwards, I interviewed all seven midwives and health nurses, whose work I had observed most closely, three doctors, and a psychologist.

In Scotland I spent time in several different places in Lochend and Strathdee, about two months altogether, mainly with community midwives and health visitors. Community midwives were based in two hospital maternity units and health visitors in five health centres. In addition, I had a chance to meet other health professionals, and occasionally, observe their work. I met consultants, staff midwives, GPs, district nurses, practice nurses, practice managers, receptionists, nursing managers, and many others with whom community midwives and health visitors were working together in hospitals, health centres, and GP surgeries. I also followed parent education classes in two hospitals, organised by the specialised midwives, parentcraft sisters, and physiotherapists. In addition, I participated in a breastfeeding workshop arranged for both midwives and pregnant women in one of the hospitals. In Scotland I interviewed eight health visitors, nine community midwives, and two midwives specialised in parentcraft education.

According to ethnographic approach, I participated in many ways in different activities relevant to my research interests. Still, most of the time I observed the situations where health nurses, midwives and health visitors met their clients in different settings (see Table 1). The number of individual encounters between health professionals and their clients do not give the complete picture of my data, or of the work of health professionals. I also discussed with them while waiting for the next client, or doing home visits, while driving long distances from one place to another. I did not have many chances to discuss with clients, but occasionally I did that too. I was, actually collecting data all the time I spent with health professionals, even when we were having coffee together or just sitting there when they were doing paper work, making phone calls or talking to each other. All this gave me a picture of how their work is organised, and how they organised it, how they discussed their work and their clients.

The observational data is documented in hand written field notes. In the interviews I collected more systematic data on how professionals understood their own work and their role in relation to their clients, and also what they saw as problems in parenting and in child care. The interviews lasted about an hour each, and they were all tape recorded and transcribed.

In ethnographic research it is difficult to draw a clear line between where the data collection starts and where it ends (e.g. Hammersley & Atkinson 1983). Actually, the best way to describe my data collection is that I was 'hovering' data all the time, even if only a part of it is documented and can be presented as text, as field notes, and interview transcriptions.

Table 1: Observed encounters between health professionals and clients**FINLAND****Tehtaala****Maternity care** Number of visits

Midwife

Clinic appointments 117

Home visits 2

Doctor 27

Total 146**Child health care**

Health nurse

Clinic appointments 82

Home visits 1

Doctor 30

Psychologist 3

Doctor and psychologist together 3

Total 119**SCOTLAND****Lochend****Maternity care** Number of visits

Community midwife

Clinic appointments 39

Home visits 39

Consultant 5

Staff midwife (in a hospital antenatal clinic) 3

Total 86**Child health care**

Health visitor

Clinic appointments 35

Home visits 22

Total 57**Strathdee****Maternity care** Number of visits

Community midwife

Clinic appointments 34

Home visits 41

Consultant 19

Total 94**Child health care**

Health visitor

Clinic appointment 19

Home visit 9

Total 28

Research relations

Above I have given an overall description of my data collection. What is missing from that description, however, are actual individuals, interaction and relations. Ethnographic research is very much an interactive process where the researcher attends as a human being to a complex set of relations, meeting different people who are located differently in the field she is studying. She needs to get access to and the acceptance of these people in order to accomplish her research. There can also be various ways in which they define her role, or identity, during the research process (Peräkylä 1989). There were three groups of people, who were very essential, and who all had a different position in the field, and in relation to me and my research, namely health care managers representing the organisation, professionals, whose work I was actually observing, and clients.

Some ethnographers have written in methodological guidebooks that finding a research setting and gaining access has just been a lucky coincidence while others have described the different kind of 'tricks' they have used in representing themselves to people they have wanted to study (see e.g. Agar 1980; Hammersley & Atkinson 1995, 54-79). In my case the story was less 'romantic'. From my own experience, I would argue that in ethnographic research in an organisational setting getting access and approval is maybe more difficult and complex process than in any other kind of research. It is probably easier to get people to fill in questionnaires or to give interviews than to get them to accept a researcher, who wants to stay with them for weeks, months or even years, writing down to her notebook all they do and say, and who is disturbing them by asking endless, stupid questions.

In a formal, hierarchical organisation, like health care, there are its own specific problems in gaining access and forming contacts with people and institutions researcher wants to study. In an institutional setting it is necessary to be responsive to organisational circumstances in many ways (Cassell and Symon 1995). First of all, researcher can't just 'walk in', but she needs the formal approval of the organisation. It is important to follow the right procedure, to start from the managerial level, to get the research proposal accepted by the ethical committee and so on. Elina Hemminki and Hellevi Kojo-Austin (1989) have discussed the problems entailed in getting formal access to do sociological research in a medical setting. According to them the medical profession protects its field from 'outsiders' by regulating the formal access to health care settings and information sources. Often this is done in the name of the patients. It is, of course, important to protect patients from unnecessary or even harmful interventions, but they argue that professionals and institutions might be more concerned about protecting themselves.

In my case, there were actually no major problems in gaining the formal access even if in both countries it was a long and complicated process. However, the length of the process was more because of the time consuming bureaucratic procedures and practical problems in arranging appointments with busy managers than because of their refusal to cooperate.

Getting formal access is the first essential stage, but it is only the beginning. The next stage, which I find very important, is getting the acceptance of the people, both professionals and clients, who are actually going to participate in the research. Even if formal approval had been given, the research cannot be completed without them. It was also

important for me as an ethical issue, how they got involved, how they were informed, and what was my position in relation to them.

Because of the hierarchical organisation of health care it was the managers, either medical or nursing managers, who acted as mediators and gatekeepers between me and the professionals whose work I wanted to study. This brought along its own problems. The situation in the two countries was quite different: In Finland the local medical manager left the final word to the midwives and health nurses. In the first health centre I was planning to collect data, several meetings were arranged before I finally got their approval. Their original response was quite suspicious. They were afraid that participation in the research would take their time and interfere their work. I also had to make some changes to my original research plan according to their wishes to get their permission. For example, I had planned to use a tape-recorder in some situations, but they refused without even asking the clients. They were also quite reluctant to take me on their home visits, and because of this I only participated in a very small number of them.¹³

In Tehtaala the basic contradiction between the professionals and me as a researcher was that according to the principles of ethnographic research (e.g. Hammersley & Atkinson 1995) I wanted to get unlimited and flexible access to maternity and child health centres, but the professionals wanted to know in advance exactly how long I would stay and what kind of situations I wanted to observe. They wanted to define the limits to my access, and also to protect the clients from my interference. Even after all the negotia-

¹³This is not, however, the only reason why in Scotland I observed more home visits than in Finland. The main reason is that in Finland home visiting is not such an essential part of the work (see also Chapter 5).

tions I did not quite manage to win their confidence. During my stay in the centres they were polite, helpful and friendly, but from time to time, I could still feel some kind of a suspicious atmosphere, and my role and presence was discussed and negotiated on several occasions. I felt that the difficulties in negotiating access with the professionals overshadowed my whole data collection in Tehtaala. Most of the time I felt myself as a disruptive outsider. I kept asking myself, do I have the right to be there if the professionals do not want my presence. The advantage of this experience was, however, that it made me more sensitive to the issues of professional resistance and power relations in health care organisations.

The response I received in all the organisations in both areas in Scotland was quite different from my earlier experiences in Tehtaala. The managers I met were very willing to help me and they arranged the data collection in a more authoritarian manner than the medical manager in Tehtaala. No negotiations were arranged with the professionals in advance, their names and contact addresses were just given to me after the formal access had been granted¹⁴. Still, only one of the health professionals commented on the arrangement. I got a feeling that I was welcomed and accepted very much the same way as students, whose practical teaching is part of their work.¹⁵ It did not seem to be strange or problematic for them that I wanted to observe their work. They did not try to restrict my participation in any way, as far as I was aware. On the contrary, they some-

¹⁴An exception was one of the midwives in Lochend, who I happened to meet before my data collection and who was willing to participate as soon as I got the formal approval.

¹⁵Also in Finland midwives and health nurses had students and from time to time they commented that also students are disturbing their work with clients.

times even arranged situations which they thought might interest me and which would show me the variety of their work.

What could be the reason for my different experiences with the health professionals in Scotland and in Finland? It is maybe not only a coincidence, but there might be some cultural and organisational differences behind it. In a similar situation, Leena Eräsaari (1995) briefly refers to cultural differences as a possible explanation using Diane Wilsdon's (1991) research on children's day care in Finland and Scotland as her evidence. Wilsdon told that, although otherwise very willing to answer her questions, the staff in Finnish day care centres was unwilling to allow her to observe their work whereas in Scotland she didn't meet any problems at all (Wilsdon 1991, cit. Eräsaari 1995). In Finland, according to Eräsaari, people have a very positive attitude to surveys or even to time taking interviews, but they hesitate about being observed. Her conclusion is that in Finland professionals, and people in general, want to control the image they give on themselves and on their work, something that is easier to do in interviews or in surveys than in ethnographic research based on observation. One possible explanation might also be that qualitative sociological research in health care settings has a longer tradition in Scotland than in Finland.

I understand the different responses I received from the professionals not only as representing methodological problems in ethnographic research, but also having a substantial importance. According to Hammesley and Atkinson (1995, 55) negotiating access, data collection and analysis are overlapping phases of the research process. Access negotiations are not a separate preliminary phase in the research process, but "much can be learned from the problems involved in making contact with people as well as from how

they respond to the researcher's approaches". I have used the responses I received as part of my data in analysing the ways health professionals understand their work. It made me ask, for example, why the Finnish professionals felt, they had to protect their clients' privacy from me, and why the Scottish professionals did not see any problems in that respect.

The clients were the third group of people I met during the data collection and to whom I needed to explain who I was and what I was doing. The relationship with the clients was even more contradictory question to me than the relationship with the professionals. I was studying the work of professionals rather than the personal lives and problems of the clients. Still, I wanted to be sure that they knew why I was there, that they accepted my being there, and that they had the right to deny my access if they wanted to. I also wanted it to be the clients, not the professionals on their behalf, who made the decisions about my access. In practice, this was often problematic.

Clients very rarely refused when asked if I could observe the visit. In the three health centres in Tehtaala there were only five clients, out of 265, who denied my access during their visit. In Lochend and Strathdee there were no refusals at all. Still, I was aware that, because of the nature of the situations, the clients did not always have a real choice, at least if they didn't want to act impolitely. It was usually the professionals who introduced me and asked the permission. In Finland, in most cases, they explained to the clients who I was and asked their permission, but in Scotland it often happened that I was only introduced, sometimes in a busy clinic even that was forgotten. Again, I was treated very much at the same way as student nurses or medical students whose presence was very much taken for granted. During the home visits in Scotland I was

even more aware that it was almost impossible for the clients to refuse to let me in together with the professionals.

The Finnish experience made me aware, right from the beginning, of the ethical issues and power relations related to the health care as a research setting, and to the relationship between me as a researcher and people I was studying. I often felt uncomfortable and even guilty for not being able to ask, for various reasons, a 'proper' permission either from the professionals or the clients. In Scotland my main concern was that I was not able to inform the clients well enough. In Finland I found it difficult to accept that the professionals were not as cooperative as I had expected them to be. From time to time I also felt uncomfortable, because the Scottish professionals were instructed to participate by their managers and not given a chance to choose, even if they did not seem to mind my being there. But again, this also tells something about the organisation itself: these hierarchial power relations are still there even if the researcher is not.

I realised that in advance, I had held an idealistic view of what my position would be and how people, especially the professionals, would response to my study. I had committed myself to the principles of feminist research and this was, at least partly, where my idealism came from. Feminist writers (e.g. Roberts 1981; Stanley & Wise 1993) have criticised traditional research methods for objectifying women and argued that feminist researchers should find new ways of doing research. A lot of attention has been paid to the research situation and the relationship between the researcher and the subjects of her research. A feminist researcher should create a situation, usually described as an interview situation, which is mutual, conversational, and free from hierarchical power relations. It has also been argued that women are willing and happy to talk to

another woman in this kind of a situation, that they find it helpful, and that they can use it as an arena to clarify their own thoughts and feelings, or even find support, information and help. (e.g. Oakley 1981; Finch 1984.)

Solidarity and equality between women in research situation has also been questioned and problematised (e.g. Ronkainen 1989; Simonen 1989; Stacey 1988). For example Judith Stacey (1988) argues very strongly that "because ethnographic research depends upon human relationship, engagement, and attachment, it places research subjects at grave risk of manipulation and betrayal by the ethnographer. ... Fieldwork presents an intrusion and intervention into a system of relationships that the researcher is far freer than the researched to leave. The inequality and potential treacherousness of this relationship seems inescapable." This is an important reminder not to make overly simplistic and idealistic assumptions about the relationship between researcher and her subjects in feminist research.

There is also another important aspect to recognise. In feminist methodological discussions, at least implicitly, women are assumed to be 'ordinary' women. In my research the vast majority of the managers, health professionals as well as their clients were women, but they were in different social and organisational positions in relation to each other, in relation to the health care as an organisation, and in relation to me as a researcher. Some of them had more power than the others to control my access to their lives. This was something I was not able to change. What I can do, is to be aware of these different relations and positions.

Analysing data

The result of my data collection was a variety of data, consisting mainly of hand written field notes and tape-recorded interviews with health professionals. In addition I had collected different kinds of documentary material, leaflets and forms used in maternity and child health care, local and national reports, and so on. The data was collected in two different countries, at different times, using two different languages. The question then was how to analyse this broad variety of material in any meaningful and systematic way?

Judith Okely (1994) describes analysis in ethnographic research as a complex and personal process where the researcher is fully involved and which is impossible to trace back and reconstruct systematically:

“After fieldwork, the material found in notebooks, in transcripts and even in contemporary written sources is only a guide and trigger. The anthropologist-writer draws also on the totality of the experience, parts of which may not, cannot, be cerebrally written down at the time. It is recorded in memory, body and all the senses. Ideas and themes have worked through the whole being throughout the experience of fieldwork. They have gestated in dreams and the subconscious in both sleep and in waking hours, away from the field, at the anthropologist’s desk, in libraries and in dialogue with the people on return visits. ... The understanding and ways of making sense of the material and of writing cannot be routinized and streamlined in introduction of methodology textbooks. Nor can it be fully assessed at this stage by a non-participant.” (Okely, 1994, 21.)

To some extent, I agree with her. But underlining the complexity and uniqueness of the analysis can also romanticise and mystify the ethnographic research process and serve as an excuse to avoid a proper analysis of the existing data. The process maybe can't be fully followed, but there have to be some guidelines for readers to enable them to understand and assess how the results and conclusions have been made.

I also agree that ethnographic research in all its stages is a very personal process, the researcher is in it 'with her body and all her senses'. She is using herself as a tool not only in data collection but also when analysing and making interpretations of the data. She is a part of the everyday world she is studying and the one who has been an 'eye-witness' and an active participant in what was going on, what was said and done in the places and by the people she studied. She is 'inside the whale' (Smith 1988, 140-143), and there is no escape from that position. Instead of denying it, it should be made visible and known and as a part of the analysis. (Hammersley & Atkinson 1995; Peräkylä 1990).

I used my impressions, feelings, surprises, likes, and dislikes as 'raw material' and as the first step to a more detailed analysis. The first attempts to analyse what I saw and heard during the data collection were based on my impressions and feelings. They also directed me to ask new, more precise questions and to look at certain themes more carefully. Later on I used the data either to support or revoke my impressions.

I analysed the data by making comparisons in different contexts. The most obvious were the comparisons in national and organisational contexts, between the two countries in the organisational practices of maternity and child health care, and in parenting.

Cross-cultural research gives a good ground in recognising organisational and cultural differences. According Phil Strong (1988) comparison is a way to find phenomena which are systematically excluded or which are so self-evident in one setting that they can be recognised only in comparison with another setting. I realised this very concretely when I started my research in Scotland. By then I had already collected and analysed the Finnish data (Kuronen 1994a), but looking at it a new context made me ask different questions from it. I realised that I had to put aside, for a while, what I had learned so far about the Finnish maternity and child health care and the ways children are cared for, in order to analyse it in a new context in relation to the Scottish data.

A specific problem in doing research in Scotland is that it is not an independent state, but a part of the UK, with a strong sense of its own history, nationality, and culture (McCrone 1992). Actually, even if I did my research in Finland and in Scotland, I also had to be sensitive to the possible differences between Scotland and the rest of the UK. What made this more complicated was that these issues were rarely made explicit in research literature. For example, in studies done in Scotland its special national and cultural features are rarely discussed. On the other hand, in many studies researchers talk about the UK, and only with a closer reading it becomes clear that the data is actually collected England.

There is a danger that the study is somehow biased, that one's own country is used as a yardstick against which the foreign country is compared, or maybe the other way round. However, my concrete 'standpoint' has also changed during the research process which certainly has had its consequences for my analysis and interpretations. I first started the project in Finland and in Finnish, continued in Scotland and in English, and finished it

back home in Finland but still writing in English. Physical and cultural closeness or distance has effected my ways in seeing and interpreting things, and also made the process more complex. This is something that should be discussed more in relation to cross-cultural research.

To give examples of how my own position and interpretations have shifted during the research project, I will mention two substantive themes: first, practices in baby feeding, and second, home visiting as part of the professionals' way of working.

Coming from a culture, where breastfeeding is taken for granted both by mothers and by health professionals, it was first a cultural shock for me to realise that this was not the case in Scotland. I kept asking myself why so many women in Scotland refused to breastfeed their babies. At the beginning I found myself being very moralistic. I just couldn't understand these women or the health professionals who let this happen. It took me a long time before I was able to analyse the question in its cultural context in both countries. I also realised that in Finland, the issue had been so self-evident also for me that I had almost ignored it in my previous analysis. I had taken it for granted instead of asking, why breastfeeding is so 'normal'. In this case, my cultural shock gradually led me to analyse in a new way the social practices of baby feeding and the role of health professionals and expert knowledge in relation to it.

Another example is related to home visiting which is much more common in Scotland than in Finland. In Finland health professionals were also very selective in taking me to clients' homes, which I found problematic but also understandable and acceptable. In Scotland where there were no such restrictions, I realised the difficulty and embarrass-

ment I felt in attending people's homes with the professionals. This experience made me think about whether there were differences in cultural understandings of privacy in the two countries and led me to analyse this topic more carefully within my data. Furthermore, even if in Scotland I found it embarrassing to visit people's homes, it also gave me a good insight of how mothers with young children live their everyday lives and concretely showed the differences between physical environments in 'good' and 'bad' housing areas. I realised that in Finland I hadn't paid any attention to the differences in families' social conditions, and it hadn't been an issue in maternity and child health care either. In Scotland on the other hand, health professionals talked a lot about mothers living in different areas which they linked to social class differences. Going into people's homes gave me a more concrete understanding of what they were talking about. I also realised that in Finland it is actually quite difficult to speak about social class, that we are taught to speak in terms of equality, whereas in Scotland social class was a concept used even in everyday language. In this case, home visiting, which I first only saw as a difference in the professional ways of working, directed me to analyse several sub-themes relevant to my research interests.

Comparisons were not only made between the two countries. Another way to contextualise the data was to pay attention to the more exact situation, where and how it had been collected. In this respect, I have three different forms of data: first field notes from the situations where health professionals and clients met each other, second interviews and notes from the discussions with health professionals where they explicated, how they themselves understood their own work and their position in relation to the clients, and third documentary data consisting of different leaflets, books and reports, used either by professionals or clients. Documentary data had been produced outside the ac-

tual professional practices, but was organising it and used in it in different ways. An example of this kind of a contextual analysis is the way in which I was looking for the standards and expectations for a 'good mother'. I noticed that these standards were made explicit more clearly when clients themselves were not present. This was interesting itself, but the notion also directed me to analyse other forms of data more carefully. I also paid attention to 'deviant cases', situations which were somehow exceptional, and did not seem to fit to the earlier findings and analytic scheme (Silverman 1989, 21-22).

Because ethnographic research produces a complex set of data, it provides a good ground for different comparisons. However, it has often been seen as a problem that ethnographic data collected with different methods in different situations produces contradictory results. Different parts of it seem to give different answers. There is also another way to understand these contradictions. It is interesting to ask, why they exist and what do they tell about the subject of the study. (Baruch 1981; Silverman 1989.) The picture, my complex data and my analysis produced, is not necessarily complete and without contradictions. But then life itself is not without contradictions either.

Writing ethnography

Ethnographic research is a literary process in all its stages, but the most important piece of writing is its end product. It has often been assumed that writing up the results of ethnographic research, or of any other kind of research, is an 'innocent', straightforward final stage in a research project. The end product of a research process has only been

seen as a description of, how things really are 'out there'. Recently, there has been more interest in ethnographic writing (a good overview can be found in Hammersley 1993). According to this way of thinking, ethnographies could and should be read as texts, which have been written by authors who use different kinds of textual strategies and styles in 'telling the story'. (e.g. Clifford & Marcus 1986; Van Maanen 1988; Atkinson 1992).

This notion emphasises the role of the author. For example, according to Judith Stacey, instead of producing a cultural reportage the ethnographer produces a cultural construction, whether or not she admits it or shows it openly to her readers: "the research product is ultimately that of the researcher, however modified or influenced by informants. ... As author an ethnographer cannot, and, I believe, should not, escape tasks of interpretation, evaluation and judgement." (Stacey 1988.) Throughout the text I want to show my active presence, but I also want to show the presence of all those people, who have been involved in the research process.

Dorothy Smith (1988) emphasises that feminist research should maintain its standpoint in the everyday world in writing the research results and not only in the earlier stages of the research process. Actually, she does not separate these stages from each other. She also understands texts and textuality as important constituents of our everyday world (Smith 1990b). That is why it is important, what kind of texts are produced. A feminist researcher should also be able to write differently in order to do sociology for women, to give them means to understand how their, and our, everyday world is organised. At the end, it will be the reader, who will judge how well I have managed to do this.

CHAPTER 4

PROFESSIONAL RELATIONS

What is the professional field and relations which women enter when they become clients of maternity and child health services? Who are the professionals women meet and how they are located in the field? In this first empirical chapter I will concentrate on these questions analysing the professional relationships in maternity and child health care, mainly the relationship between the professionals of medicine and nursing. I will also discuss the cooperation between other professional groups and organisations and the relationship to voluntary organisations working in the field of maternal and child welfare.

My main informants have been midwives and health visitors in Scotland and midwives and public health nurses in Finland. Thus, the analysis is very much based on the interpretations of the nursing professionals, how they understand their relationship with other professionals, how they define their own place in the professional field, and in relation to the clients. This is also my response to the feminist medicalisation critique¹. I want to make visible the important role of nursing professionals in the field and show that professional relations are not hierarchically fixed but negotiated in everyday practices of maternity and child health services.

¹See Chapter 1.

Doctors' handmaidens or independent professionals

In sociological research, there has been much discussion about professional relations in health care settings (e.g. Hearn 1985; Hughes 1988; Hunt & Symonds 1995; Henriksson 1998; Porter 1992; Riska & Wegar 1993; Witz 1992; Walby et al. 1994; Svensson 1996). These studies have emphasised the subordinate position of female nurses to male doctors and revealed the hierarchical power relations in health care. More recent studies have also shown that these relations are not necessarily straightforward and unchangeable. Instead, they are contextual and negotiated on a daily basis at the interactional level. The formal and informal rights and responsibilities of the professions might differ from each other. Also, power relations are not one-dimensional, but, for example, an experienced nurse might have a lot of power and influence over an inexperienced doctor. (Walby et al. 1994.) Roland Svensson (1996) also argues that the fact that more women than ever before are practising as doctors might have changed or will change the power relations between doctors and nurses.

There are two competing models of how the relationship between doctors and nursing professionals has been understood. According to the first, nurses are seen as doctors' 'handmaidens', strictly subordinate to their medical authority. According to the second model, which is a more current way of seeing the relationship, medicine and nursing are two complementary professions, the first specialising in treatment and the second in care. This view is strongly supported in nursing, in its practice, teaching, and research. The strong emphasis on the 'independent professional' -model in nursing has also been used as a gendered project within health care to increase the professional status of female nurses. (Walby et al. 1994, 57-59.)

In my research, health professionals in both countries emphasised their independent role in maternity and child health care. The issue, however, seems to be more topical in Scotland than it is in Finland. In Scotland, especially the relationship between doctor

and midwives, but also to some extent, the role of health visitors in relation to doctors, seems to be subject to constant change and negotiation. The independent position is not self evident, but according to health professionals, it is a matter of personal relations, negotiations and contradictions. It is something that has been achieved with hard work over a long period of time and it still has to be maintained and guarded all the time.

In Scotland, the specific role of health visitors in relation to doctors in child health care seems to be quite clear and settled. GPs meet children routinely for a medical examination 3-4 times before they start school while the rest of the work is done by the health visitors. In this respect, the situation is very similar in both countries. Health visitors described the relationship with doctors as ideally being team based work where they have the opportunity to consult each other when necessary.

The one thing in this practice is ... there is maybe better team work than in some other areas. We have a weekly practice meeting so if we have any worries about children or concerns, or if it is the other way round, if the doctors have concerns about children. So it is not like in some practices where they don't have things like that, you have to actually go and see the doctors.

Scottish health visitor 3

The role of community midwives in maternity care is more problematic. They are working in between two different groups of doctors, consultants in the hospitals and general practitioners in the community clinics. Community midwives in both areas in Scotland were employed by the Hospital NHS Trust and they were based at the hospital, but were seeing their clients at the health centres and GP surgeries. Most of the conflicts they described seemed to occur with general practitioners. Midwives often described the relationship as a competition. At the same time they had to avoid open conflicts. They had to be careful not to disturb the existing balance. Still, many of them strongly emphasised the need for more independent midwifery care which they also saw as beneficial for the clients.

INT: It seems to be different in different areas, how this work is divided between GPs and midwives.

MW: That's right. A lot of that is very dependent on the GP and I think a lot is dependent on how much self confidence they have. The more confidence they have the more they are likely to let the midwife do it, the less confident the more they want to be involved. They do get paid a large sum of money per head per antenatal so they want to make sure they have got an input into it, approximately £200 for every pregnant lady on their books so for that they have to provide a service. It depends on the GP whether you do everything for them or you work with the GP or work outside them and because we are employed by the Trust our services really are loaned out to the GPs so they dictate how far we can go because we use their premises etc. Scottish midwife 2

Anne Witz (1992) has analysed historically the professionalisation process of midwifery in Britain. It was not a battle with doctors simply on the other side and midwives on the other. According to her, different groups of doctors had different opinions about the role of midwives in maternity care: Obstetricians seemed to have been more willing to give midwives a recognised independent status whereas general practitioners wanted to keep them in a strictly regulated subordinate position. To some extent, this seems to be the case even today, or at least this is the way in which the midwives interpreted the situation.

I think certainly there is quite a good rapport with the consultants in the hospital. This hospital tends to be quite kind of midwifery orientated and the midwives having a big part to play in the care of the women and everything is done with back-up and consultation. For my own personal part, because I have been in the hospital for about 10 years or so the majority of the consultants that I have come across know me. They have known me for that length of time so I don't have any problems with any of them in particular. I think communication in general is quite good. GPs are a bit of a different story, again particularly the area that I work in because we are just new to the area so we are just slowly but surely trying to establish ourselves and it is getting better. I think some other areas, where the midwives have been working there for a long time and there is a strong connection with the consultant as well, I think communications are generally better. I think it is just individual GPs and individual areas if there is a problem.

Scottish midwife 6

What we would like is midwives to be referred to without the GP but then you are looking at setting the midwifery service up as almost independent. Independent midwifery is ideal but it is not practical from a business point of view unless you have got very good business experience behind you. We have to continue to demonstrate that total midwife care is an entirely safe alternative and that has already been demonstrated. So midwives giving care is as safe as shared care and unfortunately it is a politically financial argument and we are not a power house, midwives. So you are in a position where you have to stay visible, you have to keep being out there in the community even if you have got little clinics where there are only one or two people, you are there for an hour and you think it is a bit boring, you have always got to provide the service whether it is busy or when it is quiet. And if you stay visible then people know who you are.... Midwives would have to somehow heighten their profile in local communities without alienating the GP's and that is not at all easy. But I think if we provide good care and safe care and the women prefer it, definitely do, because they tell you.

Scottish midwife 8

Some of the midwives are highly critical of GP's. With consultants the relationship seems to be more settled. There is a more established division of labour between them and usually midwives also recognise the medical expertise of the consultants, unlike the one of GPs in maternity care. In many cases they also personally knew the consultants better than the general practitioners and over time this had developed a mutual trust and respect.

The relationship with the consultants was not always without conflicts either, especially in the situations where a midwife and a consultant concretely worked together in the consultant clinics. In those situations the whole behaviour of the midwives changed and they were transformed from being independent professionals to doctor's handmaidens. They stayed back stage during the visits, serving the doctor, and always calling him or her Doctor.² Afterwards, however, they sometimes criticised the position given to them

² This was the way all the health professionals called doctors, Doctor Surname, whether or not they were actually present. I never came across this in Finland, where they called doctors either by their first name, full name without the title, or avoided this kind of address altogether. This question of titles and formality

and the authority of the consultant, sometimes even in the presence of the client, but never openly in front of the doctor. The fact that community midwives, and health visitors, rarely actually worked together with doctors seems to protect their independence giving them more space and flexibility.

The opinions of individual midwives also reflect the wider political debate that has been going on over maternity care in recent years where the same kind of arguments have been used. Discussion has focussed on the extent to which clients would prefer midwife only care if this were 'proved' to be a safe option, and also on the financial consequences of different models in maternity care. (e.g. Provision of Maternity Services in Scotland 1994; CRAG/SCOTMEG 1995; The establishment of a Midwifery Development Unit based at Glasgow Royal Maternity Hospital 1995.) However, there is still little detailed discussion how the services offered for the clients would actually change.

In Finland midwives and health nurses also saw themselves as independent professionals, although they did not emphasise the issue as much as their colleagues in Scotland. In Finland the relationship with doctors seems to be more established and there is no need to protect or fight for the independence of nursing professionals. Instead, health nurses, and also doctors, emphasised that they were working as a team, with their own specific tasks and responsibilities for the care of their clients. Health professionals wanted more cooperation with doctors and more time to talk to each other. The relationship also seemed to be less formal and hierarchical than in Scotland, for example health nurses and doctors often called each other by their first names.

I'm in this stupid situation where I have a different doctor all the time; it has been like this I think for two years at least. It's impossible to create any kind of working relation-

is not just confined to health professionals but runs through the British society (I would like to thank Robert Hollingsworth for this comment).

ship ... With Anna (the doctor for the other area) we have tried to solve the most problematic cases.

Finnish health nurse B

Of course, it would be good to have more time to discuss things with the doctor when she is here, not only that she would meet her clients and leave. We have tried to use a little bit more time for each client than before. On the other hand, it would also be easier for the doctor. Now if there is ten minutes for each client, that's quite a rush. And some of the mothers also wish that the doctor would have more time to discuss. But at the moment, her work has to be concentrated very much only on the physical follow-up of the pregnancy.

Finnish midwife C

In Finland the relationship between nursing professionals and doctors (general practitioners) in maternity and child health care was officially established in the Maternity and Child Health Centre Act in 1944³. Nursing professionals, midwives and then health sisters, were given an independent role, and ever since they have had the main responsibility in running the centres and in caring for the clients.

Doctors, even if they are the medical experts and authorities, are very much 'temporary visitors' to the maternity and child health centres, and must to rely on the expertise and experience of the midwives and health nurses. Elina Hermanson (1997), a doctor, who has worked a long time in child health care, has recently suggested that public health nurses could take even greater responsibility in child health care and routine medical examinations could be cut to a minimum, without risking children's health. All the doctors I met during my data collection happened to be women, as is often the case in Finland, especially in primary health care (Riska & Wegar 1988). This might also have some effects on the nature of the relationship with the nursing professionals. In Finland the relationship between midwives and health nurses and doctors is also less competitive because they are all employed by the local health authorities. They have their own specified roles and responsibilities in maternity and child health care, as they have in other sectors of primary health services.

³See also Chapter 2.

Midwives and health visitors/public health nurses

The relationship between the nursing professionals and doctors is not the only meaningful professional relationship in maternity and child health care, even if it is the one which has most often been studied. A very important one is of course the relationship between midwives and health visitors, or midwives and health nurses, who share the same clients and transfer them from maternity to child health services.

Professionals in primary health care in the UK are expected to work together in cooperation, as a team, including midwives and health visitors (Turton et al 1993, 17-21). Both in Scotland and in Finland midwives hand over a newborn baby to health visitors or public health nurses two weeks after the birth. At least at that time they have some sort of contact and cooperation with each other, in exchanging information about the client. The hand over is done either personally, over the phone or in writing. Health visitors in Scotland were also involved in antenatal care. As a minimum they introduced themselves to the mothers a few weeks before the baby was due to be born, but often they had a greater involvement, running antenatal clinics with the midwives. In Finland health nurses worked more closely with midwives, often working physically at the same health centre rooms next to each other and sharing the waiting area and other facilities⁴. Because of that they also had a lot of informal contacts, for example during the lunch or coffee breaks.

In Finland midwives and health nurses described each other, with few exceptions, as the most important partners in their work. This was especially true of those who worked in the same maternity and child health centre. They identified themselves more with the centre and with the other professionals working there than with their colleagues else-

⁴ Nowadays, it is also common, especially in small health centres in rural areas, that there is only a health nurse with some midwifery training responsible for both the maternity and child health services. This is also the model of services which is supported at the moment in primary health care policy.

where. They also emphasised the need for communication and cooperation between maternity care and child health care.

I'm not at all a lone wolf here because we have people here from so many different sectors. You can get help and advice from just behind the wall as soon as you need it. I can consult the people at the maternity centre, the home health care, the school nurse, and that's what we quite often do.

Finnish health nurse A

Especially the midwives also complained about the situations where they didn't have this kind of physical, face to face contact with health nurses in child health centres:

INT: How many child health centres do you discharge babies to?

MW: Three different child health centres, one of them is in this same building, but the others are elsewhere. This is one thing which we have discussed in several meetings with health nurses from child health centres. And we've always said, how much better the situation would be if we could discuss face to face and not just send letters. And it would be good even to have the client present, the family there with their baby and then we could discuss things all together.

Finnish midwife C

NT: How do you discharge the babies to the child health centre?

MW: To Paula (the health nurse working at the same centre), I discharge them all face to face and give her all the papers. Then most of my babies go to Kotila health centre. I discharge them by phone, and often they know the clients already. If there is anything special I'll say so and I also write it down in the papers. Then I have one place where the health nurse hasn't wanted any contact by phone. I only write my name on the form, so that she knows it comes from me, that she knows whom to contact if there is something, and of course, I mention on the form if there is something. But usually I phone, if there is something. It's only this one place. I don't think she even answers the phone if it's not her telephone hour. I've never managed to get through when I've tried. She had already told the midwife who was here before me that there is no need to call.

Finnish midwife G

In Scotland midwives and health visitors were not as close to each other as midwives and health nurses in Finland. They had contacts with each other, and they saw them as important, but there were also some conflicts in their relationship, which were mainly

related to the role of health visitors in maternity care. In some cases there seemed to be some kind of a competition between them in the provision of maternity care, especially in the provision of parentcraft education.

INT: What are the most important topics during pregnancy that the women want to speak to you about?

HV: Yes, you mean what they would speak to me about rather than the midwife? They usually see me about or I would discuss problems within the family, whereas they want to speak to the midwife about their actual pregnancy. They prefer to see the midwife with problems relating to the pregnancy, how they are feeling, anything about their baby, that sort of thing. How they want to have the baby, what to do when the baby is there, that sort of thing. I speak to them about breastfeeding and the benefits of that or if they are going to bottle feed how to do it properly, diet as well, get enough rest etc.

Scottish health visitor 4

INT: How do you see the division of labour between you and the midwives who meet them as well?

HV: Yes, I really think that it works quite well because the midwives mainly are talking to them about their pregnancy and what is happening during their pregnancy. Whereas I am more interested in them as a whole family within their situation, in the neighbourhood and the environment that they are functioning in. Plus I think the girls get the message quite clearly that I am totally about preventive things, things they can do to keep themselves and their baby and their family healthier whereas the midwife is talking about things very defined in their pregnancy. So the midwife and I don't have a problem I don't think. There are areas where we overlap a bit obviously the midwife talks to them about breast feeding as well as me but then that can be a good thing because that reinforces it to the girls.

Scottish health visitor 6

It is interesting in the two quotations above how the health visitors define their role in relation to pregnant women, and in relation to midwives in maternity care. According to them they hold a wider view, seeing pregnant women as part of their family and the social environment, whereas midwives concentrate on the pregnancy in a more limited sense. They actually make a similar kind of distinction in relation to midwives than midwives do in relation to doctors. Midwives, on the other hand, do not grant any par-

ticular role to the health visitors in maternity care. For them health visitors are mainly professionals who take the charge after the baby is born. What they addressed were the problems in communication between the two professional groups.

In my particular area that I work in there have been problems (with health visitors - mk) just because we are fairly new to the area, we have only been working within that area in the past three years and a lot of it is geographical problems. Because we don't work in the same building if you like, we are not in regular day to day contact, so the contact is by phone and because we are all out visiting on a day to day basis, we are out working within the community, that is not always possible. But with meetings and your regular sort of get together to try and address these problems we are starting to move towards a bit better communications.

Scottish midwife 6

INT: Can you tell me something about your relationship with other professionals. How much do you see health visitors and what kind of communication do you have with them?

MW: It tends to be informal, if you are worried about a particular woman you will phone and speak to the health visitor about her. Sometimes you meet for lunch and if the health visitor is there you will liaise there and then but it tends to be more by phone. Plus if you happen to meet in the street or if you happen to meet in a house and some of them are attached to GP's surgeries so it can be that way as well. But usually if you have a problem you would make a point of liaising with the health visitor, because she is having to go in and if she doesn't know the problem it would be a bit embarrassing for her and for the mum. So it tends to be by phone but more informal than formal.

Scottish midwife 7

The physical distance or closeness seems to be one of the main factors in defining the relationship between professionals working in maternity care and child health care. In the Finnish system, midwives and health nurses work more closely together as colleagues in maternity and child health centres. In Scotland community midwives and health visitors identify themselves more with their own profession. They are working for different organisations, physically located in different places, and only meeting each other occasionally. They also define each other's roles in relation to the clients somewhat differently.

Confusing boundaries of health and social issues

Several studies (Dingwall; Eekelaar & Murray 1983; Dingwall 1976; McIntosh 1992) have shown that in the UK the professions of health visiting and social work have some overlapping elements, and that also clients might mix the roles of health visitors and social workers. Health visitors in Scotland, and also health nurses in Finland, have a preventive, and to some extent also a controlling role in child welfare. They are the professionals who see all the young children on a regular basis, are able to assess them, and obliged to report to social work, if they are worried about a child's living conditions and care. However, the professionals in my research in either of the countries did not emphasise this role in any way. Instead, they made a distinction between the fields of health and social problems, defining preventive health care and health promotion as their own field. It can't be ignored, however, that in their work they are intervening in the ways in which children are cared for and making judgements about proper standards of care.

In Finland, from the social work point of view, maternity and child health centres have been criticised for not cooperating fully with the social work department in issues of neglect, child abuse or social problems in the family. Instead, health professionals are said to either ignore the possible problems or to define them as health problems rather than social problems, and to invoke confidentiality to protect the clients from social work intervention for as long as possible. (Kivinen 1989, 62-63; Tarpila 1992.) Finnish professionals in the health centres I studied wanted to distance themselves from child welfare authorities and emphasised their own role as professionals in providing universal services for 'normal families'. Doctors rather than social workers were the professionals to whom they referred to if they suspected any problems either with the child or with the family. They also repeated that they rarely had any contacts with social workers.

INT: Would you like to have more cooperation with some other professionals or agencies?

HN: I think at the moment there is maybe as much cooperation as I want, or have arranged. ... Maybe, I still expect something more from the social work side. Maybe, when all this redivision and integration of geographical areas is done, then there might be an opportunity to meet the social workers who will be responsible for this area and to create more cooperation again. At the moment we are quite distant from them. They have had this kind of a constant change going on for so long; one day they work on a geographical basis and the next according to the clients' surnames. It is sometimes difficult to know whom to contact.

Finnish health nurse A

Personally I have had very few contacts with the social work side, usually it's only if somebody needs home help, and clients take care of that themselves. But if it's a really urgent situation, I have phoned them sometimes, and it has worked well.

Finnish midwife C

With social work it's almost non-existent. I don't know, really, what kind of cooperation we could have. I very rarely have this kind of difficult clients where I would need direct contacts with them. The only thing is that we inform them about single or cohabiting mothers to arrange child maintenance support.

Finnish midwife E

In Scotland, even if the health professionals and the midwives more often than health visitors said that they did not have close contacts with social work, there still seemed to be more contact and cooperation between them than was the case in Finland. Also health visiting and social work in Scotland seems to be closer to each other than social work and health nursing in Finland. Sometimes, when I was doing home visits with health visitors, or even with community midwives, it felt like being with social workers. Their work had more to do with the social problems of their clients than the work of health nurses in Finland, and there was more discussion of the connections between the social circumstances and health problems of their clients. Some of the health visitors analysed their position in relation to social work, and also recognised certain overlaps that might occur. Midwives, on the other hand, said they leave the cooperation with social work to health visitors.

INT: How much cooperation, or what kind of working relationships do you have with health visitors, or do you often have contact with social workers?

MW: I would say I have more contact with health visitors than I do with social workers. Social workers usually tend to be involved if there is an on-going problem. The health visitors are more sort of on a general day to day basis. Scottish midwife 6

Health visitors described the relationship with social work more widely, mentioning several different styles of cooperation:

INT: What about social work. Do you have a lot of contact with them or do you have a need

HV: No, I think dealings with the social work depend an awful lot on the area you are working in and this area does tend to be, it is not a deprived area so although I have dealings with the social work department it is all through my caseload, not through the child aspect. I think even in the way the practice does this, there is that split on a geographical basis between myself and the other health visitor. She has got the area which is more likely to come in touch with the social work department than myself and I have to say that I have not really had any dealings with the social work department as regarding children in the time that I have been in this practice. I have had dealings from the other side of the practice if my colleague has not been able to attend case conferences, but in other areas you might have a lot more contact. Scottish health visitor 3

Well yes, I think there is a certain overlap between the health visitor's work and the social worker's work, but hopefully if it is purely a social problem you do pass it on to the social worker and you don't try and give them that sort of support, because you know the social worker is the one that has got the resources and things to provide the extra help for them in the community if it is purely a social problem. So you should all be aware of each others skills and be able to back off where it is mainly her job.

Scottish health visitor 6

During the last 10-15 years child abuse has been a major public and professional issue in the UK (e.g. Otway 1996; Parton 1996). However, it is interesting to note that only one of the health visitors mentioned their role in child abuse cases or cases in which child abuse had been suspected. There is probably be the same apprehension as among

the Finnish health professionals that these are primarily social work matters where their role is only marginal.

HV: ... social work, if there is a problem social wise, the social work will deal with it. I don't have, touch wood, don't have any children on the abuse register at present. There is no one at the moment, there was a time there when I had three children on the child abuse but I haven't had for a while.

INT: What is your role in child abuse cases?

HV: Mainly as a support. Social work, that is their remit and once it has been taken up by the social work then we work with them and just keep an eye on things and the social work keep an eye on things but we just generally keep watching the child when we are visiting and we have case conferences every so often about the family and we discuss how things are progressing, things like that, but I haven't had anything for a while, thankfully, and hopefully I won't have. But often times you might get people phoning up like malicious phone calls saying a child has been abused and that starts the ball rolling. Of course, the social work have to be involved and there has got to be case conferences and things ironed out, so the social work will ask you for a report on the background of the family and what you generally feel about the family and have you seen anything.

Scottish health visitor 8

In both countries midwives seem to have their own special field of work, pregnancy, childbirth and postnatal care, where 'social problems work' (Miller & Holstein 1991; see also Jokinen et al. 1995) and cooperation with social work is very much excluded. There is more pressure on health visitors and health nurses working in child health care to handle social problems and to communicate and cooperate with social workers. There was a lot of variation in how they had responded to these demands, but in Scotland health visitors seemed to be more willing to take on that role than health nurses in Finland. On the other hand, it might be that, especially in some of the deprived areas where health visitors work in Scotland, it is impossible to ignore social problems. It is, however, far from clear where the line should be drawn between social problems and health problems, it is very much a matter of situational definitions and boundary maintenance.

Professionals and voluntary organisations

Nursing professionals also act as a link to other statutory or voluntary agencies in health and social services. In Scotland, unlike in Finland, health professionals, both midwives and health visitors, mentioned voluntary organisations as important partners and a resource in their work. They informed mothers about the local National Childbirth Trust breastfeeding counsellors, about play groups run by voluntary organisations, about groups for single mothers and so on. They also acted as a resource for the voluntary organisations, and in some occasions they set up groups themselves, as in one of the areas, where midwives and health visitors were just starting a group for breastfeeding mothers with the idea that later on they would withdraw their involvement and the group would then continue on its own. There were also many other ways in which health professionals were involved in voluntary activities.

For instance, I am on the Home Start Management Committee, which is a voluntary agency and it befriends mothers. It goes into the home, a volunteer goes into the home and befriends the mother, helps her with child care, helps her take the children to swimming baths and is just a friend, somebody to talk to, which in an instance where somebody is depressed it is quite useful for them to have someone to talk to, someone to say – oh yes you are doing all right, maybe motivate them to do a wee bit more and therefore feel a bit better. ... This is really important, it fills a really important gap in the service and we really feel it is quite vital.

Scottish health visitor 2

We are in the position too with local knowledge and we know exactly what services exist. For example, there is an organisation called here "Give Us a Break" and if a family is finding it difficult to cope, we can certainly get them involved. There are for older people if there are problems we have got "Good Neighbour Schemes" or if we feel there is people on drugs, problems as I said, we can get into. There are so many organisations locally. So our local ... the fact that we have such a good base of localised knowledge, we try to be there for the families so we can direct them to the right places.

Scottish health visitor 5

The reason why professionals in Finland never mentioned this kind of cooperation with voluntary organisations, might be that this kind of local voluntary groups and services is much more rare in Finland than in Scotland. In Finland most of the services for children and young families are provided by professional organisations and local authorities.

During the 1990s there has developed a new kind of interest in voluntary work in different sectors of health and social services in Finland. For example, the Mannerheim League for Child Welfare which in the 1920s founded the first maternity and child health centres has a strong involvement in the issues of maternity and child welfare. Today, it is maintaining help lines for children and parents and organising in some areas groups for parents, and as a new form of activity, groups for new fathers. In 1997 it also set up a new, three year experimental project in several areas in Finland to provide support for families with young children and to prevent more serious problems. The project works closely in cooperation with maternity and child health centres and health professionals often are key persons to recommend these supportive services for their clients. (Lapsiperhe-projekti 1998.) It might be that in the future, voluntary organisations in Finland play a more visible role also as partners of health professionals in the fields of maternity and child health.

Voluntary organisations are not competing with professionals, but their role is seen as supportive and complementary, mainly providing social support for mothers or families in certain problematic situations. Health professionals see themselves as persons who should inform clients about other services, either voluntary or public services. At the same time they define which clients are in need of more intensive help than they themselves are able to provide.

Conclusions - clients in the network of professionals

In the field of maternity and child health services there are several professional groups which are working together or even competing with each other as providers of services. They have to legitimate their own role in the field and to distinguish themselves from other professional groups and organisations. In Finland the role of different professionals in maternity and child health centres seems to be quite clear and settled, but at the same time the organisational boundaries around them are quite strong: health professionals working in maternity and child health centres have very little contacts with hospitals, social services or voluntary organisations. In Scotland the status of different professionals is more likely to be under constant negotiations. Midwives, especially, are seeking for their own independent role in the field.

By making these distinctions health professionals are not only defining their own area of expertise in relation to other professional groups, but also in relation to their clients' everyday life, experiences and problems. The boundary between medical issues and health issues or health issues and social issues is a matter of definition which in turn effects the services provided to clients. This can be seen especially in maternity care in Scotland where there is a heated debate going on at the moment about how much medical attention women need during the pregnancy and during child birth. In this debate women's needs and wishes are often used as an argument to change the current system and at the same time the role of different professional groups as providers of services. In that sense 'power games' between professions have direct consequences on clients.

Coming back to the role of health professionals in maternity and child health care it can be argued that it is quite independent in both countries, even if in Scotland it is more unsettled. There are very few situations where midwives, health visitors, or public health nurses are directly under the control of doctors. Instead, they are working independently, meeting their clients most of the time without the presence of doctors. Indi-

rectly, of course, they are involved in the hierarchical structures of health services and they do not openly challenge the medical authority of doctors.

CHAPTER 5

HOME AND THE CLINIC - THE SETTINGS OF SERVICE PROVISION

Interaction between doctors or nurses and their clients has most often been studied in institutional settings, in a doctor's surgery, hospital or in health centre (e.g. Davis & Strong 1976; Strong 1979; Graham, & Oakley 1981; Hilliard 1981; Silverman 1987; Davis 1982; Peräkylä 1989; Vehviläinen-Julkunen 1990). In the UK, several researchers have also studied home visits done by health visitors (e.g. Dingwall & Robinson 1990; Heritage & Sefi 1992). In these studies, however, very little attention has been paid to the physical setting itself. The main emphasis has been on interaction. Leena Eräsaari (1995) who has studied physical space within different bureaucratic organisations e.g. in social work offices and job centres, argues that the physical environment reveals the hierarchies within the organisation, and also how distance and distinctions are constructed between professionals and their clients. Thus, it is important to ask not only what is done, but also where.

Maternity and child health services are provided in different settings: in the community based health centres or GP surgeries, hospital out-patient clinics, hospital wards and in clients' homes. In this chapter I will discuss two different settings of care, the 'clinic', an institutional setting, and the 'home'. There are of course differences between different visits to the clinic and between different home visits. Even the same client might have different experiences of her different encounters with health professionals even if the physical setting remains the same. What I want to do here is to look behind these situational differences. I will discuss and compare 'ideal types' of the 'clinic' and the 'home'. The question I want to ask is: how does the physical context of service provision change

the encounter between a health professional and her client, and how do health professionals themselves give meanings to these different settings.

In the two countries, Finland and Scotland, there are no major differences in the recommended schedules of how often clients, pregnant women or young children, should be seen by the health professionals.¹ What is different are the settings in which they are seen. First, the 'clinic' in Scotland is something quite different from the one in the Finnish context. Second, home as a setting of service provision is much more common and more central in Scotland than it is in Finland.

What is a clinic

When looking at the clinic work in maternity and child health care it is important to notice that the word 'clinic' itself carries different meanings in the two countries. Language is central to ethnographic research, and even more important in doing cross-cultural research. Language is not only words, but it is also a carrier of cultural meanings. A very clear example of this is the word 'clinic'. I used to translate the Finnish words 'äitiysneuvola' and 'lastenneuvola' as 'maternity clinic' or 'antenatal clinic' and 'child health clinic'. I realised, however, that the word 'clinic' is not appropriate in this context. It sounds too 'medical'² to describe the context and atmosphere of the Finnish

¹In Finland the most recent recommended national schedule for child health surveillance has been introduced in 1990 by the National Board of Health (Lastenneuvolaopas 1990) and for maternity care in 1995 by the National Research and Development Centre for Welfare and Health (STAKES) (Screening and Collaboration in Maternity Care. Guidelines 1995). In Scotland, together with the whole UK, national recommendations for child health surveillance (but not for health visiting - mk) have been introduced in 1991 (Hall 1991). In maternity care the CRAG/SCOTMEG Working Group on Maternity Services has very recently, in 1995, introduced a recommended schedule which is based on individual care plan for each client (Antenatal care 1995). (See also Appendix 2)

² Compare for example with expressions like clinical training and clinical practice.

maternity and child health 'clinics'. The direct translation of the Finnish word 'neuvola' is advice centre which refers both to a physical setting and to certain activities. In order to avoid some of the cultural connotations included in the word 'clinic', I will use the terms 'maternity (health) centre' and 'child health centre' when referring to the Finnish system. The Scottish 'clinics' I will call by the names which are used by the organisations and professionals themselves.

In Scotland the word 'clinic' refers to certain activities that can take place in various places rather than to a specific physical location. That is why I found it very difficult to understand the way in which health professionals described their clinic work. There are several different clinics. In maternity care there are community based maternity clinics, midwife-only clinics, hospital based antenatal clinics, and consultant clinics, not to mention some specialised clinics, e.g. twin clinics for women expecting more than one child. In child health care there are open 'well baby clinics', where parents can bring their children without booking an appointment, and 'child health surveillance clinics', where children are invited at certain ages. In one of the health centres there was also a separate immunisation clinic for young children. The clinics are named differently depending on where they take place, which professional are running the clinic, whether advance booking is needed or not, and also according to the main purpose of the clinic.

In many cases, however, the name and the content of the clinic did not match. For example, a hospital based antenatal clinic was called a 'consultant clinic' even if in practise a client might not meet a consultant at all but a midwife, or at least, a midwife took care of most of the tasks during the visit. Also, the 'midwife-only clinic' was not necessarily what I expected. It did not usually mean care provided completely by the midwives, but instead care divided between the GP and the midwife. The reason it was called a 'midwife only clinic' was that there was no doctor present during the visit. By using the expression midwives wanted to emphasise their independent role in maternity care.

The maternity care system in Scotland is quite complex because there are several service providers who are, to some extent, competing from the same clients.³ Some midwives themselves pointed out the complexity of the system and saw the explanation in the competition between GPs and consultants where midwives were somewhere in between. Many of them campaigned for more independent 'midwife only care' during the pregnancy, and for their right to run their own clinics independently.

Some will see them more frequently, but personally I think all the women who are normal should just be seen in the community and if there is a problem then refer them back to the consultant in the hospital. They now come (to the consultant clinic in hospital - mk) at booking, round about 28 weeks, 32-34, just depends on the consultant. Some only see them twice in their pregnancy after booking,. It would be easier for the women because they are confused, I mean they see a midwife in the community then they see another midwife in the hospital. I think they think when they come to the hospital they would like to see a doctor.

Scottish midwife 7

Also GPs in their own surgeries regulate the provision of maternity care and the role of midwives as providers of care, maybe even more than the consultants:

In Braebank and Hillside I have a midwife only clinic and I alternate the visits with their own GP so that they feed, each GP, and between these two practices I will share about 12 GPs. So those 12 GPs will see them one month and I will see the lady the next on my own so they filter through to me and back to them and back to me, so I have no GP in with me at all in Braebank and Hillside. The Glenmore Practice which is much smaller and the GP comes in with me at those practices but doesn't clinically take part really in the examination. I do the blood pressure, test the urine, weight, listen to the foetal heart, give out advice quite happily with the GP in the room and the two of us just work as a team and it can be a different GP, all three GPs could come in for three different patients on one day. Just the set up there, they just like to come in but if the GP is not available or the GP is busy then they know that I will see the antenatals and send them away and they are quite happy with that situation as well.

Scottish midwife 4

³See also Chapter 4.

Child health surveillance clinics are run by the family's 'own' health visitor or GP, but open baby clinics are run by all the health visitors in the unit on a rota basis. Health visitors had quite mixed opinions as to whether this is a good system:

Ideally some of the health visitors here have got their own clinics. Mary, who ... you probably spoke to her, she has her own clinic on her own which is ideal, she sees her own mothers. I don't have that facility yet there is not enough room, but it is quite nice to have that and the mothers can come and see you. But then again maybe it is quite nice to see somebody else and get another opinion or say my health visitor said something and they will maybe want to come to another health visitor to see what she will say and then they will think, oh right, okay. So they play you off one against the other. Yes it is quite good having your own clinic. It would be quite nice to have that and see your own mums and that would certainly save a lot of visiting too if they know that you are on on a certain day, they will come and see you.

Scottish health visitor 8

In the Finnish maternity and child health centres health nurses only meet their 'own' clients and run their clinics very independently usually taking more time with each client than in the Scottish clinics. They also make appointments for the clients to see the doctor, not the clients themselves. There are only two different kinds of 'clinics', health nurse's clinic and doctor's clinic, which both take place in the same physical setting. Pregnant women are sent to a hospital antenatal clinic only if they need special medical attention. From the clients' point of view the complexity of the Scottish system means that they are less likely than the clients in the Finnish maternity and child health centres to meet the same person and in the same place every time they come to the clinic. This is especially true in hospital maternity clinics and in big health centres. In maternity care women usually visit at least two different places, a hospital clinic and a clinic based in their local health centre or GP practice.

The physical environment of the clinics

In Tehtaala, the Finnish city, the maternity and child health centres where I did my research were located in three different areas and buildings. The first, Takala health centre, provided services for a wide area outside the city centre. The maternity and child health centre was situated on the ground floor of the building. There were also other community health services and personnel based in the same building, such as home nursing services for elderly people and a dentist. Clients first went to a large waiting room, which was also where parenthood classes took place in the evenings. In the waiting room there were posters and advertisements on the walls, leaflets and magazines on the tables, tables where clients could change nappies, and toys and small tables and chairs for children. All the midwives and health nurses had their rooms around this waiting room. In this centre there were three midwives specialising in maternity care and two health nurses working in child health, each working geographically in separate areas and with their own clients. There were no doctors permanently based in the health centre, but every one of the health nurses had a doctor's clinic, usually few hours once a week for her own clients.

The second health centre, Kujala, was much smaller. It was only a child health centre run by one health nurse. Maternity services for the area were provided in another health centre. The area around the clinic was a suburb, about five kilometres away from the city centre. The area was mainly built between the 1960s and 1980s and was composed of blocks of flats and more recently built terrace houses on the outskirts of the area. The child health centre was situated in a wing of a school building and school health services were also situated in the same wing. There was a large waiting room, not quite as cosy as in the Takala health centre, and two rooms for the child health centre. One of them was used by the health nurse as her office and the other one was used by a doctor or a physiotherapist when they had their clinics there.

The third health centre, Pihala, was situated very close to the city centre in a large office building, and although the building had been recently renovated, it looked less inviting than the other two centres. It was a huge six storey building and was the base for several other municipal health and social services. The maternity centre had its own entrance together with the child health centre and a family planning clinic. It looked more like a 'medical' setting in contrast with the other two, for example the waiting room was much smaller and looked more 'formal' than the two others. Pihala also served as a 'central maternity centre'. For example, ultrasound scans for pregnant women were all done here by two obstetricians. In the maternity centre itself there were three midwives who were working in separate geographical areas providing services mainly for the inner city area.

In contrast, in the two areas in Scotland community midwives were based in hospitals. In Strathdee, there are four hospitals with maternity units. In principal, these hospitals are providing services for certain geographical areas, but women are free to choose whichever hospital they want to go. I did my research in one of them, where there were about 20 community midwives who shared one quite a small office. They mainly used the office in the mornings and in the late afternoons. It was not meant for meeting their clients. Most of the time they were out doing home visits or running antenatal clinics at GP surgeries and health centres in the wide area around the hospital.

Mornings in their office were quite hectic: the room was crowded, midwives were organising their files for the day, answering the telephone, were changing news, sharing with each other the case loads of colleagues who were on holiday or off sick, having discussions with their manager, eating breakfast and chatting. The midwives did not even have their own desks in the office but two or three of them were sharing the same desk.

I observed the work of four community midwives based in the Strathdee hospital. They were all mainly working outside the city centre in areas which differed a lot from each other. They covered rural areas and small villages and towns as well as large urban housing estates. Most of the GP practices, where they had their antenatal clinics, were small, with two or three doctors working there. The consultant clinics they had outside the hospital were in big health centres. Usually the clinics lasted for one or two hours, and during that time midwives had very little contact with other members of the staff. They did not have their own room at the surgeries or health centres and used consultation rooms available for their use only for the time of the clinic. Rooms were very neutral and plain containing only the necessary furniture and equipment for the examination. Some of the midwives were also involved in the consultant clinics in the hospital.

The Strathdee health visitors I studied were all based at the same large health centre, Parkend, on the outskirts of the city centre. The health centre was a large building built in the mid-1980s. Although the health centre was quite modern, it looked formal and complex, a 'hospital like' setting. On the ground floor there was a large waiting hall with an information desk. There were several GP practices based at the health centre, each one of them in a different part of the building, and the health visitors worked GP attached. Their offices were not, however, in the practices where they had the clinics, but were situated on the first floor all along the same corridor. Each shared an office with two or three others, either other health visitors or district nurses. The health visitors spent at least half of their working time outside the health centre doing home visits. Most of the health visitors ran their clinics at the health centre, although one of them had hers in a small GP surgery elsewhere. The clinics were either open baby clinics which each of them ran on a rota basis, or child health surveillance clinics which they ran together with a GP. Health visitors also ran separate immunisation clinics. Clients waited their turn in large waiting areas together with other patients.

The area I call Lochend is not just one city, but the area covers also smaller towns and villages around it. The four local areas and health centres, where I collected the main part of my data, were quite different from each other. The first one was in the centre of a smallish town, Inveralan, about 10 kilometres from Lochend. It was quite a large health centre providing services also to several villages around it. On the ground floor there were two receptions, consultation rooms and GP practices, a room where parenthood classes were held, and waiting areas for the clients. On the first floor there was an office for health visitors together with other nursing staff. When health visitors had their clinics they used one of the consulting rooms downstairs, as did the community midwives.

The second health centre was in a small former mining village also quite far away from Lochend. It was a very small health centre which looked as if it had been built only for temporary use. There were no GP practices based in the health centre, but some of the doctors came at certain times to see their patients there. There was only a reception, a large waiting room with nice toys for the children in the corner, and a few rooms. The health visitor had a small office of her own, but she had her baby clinic in the waiting room with several clients present at the same time and children playing in the corner. She was actually the only health visitor who was working on a geographical basis, all the others were attached to GP's.

The third health centre, Braebank, looked more modern than the other two. It was also in a village outside Lochend, but closer to the city centre and in a wealthier area, as the health visitors often emphasised. There were two health visitors in the health centre sharing an office together. Next to their office was a larger room where they had their baby clinic and where they also sometimes met their clients individually. The room was also used for other purposes, such as the weekly clinical meetings and for different kind of small groups. One of the community midwives had her clinic in this health centre once a week.

The fourth health centre was the only one in the Lochend city centre, but served a much wider area. There was a small reception area on the ground floor and consultation rooms and offices on two upper floors. The health visitors had their own small offices on the first floor where they also met their clients. The baby clinic, however, was held downstairs in a consultation room. Besides these four places I visited many more areas and health centres in Lochend area, because almost all the community midwives ran their clinics in more than one health centre and were attached to several GPs and GP practices.

All the community midwives in the Lochend hospital shared a small office in the hospital maternity unit which was very much like the one in the Strathdee maternity hospital. Mornings in the office were just as busy as in the Strathdee. The rest of the day the community midwives did home visits and ran antenatal clinics in different health centres, often coming back to the office in between or at the end of the working day. For them the hospital was also a kind of an information point, from where they got information about new clients, clients' test results, and new babies born in their area.

The long description above shows that, unlike the Finnish midwives and health nurses, in Scotland community midwives and health visitors share their working time between various physical settings. They are based in a certain place, usually in a hospital or a health centre, but this is not necessarily the place where they see their clients. Instead, they travel between different places during the day. The Finnish health professionals mainly work in one physical setting, in a health centre, in their own room where the clients come to see them. The fact that health nurses have their own offices in the health centres also has its effect on the physical environment. They have decorated their offices with house plants, posters, photographs, and children's drawings which makes the physical environment less official and 'medical'. In one of the health centres, at the time of my data collection, they were just choosing new curtains for their rooms.

On the other hand, most of their Scottish colleagues had to share the office with several others and held their clinics in consultation rooms used also for other purposes. They could not create a space of their own in the health centre or in hospital. This lack of space tells us something about their less independent professional role compared with their Finnish colleagues. But it also indicates the different ways of doing maternity and child health work. In Finland the work mainly takes place in a certain institutional physical space that health nurses have made 'their own', whereas in Scotland it mainly takes place somewhere else, either in the clinics elsewhere or in clients' homes.

Home visiting and cultural meanings of home

Maternity and child health care takes place not only in the clinics, health centres and hospitals, but also in clients' homes. Especially in Scotland home visiting has a central role in service provision. Visiting is undertaken frequently and routinely, most often during the first days and weeks after a baby is born. It is interesting to ask what gives the health professionals permission and the legitimacy to enter into their clients' private sphere and also how and why home visiting occurs.

Home and privacy

Understanding of home and home life are loaded with positive cultural meanings. Home in modern society is seen as the most private of all places, a place for relaxation and retreat from public life. It is a place where people can exercise control over access to their privacy. Amos Rapaport (1977, 289-90) defines privacy as the avoidance of unwanted interaction with other people. Rules and symbols are used to establish boundaries between public and private, between us and them, ensuring the desired levels of interaction, inclusion or exclusion, and providing the appropriate defences. Unwanted

interaction can be controlled in different ways: through rules e.g. manners and hierarchies, through psychological means e.g. internal withdrawal, dreaming, drugs, through behavioural clues, through structuring activities in time, through spatial separation, and finally, through physical devices e.g. walls, doors, curtains and locks. People can use these means to control access from the outsiders to their homes, but also to avoid unwanted interaction inside the home with outsiders, or even with other 'insiders'.

There is also a strong connection between home and family: home is the place where families live their lives. The cultural meanings of home might be widely shared, but home is not the same for all family members. In this respect the private image of home and family is a contradictory issue. Feminist researchers have criticised the notion of home as 'a haven in the heartless world' (Lasch 1979) arguing that this is very much an idealised and male oriented view. Feminist work has shown that for women home is also a workplace where they provide services and care for other family members. Even if home is very much seen as a 'women's place', they don't have time of their own at home. Even the space and the use of space in modern homes is divided between men and women, and between adults and children. Women tend not to have the same privacy in their own homes (Munro & Madigan 1993; Saarikangas 1993). Furthermore, feminist researchers have pointed out that inequality, oppression and violence towards women and children within homes have tended to remain unseen, unrecognised and unchallenged just because of the private image of home. (e.g. Naisiin kohdistuva väkivalta 1993; Foreman & Dallos 1993).

Dichotomies between public and private create hierarchical gender divisions of a public man and a private woman (Elshtein 1981; Gamarnikow 1984). Women, and even more so children, have been seen as located in private, in the sphere of family, home and caring. But the boundaries between public and private are not unchangeable, they can be drawn in different places in different contexts (Eräsaari, Julkunen & Silius 1995). Women often act as mediators between family and the state, between private and public

spheres in the modern welfare state (Simonen 1990, 115; Borshorst and Siim 1987, 137-138). As professionals and users of the welfare state services they are crossing and reconstructing these boundaries. In maternity and child health services women, as professionals and clients, not only deal with private issues, pregnancy, childbirth, child care and family life, but health professionals also have access to their clients' homes, to the most private of all places.

Schedules of home visiting

In Scotland home visiting is an essential part of the maternity and child health care services, it is daily routine for both community midwives and health visitors. In Finland home visiting has a much more marginal role. There are routinely only one or two home visits during the first weeks after the baby is born. Nowadays, at least in some areas, even these 'first visits' have become more selective and are done only if seen to be essential by the health professionals or specifically asked by the mother. Otherwise visiting clients at home is highly exceptional. There have been some local experiments to undertake certain developmental assessments of children at home as well as suggestions that it would be beneficial to have at least one antenatal home visit, but these have remained exceptions rather than common practice. Even in rural areas with long distances to the health centres, the solution has been to set up local temporary satellite clinics instead of doing more home visiting.

The services provided and contexts in which this provision occurs depend on national and local regulations, organisation of the services, and on professional traditions, and also on how these regulations are put into practice at the everyday level. In Finland there are no legal requirements for midwives or public health nurses to do home visiting, but two home visits within two weeks after baby is born are mentioned in national guidelines for maternity and child health centres (Lastenneuvolaopas 1990, 10; Screening and

Collaboration in Maternity Care. Guidelines 1995, 15). In Scotland some of the visits are statutory. According to the rules given by the United Kingdom Central Council for Nursing, Midwifery and Health Visiting (UKCC) all women should be visited by a midwife at least for ten days after childbirth, and if needed up to 28 days. Accordingly, a health visitor should do a home visit right after midwife has discharged a woman and a baby, usually at the 11th day after the baby is born. However, these statutory visits are not the only home visits that are done.

In Scotland, there seems to be also some variation in local practices in the number and timing of home visits. In Lochend both community midwives and health visitors seem to do slightly more visiting than in Strathdee. The main difference was in home visiting during the pregnancy. In Lochend a home visit was undertaken in most cases, whereas in Strathdee visiting during the pregnancy was more exceptional and selective. There are no clear reasons for the differences in antenatal home visiting. The recent CRAG/SCOTMEG Working Group on Maternity Services report for antenatal care (Antenatal care 1994) mentions reasons for and against different locations of antenatal care. It recommends home visits in isolated areas and because of social circumstances, like the lack of transport and premises available for clinical work, because of particular individual needs, and when there is need for convenience and reassurance. Reasons given against home visiting were resource and safety implications, increasing numbers of (unnecessary) visits, and finally because home visiting could encourage isolation and may be overprotective. (Ibid. 52.)

Even if there are schedules of how often pregnant women or young children should be seen, both midwives and health visitors in Scotland were quite unwilling to give any kind of routine schedules for their home visiting. Instead, they stated that visits are done according to individual needs of the client and according to their own professional judgement.

INT: Do you have a certain schedule how often you visit?

HV: Some of it is dictated by when assessments are due, there has to be assessments at certain periods, so that does dictate. If I was concerned especially new children, new babies, if I felt I was really concerned that the mother or the father there was some real difficulty about the care of the child I would go back probably within a week and that would be really very much up to myself. If everything was okay I would try, after I first visit the child, I would try and go back within about two weeks to see how the family were doing anyway and then the 6 week assessment. If I was concerned about it then I would go back sooner than that. If not then I would try and go at 6 weeks, I would like to try and go again about 3 - 4 months, ... Then I would really just basically be the screening times, the two years and then the GPs do the one at 3 years and then we would do the one at four years or else if a parent requested a visit.

Scottish health visitor 7

HV: Well, by right we only have one compulsory visit and that is the notification visit. After that each health visitor interprets it differently and I do more really intensive visiting that some folks but that is merely because of my training. I am trained such a long time ago, though I had refresher since then, but the fact that I also believe in how input has a lot in helping the parents to cope, not only in coping but I believe in optimum health for the children and in a way is the future generation and to me a lot of investment in this generation, in this age group, is in the long term very, very beneficial.....

INT: How often do you visit then, or does it depend on the family?

HV: Well, a bit of both. I have a regular, my own strategy of visiting, or plan of visiting. (She is explaining that) So that's the kind of pattern I would do but if it's families with problems, social problems, single parents, marital problems, in between hopefully we will establish a relationship that they can, you know, call upon you in between, or you can hear from referrals from primary health care team or the GP or whatever, you would then go and visit more often. ... So the pattern is there but then I think I can put on top extra visit depending on the needs, so that's my initial visiting pattern.

Scottish health visitor 1

Midwives often pointed out the statutory requirement to do postnatal home visits, but even then they emphasised the individual needs of the clients and their flexibility according to clients' needs and wishes.

INT: Do you think it is important to visit them as often postnatally as you do now, almost every day?

MW: Well, we don't, and yes we do certainly visit every day until up to and including day six and then we can stagger the visits so then we visit day eight and day ten if that lady wishes us to visit, she feels she has a need. For some ladies who lack confidence, they need a lot of reassurance and they are just not happy to have a free day where nobody is coming in. They like the idea that somebody is going to come in. They think it is a wonderful system, and if they think it is a wonderful system and they need it then fine. Then there are other ladies who are quite sure. They don't need that amount of care, those are the ones that certainly get the staggered visits after day six. Some can possibly even get staggered visits before day six, if they are well and the baby is well and they are going along quite confidently. But it is a statutory obligation of midwives in Britain to visit until the 10th postnatal day and until that is changed then we go in but I have certainly come across a lot of ladies who could have been well stopped visiting long before the 10th postnatal day and others who needed visiting – I had a girl who I visited until day 20 and I really needed to wean her off the visits because she just wasn't ready, she wasn't confident.

Scottish midwife 4

We tend to visit, it tends to be we cater for the individual needs. If the woman needs a visit daily we will do one. If we think she is coping well or she personally wants less visits, requests it but we find that women with their first baby, it tends to be daily but a woman who has had one or two babies they don't need you as much and they are quite happy to let you miss them which gives you more time to spend with those who need it. It does tend to be individual need basis. It has to be on the needs of the woman and you cannot do that until you have seen them.

Scottish midwife 7

Flexibility in visiting schedules is also recommended in official reports on maternity care: “For some women, after the first few days at home, it will be enough to know that they can contact their midwife for advice or a visit if they are concerned about themselves or their babies. For others, the visits of a familiar midwife, and their GP, in the period up to 28 days after the birth of their babies will be essential to build confidence of their own abilities. Patterns of care must also provide for a smooth transition from the care of midwives to health visitors. It will usually be appropriate to discuss with the mother how and when, within the 10-28 day period, she would prefer the transfer of main support from the midwife to her health visitor to take place.” (Department of Health 1993, 32)

In spite of the strong emphasis on 'individual needs', most women were visited routinely according to a fixed schedule. 'Individual needs' of a client were very much interpreted by professionals not by women themselves. Home visiting is not done on a contractual basis. Even if, especially in maternity care, the principle of 'customer's choice', is very much expressed today and women are asked about what services they want, the 'choice' does not include home visiting. Women are given some choice only if, according to professional judgement, they can be given the choice without risking their own or the child's health and well-being.

Midwives and health visitors in Scotland also did so called 'defaulter' visits. This was the most controlling aspect in home visiting. These were visits that were done, if the client had not attended the clinic. In the Scottish clinics, both in maternity care and in child health care, it was quite common, and even almost expected, for some clients not to keep their appointments. In maternity care defaulting has been seen as a serious problem (Reid 1983; Porter & Macintyre 1991). Midwives tried to trace these women by doing home visits and if they managed to find them at home, they also made very clear that they want them to come to the clinic for more thorough examination, to see the doctor, or for the ultrasound scan. In these cases midwives often acted on behalf of the doctors who are the medical authorities of maternity care⁴.

On some occasions professionals tried to hide the controlling aspect of defaulter home visits from the clients, for example by not visiting right after the appointment where the client hadn't attended.

Health visitor is waiting for the next client. She tells me that this is really a problem family (telling about the problems). This is already the second appointment, last week they didn't arrive. The mother had phoned her afterwards explaining the reason, why they couldn't come. However, health visitor has talked with their social worker, and

⁴About defaulting see more in Chapter 9

found out that the reason the mother gave her, couldn't be the real reason. They didn't arrive this time either. Health visitor says that she has to go and see them at home, but not today, because then the woman only has to tell her more lies. She told she maybe goes tomorrow, when she has another home visit to do at the same area.

Lochend field notes 28

In Finland defaulting has not been seen as a problem. Instead, there has often been praise from the health care experts for the high attendance at maternity and child health services. Women have very much accepted the expert view that professional surveillance of pregnancy and child development is beneficial, or at least, that they have a kind of a moral obligation to attend the health centre for regular check-ups.

In both countries maternity and child health services can be described as supply- rather than demand-driven services. Services are offered whether they are requested or not (Heritage & Sefi 1992). This is even more the case in Scotland where home visiting is undertaken whether or not required by the clients. The principle of universal visiting can also hide the fact that some clients are visited more often and for a more controlling purpose than others. As long as visiting is universal, it is generally seen as legitimate and its purposes and benefits are rarely questioned.

Access to home

Both Finnish and Scottish health professionals see themselves as welcomed visitors to clients' homes. Other kinds of experiences are described as rare exceptions. Still, there is a difference in how they understand their access to clients' homes. Finnish professionals stated strongly that they only visit if the visit is agreed with the client:

And nowadays health nurses are actually the only officials who are welcomed to the home, and expected. They are disappointed, if for some reason, you don't have time to visit them. And the first meeting there at home when you are there on their conditions,

and with their permission, it creates the ground for the future.

Finnish health nurse A

In Scotland health professionals emphasised not only clients' willingness to have home visits but also their professional or even legal obligation to visit, whether or not they are wanted by the clients.

There aren't many who won't let us into their homes. They know who we are and they know what we are doing so that they are quite willing to let us in. Obviously there are sometimes a patient who doesn't like me very much but then I may not like her very much, or she may not like but then they really never refuse you entry.

Scottish midwife 3

Most people are quite happy to have you in the house but every now and then you do get the distinct feeling that this woman would rather you weren't there. It is not that they don't have choice about postnatal (visits), it is on offer just now, so everybody gets it, but we do more selective visiting. So if I go into a house, I had a situation recently where the woman wasn't in for the first date, or the second, I found her on the third and it appeared to be an absolute nuisance for her to be in. So I just had nothing until day 10 and we agreed that I would miss her with the understanding she would phone the hospital if there was a problem. So she got two visits, other people can get six. I was able to do that because she was well and her baby was well, if there was a problem then that wouldn't have been an option but she was an experienced mother and I think she just saw my input as a waste of time. So all I did was to fulfil the statutory legal requirement.

Scottish midwife 5

There is also a difference in the ways home visits are arranged. In Tehtaala midwives and public health nurses organised the home visits in advance, whenever it was possible, by phoning the client and arranging the time for the visit. In Strathdee and Lochend clients were often informed about the visit by phoning or sending them a letter in advance or by arranging the next time during the visit, but it was also very common for midwives or health visitors to just 'pop in'. It is not unusual to visit without making an appointment in advance. If the door was opened, no refusal was expected. The people who came to open the door, also never asked for a specific reason for the visit or for any con-

firmation of identity. As Dingwall and Robinson (1990) also noticed, there was no attempt to 'sell' the visit or to give a specific reason for it.

Graham Allan (1989) has studied, how boundaries around the home are controlled and maintained, how the status of 'insider' or 'outsider' is defined. He has looked at three groups of 'outsiders': kin, neighbours and friends, but doesn't mention anything about professionals. According to Allan, there is variation according to, for example, social class and gender, but in general in the British culture kin have privileged access to one's home, neighbours are kept in friendly distance, and friends are usually invited into the home. However, according to Allan, only among close friends do visits occur without invitation. Entering without forewarning indicates a high level of mutual trust.

There is very little research on how clients themselves find home visiting. Berry Mayall and Marie-Claude Foster (1989) studied different views of child care between mothers and health visitors. They found that although mothers accepted the principle of surveillance, this did not mean that they accepted the 'surprise' visit. Health visitors talked of 'dropping in' and 'popping in', but the ('surprise') visits looked to many mothers more like an inspection of their child care standards. Alison Bowes and Teresa Meehan Domokos (1998) who have studied health visitors' work in multi-ethnic society in Glasgow, among Pakistani and white women, have made an interesting notion: According to their research: "The appreciation of home visits was especially marked for Pakistani women ... Nearly all negative comment on health visitors came from white women, who referred to health visitors who had acted, as they saw it, autocratically or threateningly, leading to worries that their children might be removed." Bowes and Domokos, unlike many other researchers (e.g. Abbott & Sapsford 1990; Heritage & Sefi 1992), emphasise the supportive aspects of home visiting for women.

Differences between the two countries are also visible in the ways in which health professionals saw my access to their clients' homes. In Finland it was very important for

them that clients had been informed in advance and given their permission. I did very few home visits in Tehtaala, not because clients refused but because professionals were unwilling to take me with them. They made excuses for not taking me for home visits. Even if they did not question their own access to people's homes, they saw me as an outsider whose access they regulated in order to protect their clients' privacy.

In Scotland community midwives and health visitors had no objections to my coming along on home visits, being with them, I had the same access to clients' homes as they had⁵. This time it was me who found it confusing and difficult to enter into people's homes so easily. For me it was a difficult ethical dilemma: On the one hand home visiting was an essential part of the professional practices I was studying. On the other hand I had the feeling that I was intervening in people's privacy without their permission. I was very much aware that clients did not have a real choice about my visit. There was also more than that: I had an unpleasant feeling of being an outsider and intruder. Because of my cultural background I defined home as a private domain, and I realised that I wouldn't have wanted health professionals, or a researcher, entering my home with no advance notice and without my permission.

Some of the Finnish health professionals also told me about their discomfort in relation to visiting clients' homes. They saw themselves as exceptions, as 'the only officials, who have this right of access to people's homes' (health nurse A) Some of them described the difficulties and contradictory feelings they themselves had about what they saw, to some extent, as an intrusion.

⁵There were only two occasions, where they said that they would rather do the visit alone Both situations were somehow exceptional and I understood the reasons of their refusal. In the first one of them the baby had died and in the other the midwife told me the woman had a postnatal depression. There were some other occasions, however, where I was involved in very delicate and difficult discussions during the home visits including two occasions when the woman had just had a miscarriage and was very upset.

Home visiting can be very rewarding. But somehow it is also stressful, it takes strength. It is also somehow difficult to go into somebody's home. I haven't really find out why... is it only my own feeling, or why it is sometimes difficult. I have been thinking, that maybe it is easier for me to visit an ordinary, simple home, but it is more difficult to knock on 'a golden gate'. I do have these families in my area, who are economically very well of. But I have also noticed that there is quite an ordinary family in the middle of all that luxury, who maybe needs advice in very simple everyday matters. ... But for me an ordinary home is much easier to go into. I think that these ordinary mothers also more openly show their feelings, their happiness about the baby. They want to show you if they have something new in the house, and that sort of ordinary things. And then we just sit there and talk, it's so natural. And we can talk about husband's work and how the older children are doing at school, and things like that. Quite often if the children are at home, I go and ask them how is it going, and how do they like their little sister or brother. ... But then in other places, if it's more formal, it's not that easy anymore, and then it can be quite hard.

Finnish midwife E

Silva Tedre (1995; also 1997) has studied home care for elderly people in Finland by observing the work of home helpers. She writes about ethical issues of going into someone's home as a researcher and describes her contradictory feelings in the situation. She went in with home helpers, whom clients knew in advance, and who also arranged her access. There were different ways of requesting access. The way used depended on the relationship home helper had with her client. If the relationship was distant and formal, access was asked in advance, but if it was close and personal, such formalities did not occur. According to Tedre clients regulated the distance and formality of the relationship both with the researcher and with the home helper.

The clients' different expectations, according to Tedre, based on their different social and cultural experiences. She goes back to her childhood memories in Finland in the 1950s where two different cultures lived side by side in a small industrial community. Middle-class families kept their distance from the neighbours, all visits were planned and arranged in advance, whereas in working class families the front door was often open and neighbours just popped in for a chat. According to Tedre, the old working

class, and from my own childhood experiences also the agrarian, lifestyle has very much disappeared in the modern Finland, even if it still exists among the older generation. The dominant modern lifestyle in Finland, however, is nuclear family centred, private, and very much closed to outsiders.

It could be argued that in Finland, privacy of the home and insiders' right to control the access are strong cultural norms, which are also recognised in the health service provision. Another reason for the health professionals not to enter into people's homes might well be a more bureaucratic style of service provision where professionals do not 'bother' leaving their offices. This does not mean, however, that the Finnish, health professionals are less interested in what is going on within the home walls of their clients. It only means that their ways of trying to find it out are different from their Scottish colleagues.

Professional meanings of the home

Although home visiting plays a different part in maternity and child health care work in Finland and Scotland, in both countries professionals see it as an important part of the work. Also, the reasons why home visiting and getting to know the clients home environment are seen as beneficial are quite similar. First, home is a place, where they find it easier to build up a close relationship with the client, and second, to observe the interaction between family members in their own environment. It is also important for them to get to know the physical environment more widely, not only the house itself but also the surrounding area.

Home as a physical environment

One reason for visiting clients at home is to see the physical environment of the home and the area where they live. The home as a physical space is important first, to direct the advice according to individual circumstances, and second, to use it as a 'key' to finding out about problems in the family.

Women continue to be held responsible for the home. According to Moira Munro and Ruth Madigan (1993) for mothers with small children it is often difficult to maintain appropriate standards of tidiness, which could force them to retreat from socialising with all except very close friends and family and people in similar circumstances who 'know what it's like'. Health professionals want to see the home exactly as it is normally like, not cleaned and tidied for their visit. Mothers also seem to accept them as persons who know 'what it's like' with small children.

Even within the home some areas are more private than the others. The living room is usually the most public place in the home, the place where visitors are invited. However, health professionals have access to almost all parts of the house. They might examine the woman and baby in the bedroom or wash their hands in the bathroom or in the kitchen. It gives them an opportunity to see the whole house. Hardly any place is hidden from them.

Some of the advice professionals give during the visits deals with the home environment. The main topic of advice in this respect is concerned with home safety: what parents (mothers) should do to make the home a safe place for the children.

I have been working in this area for a long time, so I know already from the address what kind of a house is it, is it a flat, a terrace house or a detached house. But still, if I haven't visited there, it takes longer to really get to know that family. And when this work is mainly advice giving, it is much easier for me to direct the advice properly when I know

the address. You know the places, where they wash, sleep and where the children play. You know the yard, is it maybe dangerous for the children to play, or is there dangers in the house, or the heating, and several other things. Finnish health nurse A

Historically, especially in Britain, one of the main reasons for health visiting has been to inspect the conditions of working class homes and to teach mothers better hygiene. Poor hygiene conditions were seen, at the turn of the century, as the main reason for high infant mortality. (Dingwall 1977; Davies 1988.) Even today, during the home visits such issues as sterilising equipment, washing up the bottles, importance of fresh air and proper room temperature for the baby, were taken up as topics of advice by the health professionals. However, dirtiness and the hygienic conditions of the home were never mentioned directly. This doesn't mean, however, that these things were not noticed by the health professionals. After the visits, they sometimes made comments like "These parents are maybe not too hygienic and that could be the reason for the thrush in baby's mouth." (Lochend field notes 5) or "In a clean house like that, I don't worry about such things. The equipment will be clean enough. (The mother herself had asked during the visit, what is the proper way to clean the bottles)" (Strathdee field notes 25).

It seems to be a contradictory and a delicate issue, if and in what ways professionals could and should intervene in hygienic standards of the home. They see this kind of an inspection belonging more to history rather than to modern style home visiting. Very few of them even mentioned it in the interview. The following quotation from one of the community midwives is very much an exception:

We have to watch the state of the house because if the house is dirty, unkept and the baby is going into that environment, obviously we have to work a lot harder in getting things up to scratch for this baby to go into. It is not easy to do that because it is their home and you can't sort of dictate to them, but we visit them a bit more often and just try and get to know them and that they get to trust you and maybe each visit saying how about maybe trying this and trying that, tidy up the house a wee bit, just general hints on how to prevent infection, hygiene things like that. Scottish midwife 5

Tidiness of the home is not only a question of hygiene, but the outlook of the home can also act as a sign of other deeper and more severe problems. Women are held responsible for the standards of cleanness at home. If they fail, it could be seen as a sign of carelessness, but especially just after child birth also as a possible sign of depression:

INT: Are they quite willing to talk with you about some special problems. How do you find that?

HV: Most of the girls will admit it to me, most of the girls will talk to me about it because I think they know me quite well because they have met me antenatally. Failing that you might find it out just by their general behaviour towards the baby by the sort of things they say to you when you go in to visit them. The way the house is, they are maybe somebody that's house has been nice and tidy and very organised and it gradually becomes more disorganised. Now, all right, there is a change because they have got a new baby there, there house is always a bit more disorganised but that is different from a girl that is starting to get apathetic and lose interest in her appearance and things around her house and I think you get signs like that when there are problems if they don't tell you themselves.

Scottish health visitor 6

Not only the home, but also the area can tell them about the problems clients might have. In Scotland, much more than in Finland, the physical environment is connected with people's lifestyle, health, and social situation (e.g. Reid 1983; Graham 1993). Areas are divided to deprived and affluent areas. For the health professionals visiting different areas, especially the most deprived ones, give more understanding of clients' problems and their connections to local social circumstances.

I was working in Craigs just at the time where a lot of the young families their children were growing up and there was a lot of trouble in that area at the time. I think it gave me an understanding of what it was like to be living in an outlying area of the city which I had never really been aware of before. Now where I am working I have much more variety, that was quite concentrated, the same type of housing but now it is much more of a variety of probably groups of people and I travel from quite deprived areas to areas which are probably very affluent, so it is a much wider range. It is probably more natural really rather than just having a concentration of just one type I would say.

Scottish health visitor 7

Local understanding can be important, especially when the environment health professionals live themselves is probably quite different. In Scotland, health professionals could be quite judgmental sometimes, blaming people about their circumstances, but they also had a good understanding of problems women with young children might meet in a deprived area. Much more than their Finnish colleagues, the Scottish professionals were aware of social problems, many of their clients met in their everyday life. It is another question if this kind of local knowledge can be achieved only by home visiting.

Home as the location of the authentic family

For the health professionals another important reason to do home visits is to see the woman, child, or the 'whole family' in their own environment, in the place that health professionals consider as the most 'natural' setting of the family, where they can observe how the clients 'really' are.

...and I think the family unit in a way crystallises there at their home. ... But for me it is an honour to go for a home visit. It is a kind of a highlight of your work, when you hold the baby in your arms, and you see her there at home in her own cradle or bed, and on her own clothes, and you realise that this baby has come to this home. There is so much ... something I can't even explain. Home visits are very rewarding.

Finnish midwife E

I don't like to lose contact with the home either. It is all very well bringing mums up to the clinic but at the same time I still like to get out to the home to see the family situation. ... Quite often when you visit at home you can see the whole family, other children and the partner and how the family all reacts, interacts as a family. How they behave in their partners presence and I feel you can gain quite a lot from doing a home visit. I don't like to lose that contact.

Scottish health visitor 4

I think it is of the ultimate importance that you see them at home. You have got to see them in their surroundings, that is where they are most comfortable, that is the baby's environment. That is where the family and the family activities take place, so that is the

best place to see them. You are on their territory if you like, you are a guest in their home and if you have known them beforehand and they are comfortable with you then the home is the place they are going to be most comfortable in, then they are more likely to confide in you and tell you if there are any problems and then you are then more likely able to assess for yourself what potential problems are going to be.

Scottish midwife 6

Seeing 'the family unit' doesn't necessarily mean meeting all the family members, even if, especially in Finland, 'family rhetoric' is very much used in maternity and child health care (Kuronen 1994a, 68-75)⁶. The most important thing for the health professionals in both countries was to see the mother and child, to be able to observe the mother's way of taking care of the child, and the interaction between them. In maternity care it is of course self-evident that the woman is the recipient of the services and the main target of advice and surveillance. Still, also in child health care professionals wanted to see the mother: it is not enough to see the child, or even the father, or some other adult, with the child. For many practical reasons, this was also usually the case, but during my data collection in Scotland, there was one exception where the mother repeatedly wasn't at home. This became a reason for special concern for the health visitor.

Health visitor tells me beforehand that one of the babies she is going to visit has just moved to her area. She hasn't seen the mother during the pregnancy, as they normally do, and when she has visited there after the baby was born, mother has been at home only once. Father has been at home alone with the baby. The baby is now six weeks old. She says that she would like to see the mother as well. She wonders what is going on there.

Also this time father is at home alone with the baby. Health visitor examines the baby and discusses with the father. So far the visit is very much like any routine visit, health visitor talks with the father very much as she would do with the mother, but then she changes the topic and asks, where the mother is. He answers something, I can't hear. Health visitor says to the father that he has to do quite a lot of baby sitting, does he

⁶What I mean by 'family rhetoric' is that the Finnish professionals, more often than their Scottish colleagues, talked about 'the family' as their client, even if it could be read between the lines that they actually meant the mother, or mother and child. The same rhetoric can also be found in official documents on maternity and child health services.

mind? Father says no, but he doesn't seem to be willing to talk more about that. Health visitor still keeps the conversation at the same topic, asks if the mother is all right, if she has had her 6 weeks postnatal check. Before she leaves she says that she is going to visit again next week and then she would like to meet the mother as well.

Afterwards in the car she still talks about mother not being at home. Especially, when it has happened several times now, she thinks it's quite strange.

Lochend field notes 5

In this case, although there did not seem to be any major problems in the way the baby was treated and cared for, he was looked after by his father, was healthy and well grown, health visitor insisted that she wanted to meet the mother and see for herself the way she cares for and interacts with the baby.

Especially during the first days and weeks after the baby is born, the need to visit is very much defined according to mother's ability to 'cope' with the baby. During the visits health professionals ask questions about very practical things in relation to caring for a baby, feeding, sleeping, crying. They also observe such things as, how the mother is handling the baby, how she interacts with the baby, how she herself looks like, does she look tired, pale, or if she has been crying. Very rarely there was a single concrete reason to make judgements whether or not mother was coping. Instead, it was more a question of general impression that she 'looks very confident' or that 'there might be something wrong'.

During the home visits, men were often out, or when at home they often stayed in another room⁷. Professionals did not make any effort to get them involved in the visit. The relationship between the woman and her partner only had secondary importance after the mother-child relationship, and observing the interaction between the father and child

⁷ In Finland fathers are maybe more often present during the home visits than in Scotland, because visits are mainly done right after the baby has been born, at the time when many of the fathers are on paternity leave.

was not mentioned at all. On a few occasions where men were active, dominated the situation and did most of the talking, professionals even tried to ignore them and to get women more involved.

Children, even more than adult members of the family, are culturally connected to home and family, and are seen and treated as dependent on adult family members, most often on their mothers (Alanen & Bardy 1990; Qvortrup 1995). Because children can't speak for themselves or demand services, children's health, development, and happiness are very much defined by observing them and using the parents as informants. It has often been assumed in child welfare work that the health professionals are the most important professionals to recognise problems in children's care and living environment. In child health care, especially in Britain, it has been constantly emphasised that home visiting is an effective way of finding or preventing problems.

According to Robert Dingwall and Kathleen Robinson (1990) there is an ideological shift going on in health visiting in the UK, according to which home visiting should be undertaken only by prior agreement with the client. They are critical of this kind of contractual orientation. For them it means the abandonment of the idea of universal services, and of people who are unable to speak for themselves, in this case children. It would mean that children are only seen at times and places chosen by the parents: "A child brought to a clinic can be cleaned, fed and dressed for the occasion. Any peculiarities in the child's behaviour can be attributed to the unfamiliarity of the setting. The point is not that parental care should routinely be treated as suspect, but that its inadequacies are most vulnerable to identification in the home. By treating the family as a self sufficient unit of autonomous individuals, this strategy ignores the abundant evidence of physical, economic, and cognitive inequality. Its effect is to give priority to the views of those, such as parents and especially men, who have political access to the process of defining social problems and legitimate responses, neglecting those, such as children and to a lesser extent, women, who do not." (Ibid. 269)

According to Dingwall and Robinson (1990) health professionals should act as advocates for children and women and bring their problems into the public arena, but they are able to do so only if they have access to people's homes. Meeting clients at home is very much based on an assumption that outside the home people present themselves and hide their real self behind 'the public face', whereas at home they can't hide what they 'really' are, or they have no need to do so. Professionals want to find out, what is 'really' going on in the family. It could be argued, however, that also at home people always present themselves, that there is no such thing as the authentic self (Goffman 1990)⁸. It can be also asked, why shouldn't people have the right to present themselves outside the home, or even in front of the visitors in their own homes.

Conclusions - Home as a non-clinical setting

Regarding the settings of service provision the difference between Scotland and Finland is quite clear. In Finland maternity and child health work is mainly done in small community based units, whereas in Scotland it is much more based on home visiting, and in maternity care also on hospital based services. Also the way in which health professionals describe the settings is different. In both countries professionals emphasise the 'home' as an ideal setting to meet the client and to get to know the 'whole family', and to talk in a peaceful, relaxed atmosphere. But for the Finnish professionals home visiting is merely an addition to their ordinary way of working, meeting clients at the health centre,

⁸Jaber Gubrium and James Holstein (1987; 1990) have criticised, in the context of family research, that also researchers share the ideal of finding the authentic family, which is situated only in private sphere, physically at home. Methodologically this has meant that to do family research, researcher should go to 'real' families, meet 'real' family members, ideally in their own homes. It has been difficult, however, to fulfil this ideal because of the private image of the family. Instead, they are arguing, that there is no 'authentic' family, which researcher could reveal, but it is always contextual, and family research can be done, wherever family becomes topical, where it is discussed and negotiated.

whereas in Scotland it is a much more essential part of their work. The Scottish professionals also very much place the clinic and the home against each other as settings of care, whereas their Finnish colleagues do not see the same kind of a contrast between them. In that respect the whole logic of work is different.

For the Scottish midwives and health visitors the client's home is something the 'clinic', an institutional setting, can never be:

I have been thinking about that recently because now that we have got these new (child assessment) forms to fill in ... you see one of the things is too to really do a thorough assessment (in the clinic) if you want a real weight chart, weight and height. We are trying to get the equipment to take out to the houses, but it would mean bringing them in. It is funny I was thinking about it and I was just thinking that you do lose something with home visiting, I think probably because you are actually in the family's home you are a visitor and I think sometimes the parents are maybe a bit more relaxed. You also see how the children react even if it is still only a one visit you see very much more easily how the child is in their own home situation. Whereas coming in here it is quite a strange, ...and I think you are sitting in a waiting room and you are waiting for people outside, there is more pressure on you... Whereas if you are in a home situation, I think probably it is more relaxing and more helpful towards the parents. That is the benefit I probably see from home visiting although I think too sometimes to really get a real clinical assessment done it is better, I think, it has to be carried out in a more clinical setting. I think you see the interaction better in the home. It is a difficult thing to gauge the actual benefits whether there are benefits.

Scottish health visitor 7

They are different in their own home than they are quite often when they come to the clinic or the hospital because you are putting them in a clinical setting and most of us are the same, the minute we step into a hospital, there is that slight feeling of fear, all these white coats and machinery. So you remove that when you visit them at home, so you are seeing them on their territory and I think you are really getting to know them as they are in the comfort of their own home. Once you know that person then when they come to see you in the clinic it is different, it is just a different atmosphere and I think to constantly see someone in a clinical environment all the time, I don't think you would really get to know the real person because that element of fear is not removed in the clinical setting, whereas in their own home, that is their domain, you are a visitor to them now

and they are on their territory and you really get to know them quite nicely.

Scottish midwife 4

Coming to clinic is one issue but not as important as home visits. So I think maybe that's the difference, you see, because they feel we can't ... they must make an effort, present themselves nice, get the baby dressed beautifully, they come all dressed up, but you never know what's happening, do you know.

Scottish health visitor 1

Meeting in the clinic is described as busy, technical, formal and frightening to the clients, whereas at home, according to the professionals, the environment makes the atmosphere relaxed and informal. Clinic work is also described as more routine like and more focused on examinations, tests and assessments, whereas at home 'getting to know the client', talk and interaction, are seen as the most important features of the visit.

The way in which the Scottish professionals discuss the two settings is very similar to the recent discussion in social services and in health care, where the home is very much seen as opposite to institution, and home care as opposite to institutional care. Since the 1980s there has been an ideological shift, both in the UK and Finland, from institutional care to home or community based care, or to care in smaller 'home-like' units, which are seen as more human, allowing more respect and privacy, and 'normal' home life. This is the trend in all forms of institutional care, for example in old people's homes, psychiatric hospitals and children's homes. (Higgins 1989; also Forsberg et al 1991.) In maternity and child health care, there is, however, a long historical tradition of home based services in the UK. Preferring home visiting is not adaptation to the new ideal, but rather protection of the 'good old' tradition. Health professionals in Scotland are opposing the pressure to work more in the clinics, which has been seen by their employers as more effective way to provide services (Dingwall & Robinson 1990).

In Scotland, the heavy emphasis on the importance of home visiting could be seen as a critique of the clinical model of care. In the UK, especially the care of pregnant women,

and maternity care as a whole, has been criticised in several studies (e.g. Porter & Macintyre 1991; Oakley 1992). It has been argued that antenatal care provided by doctors, doesn't give women the information, social support and encouragement they want and need. Maureen Porter and Sally Macintyre (1991), for example, emphasise the features of medical training and of task-oriented specialist hospital clinics that render good doctor-patient communications difficult. In spite of their critique of the medical care, they remind us that it is important not to assume that because midwives, or women, are providing care, it will necessarily be better than that provided by doctors, or men. I would like to add that it shouldn't be assumed either that home based care is necessarily better than the services provided in an institutional setting.

Midwives and health visitors may distance themselves from the medical model of care, but they also see their own work differently in different settings. Midwives, and health visitors, blame the physical environment and organisation of the clinic, which does not allow them to give enough time to the clients, or for the clients to ask the questions they want to ask or to discuss their worries. For them home visiting and clinic work have their own separate logic or rationality.

INT: It (home visiting) takes a lot of time?

MW: I think you have to put that time in to get back what we are looking for, you have to put that time in because if we didn't you could just be anybody, anybody could do the clinics. You could have anybody being a caseload holder. It is what you bring as an individual to that caseload that is important, it is how you are as a person. Midwives are people's people. They are masters of small talk, making a conversation, finding out the information, reading between the lines and it is knowing how to do that is important. If we get back to clinics you could be obstetric nurses, but doing it at home is what makes us different.

Scottish midwife 2

Home visiting takes a great deal of time. It is not only that visits are usually longer than the time spent with each client in the clinic, but also driving from one place to another takes time. It wasn't exceptional for midwives and health visitors to drive 30-40 miles a

day, or even more. Still, they do not see it as a waste of time. Instead, they see it as giving time to the clients. It can be seen as part of the specific 'rationality' in care giving work. At the clinic they can meet more clients in shorter time and produce more results in numeric terms, but for them that means decreasing the quality of services, replacing quality with quantity. It is, however, important to notice that many of the home visits I observed in Scotland were very short and routine, lasting hardly more than ten minutes. On the other hand many of the meetings in the clinics, in both countries, contained much more than just routine tests and assessments.

Professionals often emphasised the benefits of home visiting to their clients, but they can be seen beneficial for themselves, and as representing their professional values. Home visiting allows them more flexibility to organise their work according their own criteria and priorities. It can also give them, maybe even more than their clients, an escape from the medical, hierarchical settings of hospitals and health centres.

Scottish professionals much more than their Finnish colleagues made the distinction between the home and the clinic. Even if Finnish professionals also saw home visits as different from clinic work, they never described clinic work in the same kind of negative terms. This is understandable, because it would have ruined the whole basis of their work. But this could also be because of the differences in the 'clinic' work and institutional settings in the two countries. Whereas in Scotland home visiting and clinical work seem to serve different purposes, home visiting is for discussion and advice giving and clinics for examinations and assessments, in the Finnish maternity and child health centres the two are more combined. In Finland, especially in maternity care, the distinction is made between 'medical' hospital based care and 'supportive' community based care in the health centres, rather than between clinic work and home visiting. Maternity and child health centres are not seen as medical clinics, but as 'advice centres'. Services are organised in a way, which allows a client to meet the same midwife or health nurse each time, which is not necessarily the case in Scotland. Professionals also allocate more time

for each client than in the Scottish clinics. The environment is perhaps more welcoming: it is often a small unit, separate from other health services, with toys for the children and plants on the window sills. It could be argued that in Finland the institutional setting has been made more 'home-like', to make it easy for the clients to attend and to talk openly. In Scotland home visits are done to escape the institutional setting, which is very much seen unchangeable, but also to reach clients who would not otherwise use the services. Health professionals discuss home visiting in positive terms, without questioning their access to people's homes, and ignoring the controlling aspects of home visiting. Home visiting is described as beneficial for the clients and as meeting their needs. This rhetoric legitimates the access to people's private sphere. Home visiting is also legitimated on the basis of the welfare of children, which is prioritised before the privacy of adult members of the household. It could be argued that in Finland there is perhaps a greater trust of parents, and their willingness to use services and to seek professional help and advice.

CHAPTER 6

WORKING WITH MOTHERS

When I started my data collection in Finland, in the first health centre in Tehtaala, something that impressed and surprised me was the relationship between health professionals and their clients. They seemed to know each other well, for example, they often called each other by their first names. From time to time they also discussed issues which had nothing to do with the actual purpose of the visit, like holiday plans, gardening, and once a client even mentioned the new hair style of the midwife. In most cases the relationship looked to me very relaxed and informal. I found this quite surprising because, based on my own experiences as a client in different health care settings and on feminist research on medical encounters between women and doctors (e.g. Oakley 1980; Roberts 1985; Macintyre 1985), I expected relationships to be more official and formal. What was even more surprising was that all this happened in a city rather than a small town or a village, where people are more likely to know each other. Later I was to find the same phenomenon in Scotland, in both villages and inner city area.

In this chapter I will discuss the relationship between clients and health professionals: what kind of meanings professionals gave to the relationship with the clients, and how they developed these relationships. I will also consider how my findings correspond to

feminist discussions about women as users and providers of health services, and about women in care work and in caring relations.

Relationships in care work

In feminist research caring is an important concept which is used to analyse women's work and its specific features.¹ The concept of caring is, however, defined and used somehow differently in the British and Finnish, or Nordic, feminist research (Anttonen 1997, 110-141; Simonen 1990, 18-28; Ungerson 1990). In the UK, feminist researchers have argued that the welfare state relies on women's informal care as wives, mothers and daughters. Accordingly, caring has been seen not so much as work, but as a specific, altruistic, personal relationship. Recently, this view has also been criticised. For example, according to Geraldine Lee-Treweek (1995) the contribution of care, including paid care, is still entangled with ideas of gender, informal care, and family roles, rather than with work and issues of occupational interests. According to Lee-Treweek, paid care should be understood as work first, and caring second. Also, power relations in care work between carers and cared for should be re-examined without assumptions about gendered notions of caring. (Lee-Treweek 1995, 5; see also O'Connor 1996, 17.) In Finland, care is, more often than in the UK, provided as paid work by female welfare state professionals. Accordingly, in feminist research caring is understood, not only as 'labour of love', but also as hard work with its own contradictions and conflicts. (E.g. Simonen 1990; Rauhala 1991; Metteri & Rauhala 1993; Tedre 1995; 1997).

¹ See also Chapter 1.

Even if care giving is recognised as work and not only as a personal, emotional relationship, it cannot be denied that the relationship with clients has been given a special meaning in care giving professions, and perhaps in women's work in general, whether or not it is classified as caring. For example, Riitta Järvinen (1993) who has studied female office workers, says that they pay much attention to the relationship with customers, even if they have no direct contact with them. They regard the relationship as important and understand their own work in terms of 'working with and for customers'. The knowledge that they are serving the customers also increases their work satisfaction. The same phenomenon can be found even at what could be seen as the other end of the professional scale, namely in the work of female lawyers (Silius 1992).

It is also important to recognise the specific features of different female caring professions. They differ in many respects, for example, in who the recipients of the services are, how dependent they are, where the work takes place, and how 'professionalised' the occupation is. Midwifery, health visiting and public health nursing can be defined as caring professions along with other female professions in the fields of health care and social services. They are closely linked with nursing which is maybe the 'ideal type' of professional caring. But unlike many other caring professionals, health visitors and public health nurses, and midwives who work in the community rather than in hospital, are rarely involved in the actual physical care of their clients². Instead, their work is based on communication, talk and interaction. Their relationship with the clients is a communicative rather than a physical, embodied relationship. Communication is a feature that

²They have of course a physical contact with their clients when they examine a pregnant woman or a child. In Scotland, unlike in Finland, community midwives also deliver babies either at home or in hospital.

characterises their work and which they emphasise themselves when talking about their work and their clients.

Being a professional friend

Health professionals emphasise the importance of the quality of the professional-client - relationship. Very often they stated that they wished to meet mothers as equals, not giving them orders but listening their needs and wishes. They described themselves as a 'listening ear', 'somebody to talk to', or even as 'a friend'. They also emphasised the importance of helping mothers to cope, giving emotional support, and building up their confidence.

I was visiting a girl today and I was in the house two hours, I didn't examine the woman, I was just talking to her. She was very upset and distressed and emotionally unstable and there was no way she would come out to a clinic if she had to, she just wouldn't bother, she would sit there being terribly unsure of herself. However, I know I was only there two hours and she has got another twenty two hours to cope by herself but at least she had someone to discuss her fears with for those two hours. I mean, there is no way I can visit her two hours every day, just today I happened to have more time.

Scottish midwife 7

'Getting to know each other' is defined as an ideal in the work. Continuity of care, meeting the same clients regularly, and having enough time for each visit, are seen as a condition which allow the relationship to develop. According to them it is different to work with somebody they know well; when they know client's background and her

tal, although that is not very common. What they emphasise more than physical contact and care, however, is the interaction with clients.

situation, her problems and needs. Some of them, for example, spoke about working with their 'own mums' compared with clients they only met occasionally. One of the Finnish midwives described the relationship in an almost 'poetic' way:

If I think about myself, I always try to approach the mothers at the same level, to act as one human being by the side of another human being. And I think, to be honest, that it is a privilege to travel along with this mother on this journey where she is expecting a baby and will give birth. Often on this basis a kind of trust will develop. That is the basic thing. When you have a lot of clients, when you get busy, there are of course moments of exhaustion, and then you realise that in this job you shouldn't ... that you should remember that every mother is just as important and you should have the strength to travel with her. There is nothing extraordinary in this, but this is the basis from which I start. Then, I've always wished I could have a sort of a sixth sense which would stop and make me listen so that I could leave the other things a little bit behind and just listen to what the worries and thoughts of the mother might be. There is so much emotional sharing in this work, we share the sorrow if there is something wrong, or the joy. I feel that what is most rewarding in this work is sharing the experience and indeed, the sharing. It's also exhausting, but at the end, that's what's most rewarding, that you get so close to the most important period in people's life.

Finnish midwife E

Others were maybe more prosaic and sparing with their words, but the message was still very much the same, emphasising the meaning and importance of the relationship with clients:

That we are equal in that situation, that the health nurse is not a person who tells the family what they should do, but that we start from the family's wishes and needs and that we are in the same position, in the same situation, in a way. Trust, honesty, sincerity, a genuine encounter (are important - mk).

Finnish health nurse J

You know them well, they are not just strangers and you know their needs because you have met them prenatally and you have discussed a lot of issues they are concerned about, so you are more aware of their needs and you tend to think: right, I know that this

particular women is very anxious about this; so you tend to think: I must go in today, tomorrow and see how she is doing. Whereas a complete stranger you don't know her needs, so you are not aware of them. And it is so much easier to visit a women that you have met before and have a good rapport with them than a complete stranger because she knows you, she feels comfortable with you and she will disclose more. Whereas a complete stranger won't.

Scottish midwife 7

We are there for them and then they will tell you gradually and through the years, and that's why, in a way, I felt better when working in Muirpark ... up to nine years, because I wasn't just a health visitor, I was their friend and I still see the folks and they still talk to me and they must tell me, like the continuing saga of their life. They still say, guess what's happened blah, blah, blah, and they will tell me the child having their teeth or their first walk and everything, because I have left them, but they still want to keep me in touch with what continuing life they have and it's fantastic because people trust you and, you know, consider you as so important, like you having your own family and they tell your friends or your parents, you know, my child's first smile, her first tooth, her first walk, first word and they want to do that with you too.

Scottish health visitor 1

Finnish professionals, more than their Scottish colleagues, saw the relationship with clients as a private and intimate relationship which they wanted to protect from outsiders. For them, clients were even more their 'own' clients. They described the relationship at it's best by using terms like 'close', 'confidential', 'unique', or even 'sacred'. The protection of the relationship became topical already when I negotiated access for my research. At the beginning health professionals in Tehtaala opposed the idea that I would observe their work, and the main argument was that the presence of an 'outsider' would disturb their relationship with clients³. In what follows a Finnish health nurse commented on the methods of my research, and also described how she saw the relationship with her clients:

³See also Chapter 3.

If I think about you, I mean, when you are doing research... so as not to get the wrong conclusions, it would be important, if it would be possible, of course it isn't but ... if you could stay with the same client all these seven years. If you could go through with them all the storms and still waters. The one visit which you have seen might be just routine. But before that there might have been all sorts of questions and again, let's say after one year, there could happen whatever. We won't take the most difficult problems up in every visit if the client herself don't want to talk about them, if there is no need for that. In that way you would get a better picture, during all those years. Or if it would be possible that the same client would allow you to be present every time when she comes here, but of course, in that case ... The relationship always suffers if there is an outsider, whether it is a student or a researcher.

Finnish health nurse A

Finnish professionals emphasised the privacy of the situation whereas their Scottish colleagues saw the physical environment as more important for building up a good relationship. For them the client's home was the best environment in which to achieve a good relationship and to allow clients to talk, because it is a the woman's own 'territory'⁴. Home is, of course, a private environment and in that sense gives more privacy for the relationship. However, Scottish professionals never suggested that the presence of other people would disturb the relationship. In Scotland, especially health visitors, many of whom had former experience of working on a geographical basis instead of being GP attached⁵, also emphasised the importance of knowing the area and 'being part of the community'.

INT: You seem to know this area and the people here.

HV: It is very rewarding, very enjoyable being in a small village because people get to know you and you know them. You know the extended family and the clinic is very easily accessible and people do use the facilities here. They see your car in the car park, they know you are in, so they will come in asking for a variety of advice.

Scottish health visitor 4

⁴See also Chapter 5.

⁵One of them was still working on a geographical basis, but all the other health visitors were GP attached.

I had a very compact area. You became part of the community and you were known within the community. This is different now. I always just think there are things for and against both. This way you are working close with the GPs, you are not so well known in the area as you were, I suppose looking back there is quite a lot to be said actually for being part of the community and being based in a small area, I think there is probably a lot to be said.

Scottish health visitor 7

It can be argued then that the main difference between Finnish and Scottish health professionals is that as a basis for a good relationship the Finnish professionals emphasise privacy whereas the Scottish professionals emphasise knowing their clients, their life situation and the environment they are living in.

There was also a slight difference, not only between professionals in the two countries in how they define the relationship with their clients, but also between health visitors and public health nurses on the one hand and midwives on the other. Midwives see their clients for a more limited period of time, about seven or eight months, and possibly again in the next pregnancy. Public health nurses in child health services in Finland, and even more so health visitors in Scotland, have a much longer relationship with their clients because they see the children from birth through to school age. In Scotland, health visitors are also involved in the provision of health services for other age groups, which, at least in principle, allows them to get to know 'the whole family' over many years or, in some cases, even several generations of the same family. Still, in terms of how they understood the importance of a good relationship with their clients there were more similarities than differences between the professions within and between the countries. All tended to define themselves as professional 'friends' with whom women can talk and share their joys and worries.

Openness as a feminine characteristic?

All the health professionals shared the view that their female clients were willing to talk to them and to seek help with their problems.

INT: I have noticed that they (clients - mk) are quite often quite willing to talk to you .

HV: Yes, they are, you find in this area particularly they are. You maybe go into a house to do just an ordinary visit and a routine assessment and you will go in and they will hit you with all sorts of things and you come out and you are going, what is going on here. What was maybe a totally normal routine visit has turned out to be a crisis. So I think I am fortunate in a way that I have been in this practice, that I have worked here for a long time, and a lot of the mothers I am seeing I know quite well and they just phone me up or they say, right can you come out and see me, I have got a problem or I am worried about the child's speech or I am worried about the child not eating or bed wetting or something like that. So they are good at letting you know if there is anything ... They can be very open with a lot of things, a lot of personal things. In some ways that it is good that they can talk. Sometimes you just need somebody to talk to and maybe once they have talked to you they feel a wee bit better, it is just that they haven't got anybody to talk to and when you go in you are the sounding board so to speak and maybe that is all they wanted, just somebody to talk to.

Scottish health visitor 8

If you give them a chance, information, not information but chance and opportunity to talk very often and it's in a way the trust that they have in you and the way you are very, should I say, honoured to be in that position ... confidential information. It gives you a better all round picture of how their health is proceeding. Sometimes just by talking to you they feel that somebody else is listening and they're talking aloud, sharing the problem, that helps because it doesn't go any further you know and we have laughs sometime and we compare notes about different husbands and lot of them say that men do this and then we will have a laugh and talk about it and in some ways you know they will feel other people is worse than me. ... Yes, it's a privileged position, at the same time a very onerous one because you've got to listen, actively listen, not just something that just... It is also very tiring, listening, actively listening and picking up the cues, things whether they want you to do something, or things they just want you to, tell you and share it, you know.

Scottish health visitor 1

It has been argued that women, not only female professionals but women in general, have better interpersonal communication skills than men, that it is easier and more 'natural' for women to talk about personal matters and to seek help and try to solve their personal problems by talking either to their friends or to professionals. For example Janet Finch (1984) argues, in connection with feminist research interviews, that there are no difficulties in getting a woman to talk to another woman. According to Finch, women are more used to accepting questioning about private parts of their lives. Secondly, in a woman's own home where research interviews - and in Scotland also health care work - often take place, an intimate relationship very easily develops, if the interviewer is acting as a friendly guest. Finally, according to Finch, the isolation and loneliness of many women in the domestic sphere makes them willing to talk to a sympathetic listener.

In feminist discussions the relationship between two women, as a professional and a client, is often seen as more equal and less hierarchical than between a male professional and a female client. This has been a strong argument, for example, in the discussion about feminist social work (Brook & Davis 1985; Hanmer & Statham 1988; Dominelli & McLeod 1989; Philipson 1992; see also Forsberg et al. 1992) and in the feminist critique of the medical treatment of women (Ehrenreich & English 1978; Stanworth 1987; Oakley 1992) This has also been one of the reasons, either explicitly or implicitly, for the feminist demand for more midwife involvement in maternity services in the UK (Oakley 1992; Provision of Maternity Services in Scotland 1994; Antenatal care 1995). The argument is based on the assumption that there is something essential in the relationship between women, something that is based on their shared experience and understanding of women's everyday life.

In recent years, there has also been growing critique of this view and more emphasis has been placed on differences between women not only between women and men (e.g. Stanley & Wise 1993, 219-222). Some researchers (e.g. Eräsaari 1990; Korte 1989; Wise 1990) have shown that in professional practice it is a too idealised view to assume the shared interests and experiences of women. Even for professionals who have adopted feminist principles in their work, there could be situations where the principles collapse with the complex realities of their everyday work, for example in situations where the interests of women and children are contradictory (Wise 1990).

Health professionals define themselves as a 'mother's friend' and a welcomed visitor to whom women find it easy to talk. There are, however, distinct interpretations of this relationship. For example John Heritage and Sue Sefi (1992) suggest, after analysing the content of health visitors' home visits, that they were seen by the mothers more as 'baby experts' than as 'befrienders' with whom they can share problems that are not directly connected with problems of baby management. Robert Dingwall and Kathleen Robinson (1990) have also studied the content of health visitors' home visits. According to them: "If the health visitor were indeed purely a 'friend of the family', we would expect to find the interaction during her visits to approximate the form of a conversation, with both parties introducing topics and sharing responsibility for movement through the encounter. On the other hand, if the health visitor was 'an inspector', we would expect to find her tending to monopolise the encounter management, probably with long chains of questions as in other kinds of investigation. In practice, however, we find neither."

Instead they argue that the main objective of the modern home visit by health visitors is simply to visit.⁶

I find it problematic to provide only one interpretation of the relationship between health professionals and their clients (see also Bowes & Domokos 1998). Instead, I would suggest that there are a whole range of different encounters. During my data collection I came across very short visits where only the basic examinations were done. There were visits that reminded me of an inquiry, where the health professional was asking a long list of questions and getting very short answers. There were encounters which were relaxed, containing joking, laughing and chatting, and finally, there were visits where women told the professionals very delicate and intimate matters of their personal life. Quite often, however, any one encounter may include a combination of different elements. An equal, open, friendly relationship between professionals and their clients is the professional ideal, but this does not encompass the range of different encounters between them.

The friendly relationship as a professional technique

I would argue that the friendly relationship with clients is a professional technique rather than an expression of the feminine characteristics of either professionals or clients. Professionals are intentionally 'building up the relationship', and using it as a means to achieve their professional targets, to get women to take the advice, and to do what the

⁶ See also Chapter 5 about home visiting.

professionals consider is best for them and their children. A good relationship with a client is used as a resource to facilitate the task and to produce a successful outcome.

So I ... we do a lot of inservice training and one of the things I've learned is motivation or interviewing techniques, which I try very hard sometimes to put in place, and that is very effective for counselling purposes and we do that quite a lot, I should say I do that, I try to do that quite a lot. OK, sometimes you let it slip because you cannot be always so serious but most of the time I try to use that technique and you get through that way.

Scottish health visitor 1

Yes, because when you, you are the person that goes in to look after them postnatally, to give them advice on all aspects of postnatal care and the baby's well being, his care, her care and if they don't trust you they are not going to listen to one word you say. If you just go in on a one off basis as a stranger to each one of them, say on a system where a different person could go in all the time and there is no continuity of care, they don't take on board I don't think from that stranger all the time, what that stranger says, particularly if there is a problem that needs resolved and if it is a stranger that is giving you advice I think you are less inclined to take it from her than from somebody you have got to know and trust over a period of nine months.

Scottish midwife 4

The situation where health professionals and their clients meet is always an encounter in which the professional has more power to define the situation, when and where it takes place, to decide the topics, and to use the information she gets for her professional purposes. Health professionals have access to women's lives because of their profession, not because of their personal relationship.

In both countries, professionals expressed the importance of the first meeting with a new client as the basis on which relationship is founded. According to them first impressions are crucial. The very first meeting can also damage the relationship if they are not careful about what they say and how they approach the client.

I think the first thing is to appear as a friend regardless of anything else. If I am not appearing as a friend somebody could be frightened and then I am lost and I might just as well give up because it is that initial visit or the initial meeting, whether that is at the booking visit or at the health centre, but that is where they have their first impression of me and if that first impression isn't a good impression then the rest of their pregnancy is going to be coloured by that. So initially what I want to do is to try and put over a friendly personality, somebody that can be approached, that can be trusted and that they maybe feel silly about asking questions they might feel very silly asking and I am trying to give them as much information as they can cope with without bombarding them with information at that particular visit but making sure that they know how to contact me for any further information and giving them the literature to read that they can get up on things as they want to and then to contact me if they don't understand anything and that I will be seeing them at the health centre as well. But the first impression has to be one of friendliness.

Scottish midwife 1

No matter how busy you are, you should remember that when you speak with a new client for the first time over the phone, you should remember to congratulate her on the pregnancy, and all that kind of thing. The first contact, and when they come here for the first time, I introduce myself already there in the waiting room. The atmosphere during the first visit. If you haven't done the booking yourself, you'll notice that the client will remain more distant, you realise that you don't know her background.

Finnish midwife G

It is the very first contact. The first one is maybe when I meet the mother during the pregnancy there in the waiting room, when I don't even know her name or her address yet. Just by saying 'hello'. But the very first time you have to be careful what you say, to be natural, but to be careful what you say as well, not to hurt the family in any way. Because, especially a mother, who has just got a new baby, is at a very delicate stage. Sometimes you don't even realise, how important it is to support her and to be sympathetic. ... And it is, of course, just human that you can't be that friendly all the time. And it might just start from something, from a small detail, but then it's very difficult to correct the relationship anymore.

Finnish health nurse A

It is interesting how much emphasis professionals put on their personal qualities and behaviour, on how to represent themselves to the clients, especially when they meet for

the first time. Rather than defining themselves as experts in the fields of pregnancy, child birth, child health and development, they describe themselves as friendly people who are easy to approach and talk to⁷. That is how they legitimate their professional role in relation to their clients, as experts in interaction, talk and listening. For them building up the relationship is part of their professional skill, a method, which is very essential in their work.

Deviant cases - when friendliness is not enough

Even if there is variations between and even within the encounters between professionals and their female clients, I witnessed only very few cases in which the friendly atmosphere of the meeting was broken. These rare incidents are 'deviant cases' (Silverman 1989, 21-22) within my data which are worth a closer look. In Finland I came across one such case. In Scotland there were also very few such deviant cases.⁸ Even though they are rare, they are still important in emphasising the 'normal' procedure. All these cases are connected with similar kind of situations where women are seen as behaving irresponsibly and thus risking the baby's health or even her life.

⁷They are more likely to emphasise their expertise in relation to other professionals than in relation to the clients.

⁸ There were two of them which could clearly be identified as such and a few others that could have been included in this category. I will present the two cases later on in connection with smoking and drinking in pregnancy, in Chapter 7.

In my field notes I have described the Finnish case as follows:

The client is a young woman, 35 weeks pregnant, expecting her second baby. She had phoned the midwife this morning and cancelled her visit because of back pain. The midwife had asked her to come and see the doctor in the afternoon. She had visited the Hospital antenatal clinic some time ago, and they had wanted her to stay in the ward because of the risk of a premature birth. According to the doctor she had refused to stay. The doctor is discussing this with her and her style of speaking is quite strict. She says to her, for example: "You'll take the responsibility if something happens. Isn't that so?" Woman agrees. On the other hand the doctor comforts her, that things seem to be all right now, there is no acute danger of premature birth, and the baby is so well grown already, that it will have a good chance to survive, even if it's born at this stage.

After the woman had left, the midwife and the doctor still discussed her case. They are blaming her attitude. The midwife gives a concrete example, saying that they (the couple - mk) went on a long journey some time ago, even though the situation was like this. The doctor asks the midwife if she knows anything about the first child. She answers that according to the health nurse she is quite lively, and the mother doesn't really put any limits on her.

D: And these are the ones who become over-active and troublemakers.

MW: And of course they are going to have more babies.

D: Is this with the same father as the first one?

MW: Yes it is, but then there was this miscarriage, that was different. You remember, we were talking about it some time ago.

Tehtaala field notes 37

In this case it is the (female) doctor who takes the different strategy. During the visit the doctor is telling the woman very clearly that she is acting against medical advice and is responsible if something happens to her unborn baby. This is very unusual in a situation where client herself is present. Actually, the midwife forwards the difficult case to the doctor who is the medical expert and the authority in maternity care. It is a question of a medical problem, a risk of a premature birth, but what becomes defined as the 'real' problem both by the doctor and the midwife is that the woman has not followed medical advice and the instructions given to her both in the maternity centre and in hospital an-

tenatal clinic. After the woman has left, professionals evaluate her qualities as a mother and her family situation in a very moralistic way.

The case described here is exceptional. Usually, mothers were treated as caring and competent and their failures or mistakes were ignored. However, it was more common that clients were discussed differently, in a more problem oriented way, when they were not present themselves, even if the case discussed here is an extreme example.

Phil Strong (1979) has named this kind of professional conduct as 'character work' in contrast to 'face-work', which was normally used in encounters between doctors and mothers in paediatric consultations. According to him, "Unlike face-work this is only rarely used in encounters, for it does not concern the maintenance of a smooth surface appearance but involves the uncovering of a person's moral essence, a rather more tricky endeavour. That essence, or the everyday concept of character, refers to an assumed moral code, inherent within individuals and transcending any particular social occasion. Character on this account is what people 'really' are underneath it all. Whereas face-work attempts to preserve the ideal image that a person may present in any one encounter, character-work seeks to go behind this and explore the reality." (Ibid. 42.)

These exceptional deviant cases are then in contrast to the ways in which health professionals describe the relationship with clients and with the ordinary mode of their encounter. They show that when politeness and friendliness are not enough, more direct measures are used, but only as a last resort.

Mothers and others

All I have written so far about encounters between the health professionals and their clients describes encounters between two women. Women are the most important clients for the professionals. This is, of course, very understandable and almost too trivial to mention in relation to maternity care, which is very concretely concerned with women and women's pregnant bodies. But this is also the case in child health services where mothers are usually the ones who bring children to the health checks and who are seen during the home visits. Children are not held responsible for their own health and welfare. For young children it is also impossible to attend the health centres alone. It is the responsibility of the parents, primarily of the mothers, to look after them and to see that they remain healthy, well developing children (Graham 1979). It has also been discovered in several studies that in the social and health service settings where 'family work' is emphasised, 'family' is often equated with mother. Behind the 'family rhetoric', mothers are those who are expected to be seen and to act in cooperation with professionals (e.g. Cannan 1992; David 1984; Forsberg et al. 1994).

From time to time however, also others are met as clients in maternity and child health services; fathers, grandmothers, grandfathers on rare occasions, and of course, the children themselves. However, the friendly relationship described above is only actively built up with women, the mothers, and to some extent, with grandmothers, who were quite often seen in Scotland, but not in Finland, either in baby clinics or during the home visits.

Even if the whole system of maternity and child health care was originally created and developed in order to keep children alive and healthy, children have a very marginal position as clients. They might accompany their mothers to the maternity clinic and they were of course the objects of all the tests and examinations in child health care, but very rarely were they given the chance to speak for themselves. They were expected both by their parents and by the health professionals to pass the tests properly and to be cooperative enough to get everything done smoothly and on time. They were given a few nice words and a sort of 'baby talk', but their opinions or feelings were not seriously asked. (See also Davis 1982.)

In the new sociology of childhood, it has been argued that children are ignored as individuals with their rights and responsibilities. Instead, they are isolated in 'child institutions', such as the family, day care and school, and adults act as their representatives in the outside world. (See e.g. Alanen & Bardy 1990; Alanen 1992; Mayall 1994.) Priscilla Alderson (1994) has studied children, between 8 and 15 years of age, who were in hospital for orthopaedic surgery. She argues that children have no rights to either physical, mental or personal integrity in health services, or, for that matter, elsewhere in our society. For example, children are the group most subject to routine invasive investigations and interventions, such as immunisation, through child health surveillance programmes. (Alderson 1994.) The younger the children the more likely health professionals are to focus their communication on mothers rather than children themselves.

Men, the fathers, were met from time to time by the health professionals, but as clients they had a marginal importance. Men are adult individuals, but it can be argued that their role as clients in maternity and child health care correspond more closely to that of

children rather than of women. The relationship with male clients is either more complicated or less meaningful for the professionals than the highly valued relationship with women (Strong 1979, 40, 60-64). Professionals themselves also recognise the difference and explain it not only with their own attitudes and working practices, but also with the attitude of men:

INT: Do you find that the situation is different, if you have a mother with children here or a father with children, or if they come together?

HN: Yes, it's different.

INT: Could you explain in what way.

HN: I think it depends on the father quite a lot. Some of the fathers take part in the conversation, but some of them just stand there and watch what is done, so ... in a way it's quite nice.

INT: What about if the father comes alone with the child?

HN: It's somehow a little bit of a helpless situation. I just had one today, and somehow ... some things like baby feeding, that they could move on to different food ... that if it gets passed on ... I always got the feeling whether all these things will get passed on to the mother, but I guess they will. Somehow they (fathers -mk) are different, that they are not like... It's just quickly the immunisation and the scales, and then out. But it's nice, it's all right with the fathers as well.

Finnish health nurse B

In this extract fathers are described as by-standers or as 'messenger boys' to mothers, not as clients with whom a close, equal relationship is actively built. This was even more the case in Scotland than in Finland where, in recent years, more attention has been paid to 'new fatherhood' and 'shared parenthood', including fathers' participation in maternity and child health care⁹. Discussions about men as clients often occurred only because my active questioning about fathers' involvement, particularly in Scotland. As

⁹Later on, in Chapter 8, I will discuss more on men as fathers.

one of the health visitors said to me in her interview, she hadn't really paid much attention to the issue before:

INT: You are very much working with mothers and children, do you meet the fathers as well?

HV: Yes. Some of the fathers, there is quite a high rate of unemployment so I see quite a lot of the fathers in the houses. It is terrible because in some ways you are almost quite taken aback if the father is working in some areas, you really get quite sort of accepting of these facts that the fathers aren't working. Yes we see quite a lot of them, some of them are beginning to come to clinics and things like that. Sometimes we see them at the antenatal clinics but not very often, not very often at all. Yes, beginning to see the fathers more, some of them are taking much more of an interest and taking part in their child.

INT: Are you trying to encourage them somehow to participate more, or do you find it important?

HV: I don't think I do. That's true, no I don't, no I don't think I do. It is something that I maybe should because I think it is very important. I try when I go in, what I find is that when I go in on the first visit if the father is there, he seems to accept that this is really her role and he usually goes out of the way and usually try to say things like, if I am going over the immunisation, like would you come in this is something the two of you have to do. Very often I will say to the mother, if the father is not there before you sign this would you like to discuss it with your partner ,but that is true quite, often I don't really take into account the father, I should really. There maybe should be a way that we should try and incorporate them into the discussion more, I think it is very important.

Scottish health visitor 7

In concrete situations, men were very much left aside in both countries. Their secondary position could be seen most clearly when a couple came for an appointment together or when they were both at home during a home visit. The physical space of the clinics was often organised with only one client in mind.¹⁰ Often there were not enough chairs in the room, especially when I had occupied the only spare chair, and the man had to stand.

¹⁰ Even I found it extremely difficult to fit in and I was always on somebody's way wherever I sat.

Often men located themselves in the most distant corner of the room. Discussion took place mainly between the health professional and the woman. If they had children with them, it was often the father who looked after them, which allowed the mother to concentrate on the discussion. There were, however, some occasions where men were involved more, and as a minimum they were asked a few questions during the visit, such as 'Are you going to hospital with her?' or 'Have you found a name for the baby yet?'. In maternity care, one of the special moments for men was listening to the heart beat of the foetus, which they were expected to be interested in.

According to Berry Mayall and Marie-Claude Foster (1989, 56) preventive health care services in the UK are structured very much on the assumption that a 'parent' can come to the clinic or be seen at home during standard working hours. In the past, and to a large extent even now, these were services designed for full-time mothers. For these organisational reasons it is difficult for most fathers, and for working mothers, to arrange time to see health professionals, who are mainly working during office hours. In another sense too, services are not oriented towards fathers. They are perceived as less important care-givers than mothers, a viewpoint which squares with fathers' own views and is also reflected in social policy - so they are perceived as less appropriate objects of advice and health education. Male clients have to be very active themselves to be taken as equal participants, and on many occasions, even that is not enough. (Also Meerabeau 1991; Strong 1979, 60-64.) This is also very much the case in Finland. Men, especially younger men, are nowadays more involved in parenthood than they used to be and more active in attending maternity and child health services, but for the health professionals mothers are still the most important clients to work with. When health professionals

discussed their relationship with clients, they referred, explicitly or implicitly, to female clients.

Conclusions - Experts in interaction

Health professionals in maternity and child health services describe the relationship with their female clients ideally as a friendly relationship where they give women opportunities to ask questions, discuss their worries and share their experiences. Health professionals in Scotland were even more than their Finnish colleagues oriented to working with and for women. They also, more openly, spoke about 'mums', 'girls' or 'ladies', whereas the Finnish professionals more often used gender neutral terms like 'parents' or 'families' along with 'mothers' when referring to their clients. Still, in practise, they both worked mainly with mothers and paid special attention to creating a good relationship with their female clients. Scottish professionals, even more than their Finnish colleagues, ignored the role of men as parents and as clients, which does not encourage change in gendered practices in parenting.

A good relationship is seen by the health professionals as a basis to help the clients and to provide them to take advice. In this respect professionals in both countries used similar argumentation. They have no means to force the mothers, but they have to win them over and legitimate their role as advice givers. It is interesting that in doing so they emphasised their skills in building up the relationship and acting as friendly people, even more than their professional expertise and knowledge.

In all the female caring professions, in the various contexts of health and social care services, much attention is paid to the relationship with clients, customers or patients. In the case of midwives, health visitors or public health nurses, the relationship is not self-evident but it is professionally created and maintained to achieve the professional targets. The question can be asked, is this simply a delicate way of exercising power over clients. David Silverman, for example, has criticised attempts to develop health services to more 'patient oriented' or 'democratic' and to teach the professionals, in his case the doctors, to communicate better with the clients. According to Silverman this kind of a model of working might be just as much controlled and managed by the professionals as is the more traditional authoritarian model, only its methods are more delicate. (Silverman 1987, 136-157, 263.)

There is no reason to deny an open and informal relationship between health professionals and many of their female clients, but it is important not to assume the close relationship to be 'natural' for women, but to understand it as an aspect of their professional role as health professionals. They defined themselves as experts in interaction.

CHAPTER 7

STANDARDS OF MOTHERHOOD

In this chapter I will analyse how motherhood is represented and defined in the everyday practices of maternity and child health services. Before going on to do this, however, it is important to discuss some of the difficulties in finding and identifying these definitions and standards of motherhood. Motherhood seems to be something so self-evident that there is no need to openly discuss and emphasise it. At the same time, it is both invisible and always present in maternity and child health care. Women are met as mothers or as future mothers. Discussions they have with health professionals are in some way connected to different aspects of motherhood. Still, motherhood is somehow a hidden agenda. It is more often discussed implicitly than explicitly. It is much easier to identify how men are defined as fathers, because their parental role is seen to be less 'natural': it is something that has to be discussed and negotiated. Motherhood is also quite often hidden behind such words as 'family', 'parenthood' or 'child care', even if these words actually refer to mothers (David 1984; Richardson 1993, 51).

The way in which expert advice is given to mothers has changed over time. According to Diane Richardson (1993) a few decades ago it was common for experts to give direct rules as to how mothers should act and feel. Paradoxically, according to Richardson, it is a modern standard that there shouldn't be any strict standards. The experts in child

care are telling women that the 'mother knows best'. What they want to offer are just recommendations or guidelines. "The newer emphasis is no longer on telling women what they should or should not do with their children, but on giving 'support' and 'guidance' where it is needed. The aim is to provide parents with a general knowledge of babies and small children which they can then use in making their own decisions about what is best for their baby. Linked in with this is the idea that because each child is different there can be no absolute rules to follow in childrearing, only guidelines." (Richardson 1993, 52.) This is the case also in maternity and child health services, and in encounters with clients it often hides the standards of motherhood behind the rhetoric of 'anything goes' and makes them explicit only when they are broken.

This is also connected to professional practices described in the previous chapter. Setting of strict standards for mothers does not fit the ideal of a friendly relationship between professionals and mothers. Instead, mothers were treated very much in the same way as in the paediatric consultations studied by Phil Strong (1979). According to him, with few exceptions, every mother was treated as an ideal mother, who was loving, caring and wanted the best for her children. During the consultations doctors avoided topics which could have proved mothers to be incompetent. Even if mothers didn't meet the criteria, the ideal of the normal mother was actively maintained during the consultations: doctors ignored their mistakes, directed towards the future rather than dwelt on earlier failures, or gave mothers good excuses.

Standards of motherhood and women's abilities to fulfil them are more often discussed in situations where clients themselves are not present. Thus, analysis can't be limited in the encounters where health professionals and their clients meet, but it is important also

to look at the other situations where health professionals discuss their clients. I also analysed different written material, forms, leaflets, professional guidelines and so on, used in maternity and child health care.

Pregnancy is always wanted?

It is a common assumption that at some point in her life every woman will want children. Childless women, especially if they are married, are asked over and over again why they don't have children, or when they are going to have children. If they can't have children, they are often pitied. If they don't want children, their decision is blamed as selfish and deviant. Childless women are seen to lose something of their 'real femininity'. (e.g. Campbell 1985.) Women with children are rarely asked to explain their decision.

On the other hand, unwanted pregnancies are seen as a social problem. In modern Western society it is very much assumed that children are, or at least should be, planned. Since women have had more effective ways of regulating their reproductive capacity, the ways we think about having children have changed. The whole issue of wanting and planning to have children is confusing: women are assumed to have a 'natural' desire to have children, but they should control this desire in rational way, by planning the number and timing of children according to their life situation. The model of rational planning has been for example behind the foundation of the family planning clinics in the

1930s in Britain¹ (Hawkes 1995) and presumably also in other countries, and it has ever since remained the dominant ideal of human reproduction in the Western world.

During my data collection there were actually very few situations where it was discussed as to whether or not the pregnancy was wanted. This was, at least partly, because decisions to continue or terminate the pregnancy were usually made before the women met a midwife for the first time. In maternity care professionals normally assumed that the pregnancy was wanted, or at least accepted, and that it would continue.

Finnish professionals, more than their Scottish colleagues, wanted to see all pregnancies as positive events. One of them even had difficulty in finding a proper expression for pregnancies which were not originally planned, to maintain this view. In the following extract she is explaining how often women visit the maternity centre:

MW: First-time mothers want to visit quite often, because everything is so new and exciting and nice for them.

INT: It is a new situation anyway. And for most of them expected?

MW: Yes, for most of them, or let's say for all of them, probably. At least they have accepted it although it might have been an accident, or a surprise, how to say it, not an accident but a surprise. They themselves have called it a surprise.

Finnish midwife G

¹ In Finland the first family planning clinics, 'marriage counselling centres' were founded in the 1940s in order to avoid illegitimate abortions and to support 'voluntary motherhood'. (see e.g. Helén 1997) It is interesting that at the same period there was a strong pronatalist ethos and women were encouraged to motherhood (see also Chapter 2).

In the Finnish data there is only one occasion where there was a discussion about whether or not to continue the pregnancy. In that case it was a young couple in their early 20s who came together to visit the midwife for the first antenatal visit (Tehtaala field notes 156). She was only five weeks pregnant at the time. Already over the phone the woman had told the midwife that this pregnancy wasn't planned. She had just had a baby a few months before and she wasn't sure if they could cope with two young children. She was on the pill, yet had still got pregnant. However, by the time they came for the visit, the couple had actually decided to have the baby. They were talking about the future with two young children rather than discussing termination as an option anymore. The midwife also pointed out the possible difficulties they might meet, but she did not try to influence their decision. After they left she commented to me that 'they are so brave these young people'.

In the Scottish data there are two interesting cases where the issue was discussed. These cases are very much opposites. In the first of these the client was a young single woman in late pregnancy (Strathdee field notes 17). When she came to see the midwife at an antenatal clinic she was very quiet and looked sad. The midwife asked her if she had some worries. She started to explain her that her boyfriend had left her and she was fighting with her mother. The midwife spent much more time with her than was usual trying to find out about her current situation: where she was going to live with the baby, if she had people who could help her and stay with her during the first days and weeks after the baby is born, also asking if her social worker had contacted her and knew the situation. At the end of the visit the midwife asked quite directly if the woman had considered whether she was actually able to keep the baby. The woman answered that she had been thinking about it, but she thinks she will cope.

The example is exceptional, because only a few weeks before the baby was due to be born the question was raised whether the baby was actually wanted. Or more precisely, what this woman wanted and how she felt were not discussed, but what her actual possibilities were for looking after and coping with the baby. In the same way as in the Finnish case, the woman was expected to make a practical, rational choice. In neither of these cases did the midwife ask, how these women felt about having an abortion or giving the baby away, which are usually seen as psychologically difficult situations for a woman. Instead, what was discussed were very practical questions like the financial situation, housing, and where to get help with child care.

The second Scottish case is completely different. This woman was nine weeks pregnant, she was in her mid 30s, married, and was having her first pregnancy (Strathdee field notes 48). This was her first, so called booking visit in an antenatal clinic. The midwife was asking her a series of typical questions for the first visit, her personal background and medical history. She also explained what happens in a woman's body in early pregnancy, what kind of symptoms she might get, and what kind of antenatal routines there were going to be. At some point the woman said that this pregnancy hasn't been planned, that is had been quite a shock both to her and to her husband. They hadn't planned to have any children because her husband had children from his first marriage and she had a job she very much enjoyed. She was talking about that for quite a long time, but the midwife paid hardly any attention to this. The woman took up the issue again later, saying that she was not very maternal, she was afraid of labour, and worried that she might get postnatal depression. The midwife commented that she had a long time to get used to the idea of having a baby, and continued the routines of the booking visit. Again, when the midwife told her about the tests every pregnant woman is offered,

to find out the risk of having a baby with downs syndrome or spina fibida, the woman said that she wanted the test and that she thought that she couldn't cope with handi-capped child. Again, she offered the possibility that she was maybe not going to have this baby. She also rejected the midwife's invitation to come to parenthood classes saying that she was not very interested.

In this case the woman expressed in many ways and very openly that this pregnancy was not wanted and planned, but the midwife paid very little attention to the whole issue. She did not mention abortion as an option at all, even though in this early stage of pregnancy it would have been quite possible to have it. Instead, the midwife seemed to assume that her mind would change during the pregnancy, that this is only her first reaction. According to Sally Macintyre (1976), it has even been assumed that in early pregnancy physiological changes in a woman's body might cause depression and desire to terminate the pregnancy.² The woman had no 'real' reasons not to have this baby: she was married, she had no previous children, and did not seem to have any economical problems. It is not recognised that, from the woman's point of view, the pregnancy would ruin the plans she had made for her future. She quite openly tried to talk about her feelings with somebody, but she was not given a proper chance to do that. When the midwife left the room for a while, she even explained to me her reasons not to want the baby. Her behaviour broke the normal routine of an antenatal visit, although the midwife tried to keep the discussion on ordinary topics and to maintain the ideal of a pregnancy as a positive event.

² Also the motives of women who want sterilisation are carefully investigated. They are expected to change their minds, and even more so if they don't have any children at all. (Porter 1990)

Sally Macintyre (1976; 1977) studied the 'pregnancy careers' of single pregnant women in Scotland in the early 1970s. According to her, their pregnancies were usually seen as 'accidents', unplanned and unwanted by the health professionals. At the same time, pregnancies of married women were seen as expected and happy events. These definitions, based on their marital status, were connected to the ways they were treated as clients in health services, and to the decisions they were encouraged to make concerning their pregnancies. According to her "women's own definitions of the situation are relegated to secondary importance in comparison with what the medical profession imputes to be their real situation or feelings" (Macintyre 1976).

Also in my examples, marital status and the existence of a permanent pair relationship seemed to be one of the reasons which produced the different definitions of women's situations. Still, it is more complex than that. Professionals also emphasised that only women who could afford to have children should have them. Single women, more often than married women, were defined as those who couldn't afford children and who couldn't cope with them, but it wasn't that straightforward. The view was that even if a woman had a partner, she should make a rational choice, to control her 'natural desire' to have babies. Scottish professionals, in some occasions, commented to me that they couldn't understand women who had babies one after another, even if they couldn't cope with them. (See also Hawkes 1995 in relation to family planning.) They compared these women with themselves, who had waited to have a profession and a stable financial situation before having children. The assumption that every woman wants babies is not challenged in maternity care, but it is expected that the number of children and the right timing is rationally planned according to concrete circumstances.

Risking the baby's health - smoking and drinking

Ann Oakley (1984) has named the period from the 1960s onwards in maternity care 'getting to know the foetus'. The development of medical technology, especially the ultrasound scan, has made it possible to monitor more concretely and more precisely the growth and development of the foetus inside the woman's womb. There has been a growing interest in the diagnosis, prevention, and treatment of possible failures in the development of the foetus into a normal, healthy baby. However, medicine alone can't produce healthy babies. It needs cooperation from women. The health of the baby has been connected to maternal behaviour during pregnancy. This has extended the period of maternal responsibility to the time of pregnancy and even beyond. During pregnancy women are expected to live healthy lives in order to have healthy babies. Smoking and drinking during pregnancy have probably provoked the most serious expert warnings. There has also been a good deal of research on the topic since the 1970s both in medicine and in the social sciences (see e.g. Graham 1976; 1995).

In the UK, according to Hilary Graham (1976), advice on smoking was incorporated into antenatal education in the late 1960s and early 1970s alongside the traditional guidance on diet and exercise. Advice was based on 'factual', medical information and on moral persuasion. In maternity services today, in both the UK and Finland, women are asked about their smoking and drinking during the pregnancy and are given warnings

and information about the dangers these actions present to the foetus.³ Women are asked about smoking during their first antenatal visit. It is one of the routine questions of the first visit and this is when smoking during the pregnancy was most widely discussed. In the Finnish maternity centres before the first visit a form was posted to women which they were expected to fill in and bring with them to the visit. On the form questions were asked about family relations, medical history, earlier pregnancies and deliveries, but also about the woman's own and her partner's smoking and alcohol consumption. In Scotland, very similar questions were asked either during a 'pre-booking' home visit or during the booking visit at the antenatal clinic. For women who did smoke this seemed to be an embarrassing question. Some of them tried to ignore the question or to play down the number of cigarettes they smoked.

MW: Do you smoke?

W: I'm not a heavy smoker. I only smoke 5 to 10 a day. Actually I gave up two weeks ago.

Midwife writes something down on the form, but doesn't continue the discussion about smoking.

Strathdee field notes 48

In the extract above the woman actually gives a confusing answer: she first says she is not a heavy smoker but continues that she doesn't actually smoke at all. I couldn't see what the midwife wrote down on her file, therefore I don't know how she interpreted the answer.

³ In Scotland, also pregnant women using drugs have been recognised as a specific problem group who are, in some areas, offered special maternity services, along with women having other social problems (Hepburn 1993). In Finland drug abuse, especially among pregnant women, has been a much more marginal issue, and it wasn't discussed in any ways in the maternity centres where I collected my data. In Helsinki, the capital city of Finland, there is a special consultation service for pregnant women who abuse intoxicants (Screening and ... 1996, 57-59).

On some occasions when women refused to give the answer right away, asking about smoking reminded me of a cross examination. In these situations the way of talking was very different from the normal friendly atmosphere of the visits.

Pre-booking visit at home. The client is a woman with a 4 year-old boy. The midwife is asking the routine questions and filling up the forms. ... She asks the woman if she is still smoking. (there is a full ashtray on the table and the room smells of cigarettes) First she says that she has kind of given up smoking. She says, she used to smoke and drink before she got pregnant. Then she admits that she is still smoking (explaining something with a quiet voice I can't hear and understand properly). The midwife says to her that she should remember that every time she smokes the baby is smoking too, and that her smoking can cause problems to the baby. Then she asks if she drinks quite a lot too. Woman says no (but it seems to me that the midwife doesn't believe her) ... Discussion moves away to other topics.

Lochend field notes 29

A pre-booking visit at home. Woman and her partner are both present. ... Midwife asks if she is smoking (yes) and how much. Woman just says 'too much'. She asks the partner the same question. He says that he only smokes 2 to 3 per day.

MW (to woman): You didn't actually say how much you are smoking.

W: Don't know.

MW: A packet a day?

W: About 20.

M: That's a packet. You can't get bigger packets than that. You know of course that it's not good for the baby. We have to mention that. ...

Lochend field notes 58

Anti-smoking health education campaigns have certainly reached these women. They know that they are not expected to smoke during pregnancy, but it hasn't helped them to give up smoking. Instead, it has made them defend or hide their smoking from health professionals. In these situations, they are not given very much help. Instead, the message is very moralising. Feminist researchers, for example Hilary Graham (1993; 1995) and Ann Oakley (1992), have pointed out the complex reasons for women's smoking.

Even if women know the health risks of smoking for themselves and for their children, it might be their way of coping in stressful situations. It is quite ineffective just to tell them they shouldn't smoke. This is likely to increase their feelings of guilt. According to Ann Oakley (1992, 364-66), even the evidence about the effects of smoking in pregnancy is confused and somewhat contradictory. Pregnancy 'outcome' is a combination of many different factors, and it is quite difficult to isolate the effects of smoking from other factors. However, smoking in pregnancy is very much discussed as an isolated problem by health professionals.

On some occasions the tone of the professionals was more understanding, like in this Finnish case:

A woman at the second antenatal visit (15 weeks pregnant).

MW: Have you managed to reduce your smoking?

W: Yes, but I still smoke about 10 per day. I have tried to give up several times, but I haven't succeeded.

MW: It would be good if you could still reduce the number of cigarettes at least to five per day. I'll give you a form where you can mark down all the cigarettes you have smoked. It might help.

W: I have tried to do that, but it makes me feel so guilty

MW: Do the others smoke at your work place?

W: Yes, and that's why it's so difficult.

Tehtaala field notes 79

In this case the midwife understands the problems in giving up smoking. She doesn't even ask the woman to give up altogether if that is too difficult for her, but to cut down the number of cigarettes as much as she can. The woman openly admits her 'failure' and shows responsibility by trying her best, and by cooperating with the midwife.

The issue of 'passive smoking' both in pregnancy and after the baby was born was also taken up by the health professionals during the visits. Women were not really expected to be able to influence smoking at their work places, but at home they were expected to educate their smoking partners. The health professionals told them to try to get their partners to give up smoking, or at least not to smoke indoors or in the room where the baby is sleeping. If partners were present at the visits, their smoking was also commented on, but more often it was discussed with the women rather than with men themselves.

Woman at her first antenatal visit. Midwife is going through the form with her. ... Midwife notices that her husband smokes.

MW: Oh, your husband smokes. Does he smoke at home and in the car?

W: We don't have a car. But he smokes at home. We have talked about that.

MW: I'll give you this leaflet about smoking and pregnancy. You can give it to him to read.

Tehtaala field notes 76

Postnatal home visit. Both parents are present with a little girl and a baby. ... While midwife is talking with the mother the partner lights a cigarette. He goes to another room but comes back soon, still smoking. Midwife asks the woman while he is away if he smokes in the same room where the baby sleeps (sometimes). She reminds her about the connection between smoking and cot death. The partner also hears at least the end part of the conversation, but he doesn't say anything., and the midwife don't say anything to him directly.

After the visit the midwife says to me that she talks about smoking quite directly. She also says that it was quite amazing that the woman defended his smoking.

Strathdee field notes 9

During the 1990s an increasingly strong connection has been made between smoking and cot deaths. In Scotland, midwives and health visitors reminded smoking women, or women whose partner was smoking, about this connection quite directly. In Finland

also, cot deaths have received quite a lot of publicity during the last few years, but in the early 1990s it was still quite a marginal topic in maternity and child health centres. It has been seen as a problem how to make the connection between cot deaths and smoking known to women in ways which wouldn't cause panic or rejection (Kunna 1994). In maternity care, smoking in pregnancy, and also after the baby is born, is always discussed in terms of risk to the child's health, whether it is low birth weight, a risk of cot death or some other reason, not in terms of the woman's own health and as a part of their social circumstances.

Drinking in pregnancy seems to be a more delicate issue than smoking. Women's drinking in general is a kind of a taboo. It is seen in a different light to men's drinking. Even heavy drinking by men is much more socially accepted. Women, on the other hand, at least until very recently, haven't been allowed to drink, not publicly anyway, and not to get drunk. In Finland still a couple of decades ago women were not even allowed into some pubs and restaurants without male company. Women's drinking is considered in relation to her caring role and to her family responsibilities. She is not only a drinking person, but a mother, wife or a grandmother (Suurla 1989; Tolvanen 1996).

Drinking in pregnancy really became a public issue in the 1980s, and the same time it gained more attention in maternity care. Maureen McNeil and Jacquelyn Litt (1992) have analysed how the issue was raised in the US, and its consequences for women. Drinking in pregnancy became a health issue, and even more a moral issue, after the identification of the 'Foetal Alcohol Syndrome' (FAS) by medical scientists for the first time in 1968. FAS has been shown to be a consequence of heavy drinking in pregnancy,

and linked to a range of symptoms including face and body abnormalities, lower intelligence and abnormal social behaviour. In the US this has led to heavy measures against women 'under suspicion'. According to McNeil and Litt the topic has also received a lot of publicity in the media, films and literature.

In Finland⁴ and in the UK the 'invention' of FAS hasn't caused the same kind of moral panic as in the US. Still, it has had its effects on maternity services and on attitudes towards women's drinking. One of the main consequences is that it has brought all pregnant women under suspicion. Although FAS can develop only after heavy, frequent drinking, the message to women is not to take any alcohol during pregnancy. In Scotland the attitude seems to be somehow more tolerant than in Finland. The New Pregnancy Book (1993, 11), published by the Health Education Board for Scotland, which is given to all pregnant women, tells them: "There is no evidence that light drinking or occasional drinking in pregnancy will harm your baby. But research shows that heavy or frequent drinking can seriously harm your baby's development. To be on the safe side, stop altogether or stick to no more than one 'unit' of alcohol once or twice a week." In Finland, women are usually told not to take any alcohol at all during pregnancy: "Even small amounts of alcohol might be harmful, if used daily. So far, no safe limit to alcohol intake during the pregnancy is known. That is why it is recommended that the mother shouldn't drink any alcohol during pregnancy." (Meille tulee vauva 1989, 20.)

⁴ In Finland, there has been discussions from time to time what should be done to pregnant women with alcohol problems. For example, in 1996 in the Parliament a group of MPs of the Christian party suggested that involuntary care should be accepted as a means to treat pregnant women who are intoxicant abusers, but they lost the vote in clear numbers 150-21 (Aamulehti 23.3.1996).

In Finnish maternity care, especially in the 1980s, health professionals were told by the then National Board of Health that they should pay more attention to the alcohol consumption of pregnant women. They were taught how to recognise heavy drinkers and how to ask clients about their drinking in a delicate way. (Raskaus ja alkoholi 1985; Vienonen 1990, 60-66.) In maternity centres women were routinely asked during the first visit about their own and their partner's alcohol consumption. There were no occasions, however, where this caused any further discussion. Women had either responded to the message or 'learned' the correct answer. In a few cases the women themselves spoke about their worries about having drunk alcohol before even knowing they were pregnant and asked the midwife if this had caused damage to the baby. For these women there was certainly nothing to worry about, but it might still overshadow their whole pregnancy. On the other hand, it has been argued that in spite of all the training professionals have received, maternity services are unable to recognise and help women for whom drinking is a real problem (Jaakkola 1988).

Smoking and drinking are issues where experts today give the most normative rules and recommendations to women. Scientific research, especially medical research, has 'created' new risks in women's lives. Women have been made conscious of these risks on the one hand via the media, and on the other via health professionals. Every time research brings new issues to the fore, health professionals are educated to educate the women in the best interest of their children. Smoking and drinking, unlike issues related to child care, are not matters where mothers are told they are the best experts (see Richardson 1993), but women are given strict rules based at 'real' expert knowledge and authority.

Both in Finland and Scotland, health education and information giving is the main method of preventing women from smoking and drinking in pregnancy. However, the official policies on smoking and drinking in general have been quite different in the two countries. In Finland, as in the other Nordic countries, Denmark excluded, the state has practised a very restrictive policy, regulating and controlling the availability and use of both alcohol and tobacco, whereas in Scotland mainly educative measures have been used. (Leifman 1995.) To some extent, these different policies for the whole population can also be identified in the content of health education and professional advice to pregnant women in maternity and child health care.

Motherhood as practical skills

Becoming a mother is seen as a big change in life, when there is lot to learn. The first weeks and months after the baby is born is also the period when professionals and mothers meet most frequently, when most advice and support is seen to be needed. Professional advice on motherhood is often seen as a modern substitute for the traditional ways in which women learned and adopted 'maternal skills': by learning from their mothers and looking after their younger siblings. According to health professionals, modern mothers often have unrealistic expectations. They even described becoming a mother as a shock which is difficult to imagine in advance.

I always stress that the first two weeks can be quite horrific and I don't think that that is very negative in motherhood or childhood or anything. I think they need to know that that is normal to be like that, that they won't have this instant bond with a baby that has made their backside sore or their breast feeding is not all quite clicking into place like maga-

zines sometimes portray it or they have portrayed it in their own mind what it is going to be like. And I think a lot of people if they could turn the clock back wouldn't consider a pregnancy as readily and a delivery as readily as they might have done in the first place. But that is after the horse has bolted kind of thing. Scottish midwife 11

In the encounters between health professionals and woman clients motherhood is very much discussed in terms of practical skills in taking care of children. During the first weeks or months after the baby is born, professionals discussed with mothers such issues as how to feed the baby, how much and what kind of clothes the baby needs, what to do if the baby is crying a lot or is not sleeping. When children grow older issues of child rearing and child development become more relevant, even if very basic questions like diet and sleeping still remain quite common. There are discussions about problems like temper tantrums, obedience, sibling rivalry. Also such issues as home safety, suitable toys for children, and child care arrangements are taken up by the professionals. Mothers are given both individual advice and written information on these issues. They are also given opportunities to ask questions and discuss things that might worry them. Although there is much emphasis on children as individuals who are developing according to their own individual schedules, there are certain questions and problems, which are seen to be typical for certain ages. Mothers are expected to know how children develop: not to expect too much too early but not to treat them as babies for too long either. If not, professionals are there to remind and advise them.

Finnish professionals emphasised parents knowledge and practical skills in the basic care of children and suggested that what they might need is more confidence in their skills and abilities. They also stressed that what they can and want to offer are suggestions or hints which mothers can adapt to their own situation. Professionals also ex-

pected clients to be active in asking questions and in seeking information. In general, they had a very positive view of mothers' abilities in relation to child care.

There is a lot of talk that people don't know anymore how to use common sense, but I think it's coming back. And that is what we aim at, or at least that's how I see it, that we encourage people to trust themselves and to find their own solutions, that there is no one right way. After the basic things are taken care of, like hygiene, food and that sort of thing, after that there are many ways to look after these things.

Finnish midwife C

The next Finnish midwife tells about her postnatal home visits and issues that are taken up during that visit:

Mainly it is to check how they have prepared for the new baby and what kind of circumstances there are to take care of the baby, and for the mother to recover. Nowadays housing conditions are so good already that there is no need to interfere in those kinds of things. There's running water, the heating works, and there is enough room. We will go through some practical things, but usually it's things like how to take the baby out. Then there are things like who does the shopping, there are often long distances to the shops, these kinds of practical things. The main thing is to discuss the delivery, how they have coped with the baby at home these first few days, how the mother has recovered and how she feels at the moment. If the father is at home, to discuss with him as well. As I said, usually the mothers have everything there so nicely, necessities and clothes and everything. Very rarely, have I had to interfere in such things like, for example, that there are not enough clothes for the baby. I have never done such a home visit ... oh, I forgot, once I had to do a visit where I checked if the mother had all the necessities for the baby. But these are very rare.

Finnish midwife E

Finnish professionals emphasised the unproblematic nature of motherhood. Problems do exist, but they are seen as usual, everyday worries rather than severe problems in parenting. Scottish professionals were more problem oriented when talking about parent-

ing⁵. The term which was often used in relation to motherhood, especially by the health visitors, was 'parenting skills'. According to Jeanette Edwards (1995) 'parenting skills' is a significant concept used by health and social service workers to describe both the difficulties of parents who are said to 'lack parenting skills', and the role of service providers who may 'teach parenting skills'. Scottish professionals used the term very much in the same way as health and social service workers in Edward's study. It referred both to the provision of the basic physical needs of the children and to the fulfilment of their emotional needs.

Sometimes the term parenting skills was used to refer to first-time mothers in general, and their 'normal' insecurity in a new situation:

INT: What do you think are the most important questions at the beginning, during the first weeks, for mums.

HV: I think feeding, sleeping, crying. These are most of the topics, colic, this type of thing we get. I think a lot of first time mums expect their babies to eat and sleep and just wake up for their feed and that doesn't often happen and they get a bit anxious and so you find that you have to do a lot of reinforcing about feeding. So we do if it is a first time mum, we go over a lot of parenting skills and just discuss things with them, like don't expect the baby to sleep for exactly four hours between a feed or whatever and that there will be problems maybe. We just try and say that they don't always just eat and sleep but you often find that they are maybe anxious because the baby is not sleeping between feeds, they are frightened they are not getting food and they want to change the milk. They come out of hospital maybe on something like Gold Cap SMA (formula milk - mk) and by the time you go and visit at 11 days or 12 days they say the baby is hungry and they want to put the baby on to a stronger milk, so you have to try and just sort of work that out with them, that you don't put the baby on something too strong too quickly. On

⁵ I am not making any judgements here as to whether there really are more problems in child care in Scotland than in Finland. I see these differences more in terms of how health professionals interpret the situation and their own role.

the whole these are the main things that we find when we do our first visit.

Scottish health visitor 8

More often, however, lack of parenting skills was seen as a problem of certain groups of mothers, mothers who are young and/or single, working class and living in deprived areas (also Edwards 1995). In this context lack of parenting skills is not just a temporary problem in a new strange situation, but a deeper, more constant incompetence to recognise or understand the needs of a child. It was also often seen to continue over generations⁶.

We are working with a long term slant and I think some of the biggest problems are lack of parenting skills. I have got quite a high percentage of children who are single parents', single mothers and quite young mothers who haven't had a good experience as children. There parents have perhaps been somewhat lacking, that sounds very judgmental but I think their parenting skills are very poor and they struggle quite a lot with this child care and they are not always appropriate in their child care. Just for things like lack of stimulation, lack of supervision, inappropriate expectations of the child. Another thing which we struggle with is diet in this area. A big percentage of people wean babies very early and with inappropriate foods, either high sugar or high fat foods which aren't really appropriate .

Scottish health visitor 2

Parenting skills, or rather the lack of them, are not only related to child care, but also to housekeeping and a woman's family role in general. Women are the ones who are held responsible for cooking and budgeting, for providing healthy food for the children, and the husband, and for a clean, tidy home environment. According to Daniel Wight (1993), traditionally in Scottish working class families it has been the women who have had the responsibility for the household, including budgeting. The husband has brought

⁶ See also Chapter 9.

the weekly wage directly to his wife and it has been a dent of honour for the wife to make that wage last and to use it wisely. Women used to have the same role also in rural crofting communities (Jamieson & Toynbee 1992). Budgeting is still very much seen as a vital skill for mothers:

HV: I would love to see a mother and baby unit. Perhaps a house for mums, children who are in difficulty, a safe place, I don't mean a refuge, nothing like that, somewhere for a young single mum who could live there for a short time where there would be 24 hours a day input. Like teaching this girl how to budget for example, how to make a pot of soup rather than go out and buy something expensive and how to care for herself as well as her baby.

INT: So do you think that these kind of very practical skills are needed.

HV: Yes, it is the basic practical skills that these girls need to survive, they can't cope with that, they can't budget, they don't know how to shop or cook really and some of them are so young and so immature themselves that they need a bit of guidance and they need a bit of mothering themselves. They really need to be shown how to play with their children and how to give love and affection. I think something like that would be wonderful.

Scottish health visitor 4

Certainly, (she has to check - mk) if they have got a proper bed of some sort for the baby and proper clothing which most of them have. They get it somehow. They do exchange with friends and they get from friends, but only the other week one of my colleagues had one of her patients got a grant and she went out and spent it on a pram and a cradle and then she had no money left for clothes. So they really need to be taught budgeting as well, but a lot of them don't have much to budget with.

Scottish midwife 3

It is those women who have the least money to use and who often have to live on social benefits, who are set the highest expectations to use the money wisely. On the other hand, professionals also recognise the contradictions in these demands, like the midwife in the quotation above who, after emphasising the importance of budgeting, added: 'but a lot of them don't have much to budget with'.

In Scotland it is the poor, lower social class, young and/or single mothers who are most often seen as lacking parenting skills. However, professionals in both countries emphasise that well educated mothers also need advice and education in parenting. They often pointed out that they might have a lot of knowledge and they are eager to find out more information, but they might miss the most basic skills, or they might be confused in the middle of the different information they receive from different sources. They seem to think that well educated mothers lack 'common sense'. Especially in the case of the very basic practical skills, health professionals seem to believe more in 'learning by doing' or in 'inherited skills' than in 'book knowledge'.

Again I think a little knowledge is a dangerous thing. They have done a lot of reading and they tend to jump on problems very quickly. Certain mums, a baby with a runny nose, wouldn't even bother about it and in other areas a baby with a runny nose has got a severe cold and, what can you tell them to do with it, and we have to deal with it. Other houses you could go into and you are telling them that the baby has got a stuffed up nose and let's get some inhalation and show you how to do some steam inhalation whereas my mums would be telling me, they would be waiting on me coming in and things like spots. A baby with a, oh dear he has a terrible spot, and you look at it and it is the size of a pin-head but to them it shouldn't be there, how do I get rid of it. And yet other babies could have a whole bottom full of spots and the mother doesn't even bother. It is amazing, just I think it is their expectations and their knowledge of what is right and what is wrong. What the baby should have and what it shouldn't have, it shouldn't have spots and therefore how do I get rid of it. So they certainly tend, certain ones to take up a lot of time but the majority of them are really good, they do well, they are confident because of the knowledge that they have picked up at antenatally and then if they have a question and you answer it and you have given them the same answer as they have got out of that book that they have just read, then that to them almost rubber stamps the book or the book rubber stamps me and that makes them quite happy they have got two stories and they are both the same and so therefore it must be right. Scottish midwife 4

It was quite common for Scottish professionals to compare different mothers with each other, as in the quotation above. There seems to be only a very narrow line between ignorance or incompetence and overanxiety. The problem with educated mothers seems to be that they get worried too easily, don't trust their own judgements, and don't know how to put all the knowledge into practice. They are willing to take expert advice from professionals, books and different courses, but they are also maybe more dependent on expert advice. However, professionals are not worried about their parenting skills.

Several authors have suggested that during this century the attention of child care experts has turned 'from bodies to minds' of children, and developmental psychology has taken a powerful role in defining standards of child development and maternal responsibility (Rose 1989; Urwin & Sharland 1992). In maternity and child health care, both in Finland and in Scotland, a lot of attention is still paid to the physical health of children and very basic child care skills. In Finland, there has also been criticism of child health centres that they concentrate too much on the physical health of children, but do not manage as well in monitoring psychological and social development (e.g. Hyvönen & Lauri 1988). Also clients have often complained that too much attention is paid on 'scales', instead of on the advice and discussion on child development. Recently, several local developmental projects have been organised in order to change the practices and to answer these expectations (Vakkilainen & Järvinen 1994). This is not to say that issues of child development or the emotional needs of children are ignored in maternity and child health care. The basic care of the child might also become connected with the psychological aspects of care as has happened in infant feeding.

Breast is best - or is it?

One of the practical skills a new mother has to learn is how to feed her baby. It is an issue which causes women a lot of concern and causes many questions. In many ways women are also held responsible in this very basic and crucial issue in mothering during the first weeks and months after the baby is born. Baby feeding is not only a nutritional or practical question, but the feeding situation is also seen to affect the relationship between mother and baby and the psychological development of the child (Carter 1995).

Historically, baby feeding has been one of the major issues in child welfare and one of the major concerns of child care experts. In the early 20th century the feeding method was considered a matter of life and death. It was shown statistically that breast fed babies were more likely to survive than bottle fed babies in the first dangerous months of their lives. Also the use of wet nurses was very much condemned, even if these babies were breast fed. Either the milk or the care of wet nurses was seen as insufficient. Mothers who were not breastfeeding their babies, whatever the reason, were often blamed for neglect and ignorance. (Hardyment 1983, Dwork 1987; Dick 1987.)⁷ During this century the concern of child care experts has turned 'from bodies to minds' of children (Urwin & Sharland 1992). This is also the case in baby feeding. Development of better formula milks and feeding equipments has made bottle feeding a safe option, but at the same time more attention has been paid on other aspects of baby feeding, especially on the 'bonding' between mother and baby. Breastfeeding is told to give the baby the feeling of warmth and safety which is important for her emotional development. In

⁷See also Chapter 2.

breastfeeding campaigns of today both nutritional and physiological aspects of breastfeeding are emphasised.

The whole agenda around baby feeding is completely different in the two countries, even if in both of them the official health policy is to promote breastfeeding and to introduce it as the best option. In Scotland, in 1993, 38% of mothers breastfed their babies one week after the baby was born and at six months it was very rare still to breastfeed. Scotland has the lowest rate of breastfeeding in the UK, even if the numbers have slightly risen since 1992. There is also a huge variation in breastfeeding between different areas. For example, in Glasgow in 1992 the number of breast fed babies at one week of age varied from 7% to 62% in different areas. In a health policy report 'Eating for Health (1996), the official health policy target for infant feeding for the year 2005 is that "the promotion of mothers breastfeeding babies for the first 6 weeks of life should increase to more than 50% from the present incidence of around 30%." (The Scottish Diet 1993; Eating for Health 1996.) Every Health Board in Scotland has been asked to take some action in order to reach the target and a great deal of emphasis has been placed on education and information.

In Finland, on the other hand, it is not a problem to get women to start breastfeeding. There are no national statistics available, but for example in the Central Finland Region in 1992, 99% of mothers started to breastfeed and still after six months 56% of them were breastfeeding. The numbers are very much the same all over the country. Health authorities have now realised, however, that women breastfeed for shorter period of time than ten years ago, and this has caused concern that maybe these high numbers are going down. Six months has now been defined as some kind of a yardstick against

which both women's behaviour and the success of health policies is measured. The option that a mother won't even start to breastfeed is fully ignored. Finland also joined in the early 1990s a 'Baby Friendly Hospital Initiative' launched by WHO and UNICEF, in order to encourage maternity services to develop practices which 'protect, promote and encourage complete breastfeeding after child birth'. The Finnish version of this programme has been named 'Baby Friendly Finland' and the target is to create 'a model country of breastfeeding'. (Sairanen 1995; Vauvamyönteinen Suomi 1994.)

In Finland the main responsibility for gaining even better results is given to professionals in maternity hospitals and maternity and child health centres. There seems to be a strong assumption that every woman wants to breastfeed as long as possible if she is only given enough support and the proper circumstances. Women are not asked whether this is what they really want. Reasons for women's behaviour are mainly brought in from outside: for example from social circumstances, practices of maternity care and from expert recommendations, which are seen to create either positive or negative circumstances for breastfeeding:

"Breastfeeding reached its lowest level at the turn of the 1970s. It wasn't at all surprising. Several explanations could be found: big social changes, rapid move from countryside to cities, industrialisation and women's increased labour market participation, short maternity leave, rigid feeding routines of maternity hospitals, early use of solid food, recommendations for short breastfeeding, and increased availability and use of formula milk." (Lyytikäinen 1995 - translation mk.)

Not only the 'bad results' of the 1960s and 1970s but also the high numbers of breastfeeding mothers today are explained using similar reasons:

“In our country a good environment for successful breastfeeding has been created in many ways. Many hospitals have adopted a system of early breastfeeding in the maternity ward, 'rooming in' (babies staying with their mothers all the time in the maternity ward - mk), and allowed unlimited access for fathers to hospital wards. All these have created possibilities for feeding according to babies' needs and for a better interaction between the baby and her parents. Maternity leave which lasts almost one year allows long lasting breastfeeding. ... Mothers are also well motivated towards breastfeeding. In some cases the mother can't breastfeed because of her own or the baby's illness, or for some reason she doesn't have enough milk. In these cases the woman is vulnerable to feelings of guilt and failure. In some cases a mother doesn't want to breastfeed. Also in these cases, instead for making her feel guilty, health professionals and those closest to her, should support and understand her decision.” (Sairanen 1995 - translation mk.)

The strong idea of the Finnish health authorities and professionals is that women are willing to breastfeed if they are given possibilities to it. Child care experts also criticise their own former practices and recommendations, and interpret the current ideas as the most advanced.

The ways in which health professionals in maternity and child health services deal with the issue of baby feeding differ in the two countries. In Finland during the pregnancy breastfeeding was introduced as self-evident. Bottle feeding was hardly mentioned. Breastfeeding was seen as a question of learning and motivation, but not as an easy and

unproblematic practice. When the baby was born health professionals and mothers discussed the practical problems of breastfeeding. Sometimes mothers had too much or too little milk for the baby, they might have sore nipples or even mastitis. The baby was maybe crying a lot or bringing up milk very easily after feeding. Health professionals gave mothers practical advice on how to handle these situations and emphasised that the mother should have also time to rest. Only in very extreme situations were women asked to consider giving up breastfeeding if the problems with it were seen to harm her relationship with the baby and her own mental health.

During my data collection there was only one mother who admitted during the visit that she had given up breastfeeding at an early stage:

Client is a mother with a 2 month old baby. They came to see a doctor at the child health centre. At the beginning the doctor asks how has it gone. Woman says that she is not breastfeeding anymore, because the baby had refused to take the breast. She says that it made her very angry. She had breast fed her first baby for 10 months and never had any problems. Doctor comments, that there can't be anything wrong with her nipples, if she had breast fed her first child. Mother continues that now she has started to give him formula milk and the baby is happy. She also mentions that she had read somewhere recently that breastfeeding doesn't even protect from allergies as has been argued. The doctor explains to her that, actually, it has been known that breast milk doesn't give any permanent protection, it can just postpone allergies from developing, maybe it has been publicised a little bit wrongly. (After that they turn to other topics)

After the women had left, the doctor and I still exchange a few words about breastfeeding. She says that maybe there is no use to encourage this mother to breastfeed anymore, it might only cause her stress .

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In this episode the mother couldn't just say she had given up breastfeeding, but she was obliged to explain her decision. She emphasised that she had only done what was best

for the baby in this situation. She also expressed the doubt that maybe the advantages of breastfeeding have been exaggerated. It is interesting how the doctor gives a new explanation for one of the arguments, prevention of allergies, which was widely used, at least in the early 1990s, to encourage women to breastfeed. After the client left the room, the doctor also explained to me why she hadn't encouraged the mother more to continue breastfeeding, as if she had to defend to me her way of giving mothers advice.

The reasons why women should breastfeed and also the recommendations of how long and how often they should feed the baby have changed over time (Lyytikäinen 1995). In Finland, in the 1980s and early 1990s women were told that breast milk is the best nutrition for the baby, that it can prevent allergies and give protection against other diseases, that the breastfeeding situation gives the baby a feeling of closeness and security, and that breastfeeding might also prevent breast cancer. Most of these arguments emphasise the 'best interest of the child', and mothers are, of course, expected to do what is best for the child. Women in Finland have adopted these arguments so well that there are really no alternatives for them, and not being able to breastfeed often causes in them feelings of disappointment, guilt and failure.

In Scotland, it was a totally different story. Breast and bottle feeding are both real alternatives. Health professionals estimated breastfeeding rates to be something between 10 and 70 per cent depending on the area where they worked. All the health professionals said they want to promote breastfeeding, but in the end it is the woman's own choice. Women were asked during their first antenatal visit in early pregnancy how they have planned to feed the baby. If they had made their decision to bottle feed midwives didn't try to change their minds. In some cases, women who had decided to bottle feed, gave

some kind of explanations for their decision like 'I tried it (breastfeeding - mk) with my first baby and I didn't like it/ it was so difficult.', which shows that they recognise breastfeeding as a norm. Often they just gave a very short answer and that was usually the end of the conversation. Also in parentcraft education both alternatives, breast and bottle feeding, were given the same amount of time, and positive and negative aspects of both were discussed. According to one of the midwives, it wouldn't be fair to concentrate only on breastfeeding when many women are going to bottle feed anyway. There were separate breastfeeding workshops in both hospitals for women who were interested in breastfeeding and wanted more information. The next quotations very clearly cites to the principle adopted by health professionals:

I will encourage any woman who wants to breast feed but I will not bully a woman into breast feeding. If I ask a women quite clearly how she wants to feed her baby. As soon as she gives me her answer, if she says bottle feeding, that is it, she has made the decision and I am not going to undermine her confidence by quizzing her about why she is not breast feeding ... it is important then if she is going to bottle feed that she chooses, she knows how to go about getting milk and the sterilising of the equipment. If a woman really wants to breast feed then yes I will encourage her, definitely.

Scottish midwife 8

I usually encourage them but I wouldn't like to put any pressure on somebody either. You see, mothers who haven't been able to breast feed or have decided they are not able to breast feed and they feel so guilty about it. They feel that they have failed in some way and this is terrible and it is a way of, I talk about it. I try to put it across that it is their choice and to try and keep their mind open until the last minute. To try and see if there are reasons why they feel it is not for them and see if they want to talk about it. I do put across the positive side of breast feeding but I always, I do always say that you can give your baby as much love and care if you do bottle feed, so I try to promote it, but I wouldn't promote it to the point of saying you must do it or if you want to give the best, I wouldn't go along that line.

Scottish health visitor 7

The feeding question is introduced in the same way, as a woman's own choice, in the New Pregnancy Book, which is given to every pregnant woman in early pregnancy: "It's never too early to start thinking about how you're going to feed your baby. ... Breast-feeding is best for the health of your baby, but it's just as important that you feel happy and comfortable about the choice you have made. You can't know in advance what breastfeeding will be like but you can always decide to breastfeed at first and then change to bottle feeding if it really doesn't work out. It's more difficult to change from bottle to breastfeeding. If you don't breastfeed at all you may later regret that you never had the experience. Some mothers have definite reasons for choosing to bottle feed. The best way to feed your baby is the way that feels right for you. "(New Pregnancy Book 1993, 58.)

It was also very common in Scotland for women who had started to breastfeed at the beginning to give up very soon after coming home from the hospital. According to the professionals, there is not enough support and practical help available for them, either in the hospital or at home, although they were visited frequently during the first days and weeks. They also argued that women are too impatient to wait for the situation to settle down and that women are not really committed to breastfeeding.

They try and they give up too soon because they in spite of being told that their breasts will perhaps get uncomfortable, perhaps they will have sore nipples, perhaps this baby is going to feed every hour, on the hour for 18 hours a day. This will only last for a few days. They can't wait those few days to get over the hurdle. Meanwhile granny is in there saying just give it up, you don't know how much feed the baby is getting, you are too tired, it is taking too much out of you. Mother is there like a dripping tap 18 hours a day, we are there an hour at the most.

Scottish midwife 3

I think they seem to make bottle feeding so easy to look at that it is just, that is easy, I can make up six bottles in five minutes and have them all in the fridge and I don't have the problem of the sore nipples and the engorged breasts to cope with and I will be fine. The fact that the sore nipples and the engorged breasts are a two or three day wonder, you can't seem to get that over to them. You really have to be committed to breast feeding, you have to want to do it and if you want to do it, you usually do. I have had some girls up in this area who, I would have nearly given up, they were in such agony but because they were so determined that they were going to breast feed they overcame all the odds and away they went and eventually after weeks sometimes and mastitis and goodness knows all what they eventually saw the light at the end of the tunnel and they carried on breast feeding for up to a year, year and a half once they got going.

Scottish midwife 4

Professionals in Scotland also recognised the problem, which is almost totally ignored by their Finnish colleagues, namely that a breastfeeding mother is very much tied to her baby and to her home. In Finland mothers are expected to live their lives in the periods of a few hours between the feeds for what is actually a very long time. It is interesting that this is very rarely recognised and discussed as a problem. It is emphasised by the professionals that mothers need rest and time to themselves, but this is not mentioned as a disadvantage of breastfeeding. In Scotland, on the other hand, it is often mentioned as one of the advantages of bottle feeding that somebody else can feed the baby as well as the mother, which gives her more freedom and flexibility. It also gives the father a chance to feed the baby. In Finland fathers are told that they can do everything else except breastfeed.

It sounds very good to leave the decision to women themselves and not to put pressure on them. It has been one of the major issues for example in feminist critique of maternity care that women's own voice should be heard and they should be given more

choice. In Scotland, in baby feeding, this demand seems to be fulfilled: the decision is very much left to women themselves. It is however, a contradictory question as what is the 'woman's own choice'. These choices are made in certain social contexts which are important to recognise (Carter 1995). In Finland women are actually denied the choice by silencing the other alternative, bottle feeding, altogether. But it could be asked whether women in Scotland are able to make a real choice under different pressures and contradictory messages coming from different sources.

Health professionals in Scotland told me on several occasions that cultural tradition and the influence of women's social environment are powerful factors in their decisions. Very much in the same way as in Finland, baby feeding is seen as an 'environmental issue', but unlike in Finland the environment is very much described in negative terms. Professionals blamed cultural and historical reasons for low breastfeeding rates: negative attitudes of partners and grandmothers, strong influence of baby food companies, government health policies, especially lack of resources in maternity care, milk tokens given to mothers receiving social benefits, and social class differences.

A lot of that again is because of the resources. The Government set targets a few years back that they wanted 50% of all women to be breast feeding. There are several problems to that. First, we do not have enough staff within the (postnatal) ward to spend the time needed, several hours per feed and you need to advise them on their posture, their comfort, getting their baby settled, positioning themselves with their baby, the physiology, all that needs to be discussed and they need to be made to feel at ease and that can take a long time and if there are only two midwives to however many patients, you can't stretch to that. Also I think one of the other major factors is we do not have a major breast feeding society. 30-40 years ago women stayed nearby their families, so they always had an older aunt or a mother who had had several children who was breast feeding. We don't have that now because young people have moved away to get jobs, employment, hous-

ing, so that social background is not there for them and until it is they won't do and I think as well the fact that you have things like milk tokens etc., is a great barrier to them feeding. I think again financial incentives would make all the difference to them, it is cheaper.

Scottish midwife 2

If the partner doesn't support the mother in breast feeding then it is a no go, you have got to involve them. And grannies as well, grannies can be a big stumbling block as well. That is ... why don't you just put it on the bottle. So I think it is important that the husband and the granny are involved in discussions and try not to put too much pressure on the mother.

Scottish midwife 5

A lot of them it is as if it (breastfeeding - mk) belongs to someone better than them, for a lot of them in the poorer groups because nobody in their family ever did it before so who does she think she is because she is breast feeding. They know that in social class 1 and 2 a high percentage of them breast feed, they know that, so I think when they find themselves wanting to even consider it, a lot of their peers and their parents even and their aunties and uncles and their sisters and brothers laugh at them. That is the reaction I have had from them like, who do I think I am. I want to breast feed. That is for people different from me and it is so silly because it is these people from a financial point of view that should be breast feeding, they could save themselves a fortune.

Scottish midwife 4

If a woman decides to bottle feed it doesn't make her a bad mother. She is seen more as a 'victim' of these social and cultural pressures and circumstances. Professionals also see themselves quite powerless to compete with these cultural pressures.

These social and cultural reasons and explanations can't then be ignored. For example Hilary Graham (1996) has shown significant social class differences on infant feeding, and actually in the whole lifestyle of mothers with small children. I would argue, however, that professionals in their daily practices also 'create' a 'breastfeeding mother' or a

'bottle feeding mother', and work with their clients according to these assumptions⁸. It is the well-educated women from highest social classes, who are described as breastfeeding mothers, whereas bottle feeding mothers belong to the lower social classes. In both groups women who act differently were seen as either positive or negative exceptions: as a 'nice girl in a deprived area' or as a 'doctor's wife who is bottle feeding her baby'. These classifications can be very deterministic: If some women are not even expected to breastfeed, maybe they are not given enough information, encouragement and support to make their own decisions. These different expectations for different women, along with social and historical reasons, might also maintain and reproduce the current situation. Scottish professionals are sensitive to the complex reasons for low breastfeeding rates, but they are not really radically challenging the current situation.

How motherhood feels?

Several feminist researchers have studied women's lives as mothers to give voice to women's own experiences and feelings instead of presenting an idealised picture of motherhood (e.g. Oakley 1980; Boulton 1983; Gordon 1990; Ribbens 1994; Jokinen 1996). They have made visible the negative feelings women experience which are not

⁸In her study Donileen Loseke (1989) has analysed the process of client selection in a shelter for battered women. In her analysis she illustrates how "on a case-by-case basis workers transformed elements of individual women's experiences, biography, subjectivity, motivations, and prognosis into those of a 'battered woman' or a 'non-battered woman' and simultaneously into those of an 'appropriate client' or a 'non-appropriate client'." At the same way health professionals illustrate the pictures of breastfeeding and bottle feeding mothers.

necessarily connected with children as such, but with the social situation they are living in: the heavy burden of work and responsibility, isolation, and lack of adult contacts.

Eeva Jokinen (1996) has explored how Finnish mothers write about motherhood in their diaries, in an essay competition, and in the readers' column of a baby magazine. She has analysed what kinds of feelings and emotions they express when writing about their experiences. According to her, negative feelings were described more often than positive ones. The most common feeling in women's texts was tiredness. They also wrote about feeling lonely, worried, distressed, busy. These were more common than feelings of happiness, joy and pleasure. According to her, tiredness is a multidimensional expression, it is a comprehensive, bodily experience which is connected to time and space. Women often connected tiredness to concrete situations of their everyday lives, for example to situations where the child wakes up early in the morning crying and the mother is still tired and wants to sleep, or where a child had ear infections one after another and the mother had carried her night after night until she was finally so tired that she hit the child. According to Jokinen tiredness is also an expression which is easy to use: It is not a shame to say 'I'm tired. That is why women might also use tiredness to describe their other feelings or even their physical symptoms, using language which is more socially accepted. For example, according to her, tiredness is not a medicalised expression in the same way as depression.

In maternity and child health care settings, both in Finland and Scotland, women are allowed, or even expected, to feel negative feelings and to meet difficulties in motherhood. During the pregnancy women often said that they were afraid of the labour and delivery, and professionals also mentioned this as one of the main worries of pregnant

women. Professionals were, however, more concerned about women's feelings after the baby was born. Their mood was constantly monitored during the visits and they were asked how they felt, but their feelings were usually discussed quite briefly. Still, professionals emphasised that it is important for women to talk to somebody about their feelings, either to their partner, friends or professionals themselves. Talking to somebody was actually seen as one of the best ways to help the woman.

And the other thing is to speak to the girl about herself and the fact that she is still important although she has got a baby because it tends to be that everybody comes in to see the baby and the mothers own feelings can get swept aside. So it is quite good for somebody to go in and sit and encourage the girls that their feelings are still very important and that you are still interested in them as a person and whether they are developing healthy emotional problems because it is a big change for a girl if she has been out at work all day and mixing with a lot of adults and suddenly she is stuck in the house with a baby.

Scottish health visitor 6

Women's negative feelings after childbirth were either defined as 'normal problems', connected to the new situation, or as various stages of 'postnatal depression'. By naming them as 'postnatal depression' women's feelings have got a professional, scientific diagnosis. Ann Oakley has criticised the way in which this concept has been used, saying that "Science, responding to an agenda of basically social concerns, has provided the label 'postnatal depression' as a pseudo-scientific' tag for the description and ideological transformation of maternal discontent." (Oakley 1980, 277; see also Jokinen 1997). Dorothy Smith (1990, 123-131) calls this kind of transformation an ideological circle where scientific concepts are used in professional settings to diagnose women's lived experience, which in this process loses its situational variations, contexts and actualities and social conditions. This doesn't only happen in professional settings: these concepts

also come as part of general knowledge for example via the media, and gives us all the 'right' terms to identify and describe our own and others feelings and behaviour. One of the health visitors actually described this process in her interview:

HV: In fact one of the things that I think was really good was Princess Di with her postnatal depression and how she felt, and whatever people may think about the situation, it was brought into the open and I think it really helped.

INT: Do you think it is a big problem in this area, postnatal depression?

HV: Yes I do. I think there is a wide range. I think the important thing is that people are now beginning to talk about it more and their feeling and I think that is the biggest thing of all is in not feeling so guilty about these feelings, that they are not the only one with these feelings and I think that helps. But I would put a very high rate on postnatal depression.

INT: Do you know why that is.

HV: I don't know whether it is people are talking about it more now whereas it did happen in the past but people just got up and got on with their life. Or whether we didn't have the same amount of training. I mean ... I think now there is so much pressure on people to have material things. I think sometimes these things are a long long time but I think for mental health it will help a lot of women the fact that an awful lot of them now are talking about these things.

Scottish health visitor 7

In many descriptions of 'postnatal depression' connections to women's everyday life still existed, but often it was just used as a term to name the problem without any explanations about its possible reasons or without connections to individual women and their lives.

Postnatal depression is such a level that you are going to come across it, because research has shown that one in ten, so that is one in ten of all women, but I don't find that we have got a specific problem there. It is not a particular problem to the area. What we can do if we come across it we can offer counselling service because research has shown that that can be beneficial.

Scottish health visitor 4

Here postnatal depression is discussed in terms of statistics, referring to scientific evidence in almost a deterministic way⁹. It is used in an abstract, diagnostic way, suggesting the treatment at the same time, in this case counselling.

Sometimes professionals told me of individual women, how they had recognised they were depressed, and what they had done in those situations. In these descriptions they actually tell more about their own work, expressing their professional skills to recognise depression and methods of working with these women than about women's experiences.

I was visiting a girl today and I was in the house two hours, I didn't examine the woman, I was just talking to her. She was very upset and distressed and emotionally unstable and there was no way she would come out to a clinic if she had to (we were talking about differences between clinics and home visiting - mk), she just wouldn't bother, she would sit there being terribly unsure of herself. However I know I was only there two hours and she has got another twenty two hours to cope by herself but at least she had someone to discuss her fears with for those two hours. ... I don't know what would the actual ... depression in Finland. It would be interesting to see whether they were higher or lower because I think they are quite high in this country. They say one in ten but I would go as far as to say one in four, one in five have some degree of postnatal depression. Mind you they also say that most post natal depression starts after the first two weeks which is when we are usually finished (visiting - mk), but usually you can tell if someone is really depressed.

Scottish midwife 7

Another example is from a Finnish child health centre:

After the clients left, the health nurse tells me that 'this is a mother, who had, a little bit later than usually, not quite a post natal psychosis, but almost. She has been treated in a mental health clinic and with medication. She had been here three times last winter, when I was on holiday, and hadn't said anything. Then it was quite bad already. That

⁹In the late 1980s, in Finland the proportion of mothers diagnosed suffering from post-natal depression was 10-15%, in Scotland 13% (Tamminen 1990).

also caused problems in their relationship. Since then she has been here more often, sometimes they have been here together, and we have discussed very openly. Now it looks good already.

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Scottish professionals more often than their Finnish colleagues used the term postnatal depression and discussed in terms of statistical evidence. Some of them mentioned it as one of the major problems after child birth. Finnish professionals used the concept very rarely, only in the case of some individual clients. According to Eeva Jokinen (1996) attempts to medicalise women's tiredness haven't been very successful in Finland, although especially in the late 1980s postnatal depression was quite widely discussed. Still, in both countries, women's mental state after childbirth was carefully monitored. Negative feelings are accepted, even seen as normal, but it is a shifting concepts when these feelings turn to be defined as depression.

Motherhood and paid work - an impossible combination?

At the turn of this century, as part of the rising public concern over child welfare, working mothers were blamed for ignorance and neglect by the experts. In those days mother's paid work was seen as one of the reasons for injurious child care practices and the high number of infant deaths. Ever since the combination of motherhood and paid work has been a constant concern of child care experts.

There have been different periods in the social acceptance of women's paid work. For example, both in Britain and Finland, after the World War II women were driven back home from the labour market, where they had been needed to replace men during the

war (e.g. Riley 1983; Satka 1993). In Britain the trend was confirmed by closing most of the nurseries that were founded during the war. In those days full-time motherhood was very much idealised. Psychoanalytically oriented experts started to emphasise the relationship between mother and child. The most influential expert in Britain in the 1950s and 1960s was probably John Bowlby with his theory of maternal deprivation, which suggested that a young child should not be separated from her mother even for a short period of time. Mother's paid work was seen, in this context, as psychologically harmful for the child. (Riley 1983.)

Also in Finland from the late 1940s to the mid-1960s experts strongly criticised mother's employment and advised, almost ordered, them to stay at home with their children. Bowlby's name wasn't mentioned, but his influence could be recognised also in Finland. Women, who wanted to return to work after having a baby were seen to 'deny their womanhood'. A woman's willingness to go back to work was seen as an individual, psychological or even a psychiatric problem. Women were divided into full-time mothers and working mothers, but also working mothers were divided into three different categories: Women, who were 'forced' to work for economic reasons, for example widows, were not blamed but pitied. Paid work of well educated women was also at least tolerated if not fully accepted, for them it was 'mental refreshment'. Women, who were criticised most were those whose return to work was seen as a modern 'fashion', who, according to the experts, didn't need to work for their living or in order to use their qualifications. All working mothers were reminded that they should choose the child minder very carefully. If they were going to work, at least they would have to find a proper 'mother substitute', preferably a nanny at home, which only middle class women could afford. (Kuronen 1989.)

In Finland in the 1950s and early 60s, experts saw mothers' employment as a sign of changing social values which were harmful for children, family life, and for the whole social order, and which should be opposed by all means. This opposing, moralistic critique was at its loudest just before mothers of young children really rushed to the labour market from the late 1960s onwards. It didn't seem to have much concrete effect on their decisions, although feelings of guilt are still often expressed by working mothers. After the early 1970s moralistic tones became milder, almost disappeared, possibly because of the new more radical social atmosphere, where gender equality came one of the main issues. (Kuronen 1989, 79-84.) Raija Julkunen (1994) has described the 1960s as a turning point in the Finnish society and in women's social position, with the debate over public day care and finally the Day Care Act in 1973 as one of its landmarks.

In Finland, more than in most European countries, paid work is an essential part in women's lives, even if they have young children. It is also normal for Finnish women to work full-time.¹⁰ Women's opportunities to combine motherhood and paid work have also been actively supported in recent decades by family policy measures e.g. long paid maternity and parental leaves, care leave, and extensive public child care provision. On the other hand, maternity and parental leaves and especially home care allowance¹¹ that

¹⁰ In Finland in 1993 65% of women with children 0-10 years of age were in paid work, 57% were working full-time and only 8% were working part time. In the UK at the same time 53% of mothers were working, but only 18% were working full-time and 35% were working part time. It is also important to notice that in Finland unemployment rate among mothers with young children was 12% in 1993, so many more of them wanted to work. In the UK unemployment rate was only 6% at the same time. (European Commission... 1996.)

¹¹In Finland it is possible for one of the parents to take care leave until the child is three years old, without losing her/his previous job, and to get home care allowance for that time. Especially in the early 90s home care allowance was quite generous, but has been cut back in 1996 (Korpinen 1997).

was introduced in the mid-1980s, has meant that more often than before mothers of young children have decided to stay home even for several years before returning to work (Korpinen 1997; also Julkunen 1995). The high unemployment rates in the 1990s has also dramatically changed women's actual possibilities to find employment¹². Even if mothers' paid work is common and socially accepted and even supported, it doesn't mean that problems women have in combining motherhood and paid work have disappeared. However, it is self-evident for most Finnish women that after having a baby they stay at home only temporarily. It is not a question of whether or not to return to work, but when to return. (Mäkelä 1995.) Still, as Raija Julkunen (1995) has noticed, even in Finland mothers' paid work is a question which has to be debated over and over again.

In Scotland, as in the whole UK, it is still more common for women to stay at home after having a baby or go back to a part-time work, even if, unlike forty years ago most married women are now in paid employment (Graham 1993, 108-110). Lone mothers are even more likely to stay at home than married mothers. In 1991 60% of all lone parents in Scotland were economically inactive (One parent families 1998). There are probably several reasons for this, but one of them is certainly the lack of reliable and affordable child care. Several studies have shown that mothers in Scotland have difficulties in combining work or education with child care, because of the lack of child care

¹² In 1996 unemployment rate for women was 16.3% in Finland. At the same time unemployment rate for men was 16.1%. At the early 1990s male unemployment was higher than female unemployment. 1996 was the first year when female unemployment rate reached male figures. (Tilastokeskus 1997.) At the moment, when the worst years of recession are over, it seems that the situation of men is improving more than that of women.

facilities. Working mothers have to rely heavily on partners, family and friends for child care. (Engender 1994, 50-55.)¹³

In Finland the important role of paid work in women's life became topical also in maternity and child health care in encounters between health professionals and their woman clients. Paid work was mainly discussed in two contexts: First, it was discussed in relation to pregnancy and woman's physical condition as a possible risk factor in pregnancy. Even more often it became topical in connection to women's decisions to stay at home or to go back to work, and to the problems in combining child care and paid work.

As far as pregnancy as a physical condition is concerned professionals in maternity centres are interested in women's working conditions. It is seen as problematic if a woman's work is physically demanding or mentally stressful, for example, if she has to work in dangerous conditions or in a place where people are smoking, or if her working hours are very irregular. From this point of view paid work is seen as a burden or as a risk to the woman's own and her unborn baby's health. Even if all these questions were asked, the ways in which professionals in maternity centres were able to influence women's working conditions are very limited. They only had an individual solution to

¹³It is interesting that for Scotland it is difficult to find statistics on working mothers. Even in the annual gender audit Engender statistics on women's labour market participation are missing this information. Instead there are statistics on industrial distribution, earnings and low pay, and regional and racial distribution. (Engender 1994; 1996.) In the Finnish statistics women's labour market participation is classified by the age and number of children (e.g. Tilastokeskus 1997). These differences in statistics might be related to differences in statistical systems, but I would like to argue that it also tells something about cultural and social preferences, what are considered as important issues in women's labour market participation.

offer; the doctor can prescribe sick leave if needed, which was also often used especially during the last months of pregnancy¹⁴. However, the idea of 'work as risk' also expresses a more general view of motherhood and paid work as separate spheres in women's lives. Pregnancy is seen as a period when women are expected to give up their work orientation and to concentrate on motherhood, to move from the public sphere of working life to the private sphere of home and family life.

The most common issue related to woman's paid work was, however, if and when to return to work. It was not even a question whether or not to take the full maternity leave, and it was also assumed that it is the woman, not her partner, who will take the parental leave¹⁵. There were only two examples in my research where women expressed different, more unusual plans to combine motherhood and paid work. The first of these women was working in the family firm, she was still at work in her late pregnancy, although her maternity leave had officially started and she said that it will be possible for her to take the baby with her to the office and to start working right away after childbirth. The other woman was self-employed and she also had plans to combine her work and child care right from the beginning:

Midwife asks the woman, who is in late pregnancy, if she has started her maternity leave already and what kind of plans she has after the baby is born. Woman tells that she is working part time. She says that after her baby is born she has planned to start working right away about 2 to 5 hours a day, because her husband also has flexible working hours, and they can take care of the baby meanwhile. Midwife seems to be little bit sceptical about this kind of arrangement saying to woman: " But it would be nice to stay at

¹⁴ Maternity leave in Finland begins 30-50 work days before the date of birth.

¹⁵ In Finland there is an universal paid maternity and parental leave which lasts about 11 months altogether (263 work days, from where maternity leave is the first 105 days).

home for a change, wouldn't it." Woman answers:" Let's see how it goes. If the baby needs to be fed every two hours, or something, I can't go anywhere."

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In both cases the midwives expressed, delicately but clearly, their opposition to the woman's plans. They saw them as unrealistic, expecting the women to change their minds after the baby was born. When women noticed this doubtful attitude they also started to hesitate instead of challenging the professional view and defending their own wishes and arrangements. It seems to me that in Finland where the welfare state has guaranteed the women a long maternity leave that they are also expected to use it. It is not asked whether all women enjoy staying at home for that long, and alternative options are not encouraged. Still, only one of the Finnish professionals openly admitted that she wanted to encourage women to stay at home, when their children are young:

MW: I think it's common in all the young families today, that mothers have to go to work. Mothers' employment is something I want to influence, and I hope I'm able to influence it at least a little bit. I would like mothers to think what is most important to them when their children are young. Is it really the career and doing well at work, earning more money, or is it being a mother and a housewife. I really want mothers to be more satisfied with their lives. In this area, there is a bad lack of child care facilities, often it becomes topical already during the pregnancy, and I really want to encourage mothers to take care of their children when they are young.

INT: In what ways you'll try to influence them?

MW: First of all I want to listen to what the mother has to say. It often starts, when she tells me that her work takes a lot of energy, and she has the family, which also takes a lot of energy. Somehow I try to say that she should stop and enjoy the pregnancy. Her job is important, and money is important, work is important and satisfying for everybody, but when you are pregnant and you have your family, you have such treasures in you life, which you shouldn't miss. It is the time, when your work should be less important, and you should live your family life, you should have time to enjoy the weeks and months

when you are pregnant, for example just to spend more time with your partner and to prepare for the birth of the baby.

Finnish midwife E

For most women the time to choose is only when the parental leave is about to end. Health nurses in child health centres often asked women if they are going back to work, how they are going to arrange child care, or if they are going to take care leave. Health professionals supported women's decisions to stay at home for longer, because according to them it's good for the child.

HN: Have you applied for home care allowance?

M: Yes.

HN: So you are going to continue at home?

M: Yes, at least until he is two.

HN: That's nice. Many mothers have decided to stay at home because of that money, although it's not that much.

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Women, who had decided to go back to work, were not openly criticised. Instead, professionals emphasised that 'if the mother is happy, the child will be happy', if she does as she wants, she will be a better mother for her children. Still the idea that home is the best place for young children and the mother the best caretaker is very strong in maternity and child health care. Professionals also reminded women that housework and child care are at least as important as paid work and it should be respected, it is not 'just being at home', as full-time motherhood is often described in Finland.

Women themselves often acted as if they needed to explain and defend their decisions to return to work. When they told about their plans, they often gave rational, socially acceptable reasons, like the financial situation of the family, instead of expressing their

own wishes (also Lewis 1991, 200-201). There was only one woman, who openly admitted that she was not happy at home and was eager to get back to work. Women also wanted to show that they are responsible mothers, even if going back to work. They stated that their decisions depended on the child care arrangements, children shouldn't suffer from the mother's work: 'If I can't get a nursery place near by I will stay at home' or 'If I don't manage to get both children to the same place, I won't go to work'. On the other hand, this is also an important practical issue for women themselves: taking children to day care in the mornings and back home in the evenings takes a lot of time and often needs complicated transport arrangements.

Even if women were expected and even encouraged to stay at home for months or even for years after the child is born, paid work is also discussed as an essential part of women's life.

MW: You are going to be at home for a long time then?

M: Yes, six years, or maybe nine, if we have a third child (she has been on care leave for three years after her first child and is now pregnant again - mk). I don't know if there is any sense going back at all. I will have forgotten everything by then.

MW: But anyway, it gives you some kind of security, a place to go back to.

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Health professionals, midwives and health nurses, who are working women themselves, and many of them also mothers, recognise importance of paid work and financial independence for women. In some cases, full-time motherhood was also mentioned as harmful for children. At least when children are near school age, professionals emphasise that it's not good for them just to stay at home with the mother, but they should spend more

time in other children's company to become more independent. In some rare cases full-time motherhood was even seen as a reason for children's behavioural problems.

Women's paid work was one of the major topics in the Finnish maternity and child health centres¹⁶. The ideal seems to be that the woman stays at home when her maternity leave begins and goes back to work when the child is about 2-3 years old. Meanwhile she is expected to devote herself to motherhood. There seems to be very little understanding for women's alternative plans and decisions. Going back to work during the maternity leave is discouraged, but later on staying home as a full-time mother and a housewife is not recommended either.

It is interesting that the long periods that Finnish women stay at home are still not considered as full-time motherhood. Many of them have a post where they plan to go back to. They are not seen as full-time mothers but as staying on leave from working life. According to Raija Julkunen (1995) the Nordic welfare state has created a system where women's labour market participation is very high, but where they spend long periods at home looking after their children. Women's relationship to their work is still seen differently from men's. It is seen as self-evident that a man's work and career should not to be interfered with because of his fatherhood, but at the same time it is seen as natural that for a woman motherhood and children are the first priority.

¹⁶ I collected my Finnish data at the beginning of the 1990s when the economic situation had begun to change dramatically. The unemployment rate was raising rapidly, but its effects were not yet visible in discussions between health professionals and their clients. At the moment, when the economic recession has continued for several years and the unemployment rate has remained high, it could be that unemployment is much more of a topic during the visits (Aamulehti 13.5.1996).

In Finland, first the long paid maternity and parental leave and, more recently, care leave have encouraged women to stay home for longer than before, even for years, and the use of these leaves is also encouraged by the health professionals. Welfare state creates the context and conditions in which motherhood and women's paid work is discussed in the maternity and child health care.

In Scotland women's work was discussed much less in maternity and child health care than in Finland, even if the themes and problems taken up were quite similar. Women clients themselves, rather than professionals, were active in taking up the issue of paid work. For example, in some occasions they mentioned they had given up their work, because it would have been too difficult to combine it with child care, or they told they were going back to work. Professionals did not make any 'recommendations' as to what women should do. There was only one case where the midwife actively tried to influence a woman's decision (Strathdee field notes 57). She had had her baby only a couple of days before. The baby was born premature and was still in hospital when the midwife visited her at home. She said she was going back to work the following day, and she was going to take her maternity leave only when she got the baby home. The midwife was very much against this. According to her it is too much for her to work and visit the baby in the hospital, it will make her too tired to enjoy the baby when she gets her home. She also told her that her GP can give her sick leave if she didn't want to use her maternity leave now. The woman was still determined to go back to work. After we left the midwife told me that she was going to contact her GP, who could also try to persuade her not to return to work. When I suggested that maybe she gets bored at home when the baby is in the hospital, she didn't accept that, but said that it was still too much for her. In this case the woman's plans to return to work were opposed for medical rea-

sons, she was not fit enough to go back to work only a few days after having her baby, but also because according to the midwife she was not going to be a good mother for her baby, if she went back to work now. Her first priority should be to visit her baby in the hospital and to keep herself in good health in order to look after her baby.

She was the only woman who planned to return to work that early, but in Scotland in general, the paid maternity leave is only 18 weeks, much shorter than in Finland. Compared to Finland women return to work very early, but also many more of them give up their jobs entirely. Professionals in Scotland very much accepted the realities and didn't make any judgements about whether or not it is good for the mothers to go to work. Sometimes they discussed with me about the problems in combining motherhood and paid work. None of them argued that full-time motherhood would be good for the child. On some occasions, they also mentioned that for poor women it would be better to work than to live on social benefits, because they would be better mothers if they didn't need to struggle with financial problems. The most extreme comment by one of the health visitors was that 'it doesn't really matter who cares for the baby as long as she is well cared for.' When Finnish professionals considered what is 'best for the child', their Scottish colleagues discussed the issue more from the women's point of view.

Compared to Finland the issue of mother's paid work was almost non-existent in Scotland. One reason for this might be that staying at home is seen as more culturally normal in Scotland than in Finland. When Finnish professionals discussed problems in combining motherhood and paid work, their Scottish colleagues emphasised more problems of isolation for full-time mothers.

(In more affluent areas - mk) you deal a lot more with things like isolation because it hasn't got such good transport links and a lot of these girls were working up until they had their baby, so they could get out and about quite easily and suddenly they find themselves in this housing estate quite a bit out of the city and not near shops and things. So a lot of the problems there for the mothers were isolation. Scottish health visitor 6

The other problem, which is maybe associated with one of the areas, is isolation. In Burnside mostly, because it is women that have been out working and perhaps don't know their neighbours and have socialised with their friends at work and then have a child and come home and they don't actually know anyone round about or the people that they know go out to work so they have not actually got anyone to associate with so they are a bit isolated. Scottish health visitor 2

The problem of isolation is connected mainly with middle class women who have worked and had been career oriented before having a baby, to whom staying at home is a new situation. Professionals have recognised what was one of the first messages of feminist research on motherhood in the 1970s: the isolation of full-time mothers (e.g. Oakley 1985). At the same time they ignore, however, that isolation might also be a problem among working class full-time mothers. They are seen as having problems of their own, but isolation is defined a middle class problem.¹⁷

It is quite interesting and even surprising that in Finland where women's full-time employment has a long historical tradition, where the dual breadwinner family model is well established (e.g. Julkunen 1994), and where paid work and a career have an important role in women's lives, health professionals encourage women to stay at home for long periods of time after having their children. Discussions between mothers and health

¹⁷This is also related to the assumption that working class women have closer family ties and female relatives living near by. See also Chapter 8.

professionals also show that problems in combining motherhood and paid work haven't been disappeared along with public child care provision. On the one hand, the Finnish welfare state has given working women rights to motherhood, but on the other, it could weaken their position in the labour market. It could be asked whether these social rights and benefits have created more choices for women or a trap and a new norm which is actually a norm of full-time motherhood. In Scotland, on the other hand, it has been more common for women to be full-time housewives and mothers or to work part time¹⁸. It still seems to be a strong assumption. Still, no moral judgements are made about mothers going back to work only a few weeks or months after the baby was born which in the Finnish context would be really early. Social and cultural circumstances and realities seem to shape professional definitions on motherhood and paid work in both countries.

Conclusions - Categorisation of mothers

In this chapter I have pointed out that, in Scotland, health professionals located women in different categories as mothers, whereas in Finland, any kind of distinctions were

¹⁸ In Scotland, there have historically been local differences in 'economic activity' of (married) women. In 1971 Tayside had the highest rate, 53 per cent of all married women under 60 were 'economically active', followed by Lothians by 49.6 per cent. In 1981 Lothians got the highest rate 62.8 per cent, followed by Tayside by 61.5 per cent and Borders by 60.7 per cent. The lowest rates in both years were in Highlands and Islands, in 1971 37.4 and 29.7 per cent, and in 1981 48.1 and 47.5 per cent, Islands having the highest increase during this ten years period. Below the regional level the districts with the highest percentage of economic activity among (married) women in 1981 were Dundee at 66.7%, Edinburgh at 64.9%, and Roxburghshire at 64.8%. These local differences still exist even if they have decreased during the last twenty years. (Mitchison 1985.)

expressed quite rarely. In Scotland these categorisations were made, first of all, according to social class. In neither of the countries such issues as ethnic, religious, or linguistic differences, not to even mention sexual differences among mothers were taken up¹⁹. At the end, I will discuss these categorisations more closely.

It could be argued that in Finland the ideal of motherhood is very homogeneous, ignoring differences between women (see also Jokinen 1996, 138-139). In maternity and child health care all women are treated in similar ways and they are expected to act and feel in similar ways. Some Finnish researchers (e.g. Rautava 1989) have criticised this kind of homogeneous treatment of women. According to her, in health education in Finnish maternity care, differences in women's knowledge about pregnancy and childbirth are ignored. Instead the education is given in a routine, uniform way. For some women the information that is given is too simple and underestimating them and it won't give them anything they wouldn't know in advance, whereas others might need more basic knowledge than is offered at that moment. It has also been criticised that the strong emphasis on 'normality' in maternity and child health care is problematic. Especially from the social work perspective, maternity and child health centres could do more preventive child welfare work, to identify and intervene in problematic situations at the early stages

¹⁹This is hardly surprising in Finland which is a very homogeneous country where only very recently, mainly along with a growing number of refugees, issues of multiculturalism have received some attention. In Scotland, instead, there has been more sensitivity on ethnic minority issues and I could have expected these issues to be taken up also in maternity and child health care (see e.g. Bowes & Domokos 1998). There might be different reasons why this was not the case. It might be because of the areas where I collected my data, but also because of my own lack of cultural sensitivity to these issues. A vast majority of women I met during my data collection were white, Scottish, or British, women. Two of the health professionals themselves were from ethnic minority background.

(Tarpila 1992). Maternity and child health centres have very much rejected this role, because it could ruin their image as services for 'normal families'.

On a few occasions some categorisations were made by the Finnish health professionals, but these referred more to women's, or families', qualities as clients than as mothers. The categories that were used could be named as 'educated mothers', 'ordinary mothers' and 'mothers/families with social problems'. Most clients were classified as 'ordinary', which was also the most popular group for the professionals: they were described as active and interested but not too challenging, and not having problems which are too difficult to handle. Educated mothers were not seen as bad mothers, but sometimes as difficult clients because they are demanding²⁰. Finally, families with social problems were mentioned as rare exceptions. In general, mothers were seen as responsible, caring, knowledgeable, interested in their children and willing to take professional advice.

In Scotland, mothers were much more clearly divided into different categories by the professionals which could be described as 'mothers who do' and 'mothers who don't'. There were mothers who use the services and those who don't, those who are interested and eager to get information and those who are not, those who care for their children and those who don't, those who breastfeed and those who don't, those who are responsible and those who are not, and so on. These distinctions were very much done according to the social class, which was grouped together with the housing area (mothers in deprived versus affluent areas), age (teenage mothers versus adult mothers), and marital status (married mothers versus single mothers).

²⁰See also Chapter 9.

Abbott and Sapsford have written about health visitors' work: "In their mode of intervention they 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." (Abbott & Sapsford 1990, 120.) According to them, health professionals only have one set of standards for motherhood, which they argue to be 'patriarchal and middle class'. Mothers are judged according to these standards as 'good' and 'bad' mothers.

I would argue, however, that the situation is more complex than this. Health professionals themselves recognised that standards of good motherhood are middle class standards, which won't suit many of their clients, and they didn't want to put pressure on working class women to reach them. Even if these standards are held as a common norm, there are mothers who are not even expected to succeed according to them. If they do, they are seen as positive exceptions. More often, however, their qualities as mothers are judged differently, in relation to the social and physical environment where they live:

That's interesting, yes. It is a funny thing isn't it? I think sometimes working in an area where you feel you can't really change the situation, you feel the situation is really detrimental to the families ... can get very demoralising at times, more for them of course, but sometimes I think you too can also take that on board as well. In saying that you can maybe see, they are maybe more welcoming of you in some ways, maybe I feel more relaxed with them and I think you can probably see more reason for your work which matters, it matters to me, you can see there are people who could maybe get more help from

our service to help themselves get a better level of help which in some ways will maybe help improve their own lifestyles. In saying that you wouldn't like people to become categorised or stigmatised by saying that they require visiting, it shouldn't be like that and very often people who are maybe more affluent they also have a need and obviously you find they are really very interested in their children and that is satisfying too. They will seek out help more readily, they themselves will phone up and say when are you coming, this is due or that is due, they are more likely to seek help. I have never really thought about that before and maybe sometimes they are more demanding actually, intellectually, maybe that is why because they are much more up to date with the information and are wanting the most up to date research and in saying that too it is also satisfying to discuss child care with somebody who is caring about their child and ... I think it probably gives you a better balance having a variety of people mind you in your work because otherwise you can become quite narrow minded almost about child care practices.

Scottish health visitor 7

There are contradictory ways in which professionals spoke about working class mothers. On the one hand, they were judged according to their individual qualities, but health professionals were also sensitive to the social environment where women lived. Often the environment was described in a very deterministic way. They also emphasised that they have to adjust the information and advice they offer according to social circumstances and individual needs of women. If women still managed to reach some kind of basic standards, they were seen as good mothers. Sometimes, the requirements were very modest, as one of the health visitors commented about parents who didn't bring their children to developmental assessments. The comment is quite extreme and maybe not meant to be taken literally. Still, it illustrates very well the acceptance of different standards:

There are certain ones that don't come, but you see them occasionally at the clinic and you see them out in the street or you bump into them and they are all right. At least you

have seen them, they are walking, they are talking and they are all right. But you do get to know the families that are more vulnerable and more at risk.

Scottish health visitor 8

Social class division, according to health professionals, is deeply rooted in society, so that even mothers themselves know, 'where they belong'. At the same time they underline the difficulties they meet in changing the situation.

The problem is that people that tend to go to the playgroup tend to be middle class people and where there is limited finances, people with limited finances feel inadequate when they go to the playgroups and probably there is a bit of a kind of, people get into a bit of a clique and I know certainly in one of my areas there is a playgroup and people don't feel they are very welcome, they don't live in the right area. I can't comment on that other than that is what the clients have told me. They don't feel that they fit in because they don't have the good clothes, their kids don't have the good clothes and there is obviously a different attitude. They want to be able to give their child the Mars bar for snacks, whereas the middle class have certainly taken a lot of the health messages on board and their snack is an apple, so the two kind of clash. They feel sort of inferior which I can understand that is quite difficult for them, so they don't go and they probably need to go because it would be beneficial getting out the house and it would give them something else other than children for a few hours a week and meet other people. But they don't go because they feel that they don't fit into that kind of scenario. They would tend to go to places like the family centre where you have the opposite working, because there are other people perhaps in the middle class area who would benefit from going to a family centre but they don't feel they can go to a family centre because they think that is for people with social, financial problems. They don't see it as being somewhere they would get a benefit ... a lot of mums would benefit from that but if you say to them family centre they think social work and they don't feel they would fit into that.

Scottish health visitor 2

A lot of them it is as if it (breastfeeding - mk) belongs to someone better than them, for a lot of them in the poorer groups because nobody in their family ever did it before so who does she think she is because she is breast feeding. They know that in social class 1 and 2 a high percentage of them breast feed, they know that, so I think when they find them-

selves wanting to even consider it, a lot of their peer and their parents even and their aunties and uncles and their sisters and brothers laugh at them. That is the reaction I have had from them like, who do I think I am. I want to breast feed. That is for people different from me.

Scottish midwife 4

Differences between mothers and in women's experiences of motherhood can't be denied. There is, for example, a lot of research which shows the social class differences in women's and children's health (Graham 1984; 1993, 1996; see also Blaxter 1990). However, categorisations according to social class are too simple and too deterministic. Hilary Graham (1993, 28-34) has criticised categorisations, for example according to class, gender, race, or disability, for three reasons: First, dimensions are often presented as properties of individuals rather than of societies in which they live. Second, there are ideological, hierarchical power relations built into these categories. For example middle class motherhood is ranked higher than working class motherhood. Third, these categories are too rigid, women experience their lives in ways that do not fit into these categorisations (see also Smith 1990a, especially 83-104).

Health professionals emphasised women's individual needs. Still, if their needs are assessed according to categories relating to 'where they belong', such as a 'working class mother' or a 'middle class mother', they are not treated as individuals but as representatives of these categories. It is a difficult dilemma how professionals could work in ways which would challenge these differences and inequalities between mothers without categorising them or just accepting the differences as part of social reality. It could be also argued that in Finland maternity and child health services should be more sensitive to differences between women, instead of forcing them all into the same mould, recognising different needs and experiences without making judgements or categorisations.

CHAPTER 8

MOTHERHOOD IN FAMILY CONTEXT

In the previous chapter I analysed standards of motherhood quite separately from the context in which motherhood is usually located, namely 'the family'. Women's family relations are varied, but they usually have some significant people around them who they call family. Health professionals also emphasise that mothers need social support and concrete help in motherhood, and in this context 'the family' is described as the main source of support. It is also increasingly expected that women will share parenting with the child's father.

In this chapter I will discuss the position and meanings given to woman's male partner and her child's father,¹ but I will also explore alternative definitions of 'family support'. I will also discuss the position of lone mothers in maternity and child health care, the position of those women who are expecting and raising their children outside marriage, or some other socially accepted form of pair relationship.

¹ It was usually assumed by the health professionals that they are one and the same person.

Sharing parenthood with men

In the 1990s, both in the UK and in Finland, there has been a growing demand for shared parenthood² and for a new, more active and participating father, a father who is present and caring, not only for his children but also for his partner. There has been a lot of discussion on 'new fatherhood' in media, in social and psychological research, as well as among fathers themselves. (Moss 1995; Segal 1990, 26-59; Forsberg 1995; Huttunen 1994.) There are, however, important differences between the two countries in the ways in which fathers are recognised as parents.

A clear difference between Finland and the UK can be found in legislation and in social policy systems. In Finland, as in other Nordic countries, the state has taken an active role in supporting men's involvement in parenting and gender equality both inside and outside the family (Haas 1992; Kaul 1991; Carlsen 1995). Legislation recognises not only mothers, but also to a lesser extent fathers, as caretakers of their children. In Finland, since 1978, it has been possible for men to take paternity leave up to two weeks after the baby is born, and in 1985 the latter part of the maternity leave was changed to parental leave. Fathers are also entitled, along with mothers, to take care leave until the child is three years of age.³

² Some authors (e.g. Haas 1992) use the concept 'equal parenthood'. I prefer 'shared parenthood' instead, because I want to emphasise that even if parenthood is expected to be shared, it is not necessarily expected to be equally shared.

³ These legal reforms haven't so far dramatically changed gender division in parenthood, but still, they create possibilities for change. In 1985 25.8 per cent of all Finnish fathers took paternity leave, but only 2.9 per cent took parental leave. In 1989 the use of paternity leave was increased to 34 per cent, whereas parental leave was still used only by 3 per cent of fathers. Men also used parental leave for very short periods of time, only 1 per cent of them had used the whole leave, which is about 26 weeks. The use of

The current legislation in the UK does not recognise men as care giving parents, even if there has been an criticism and demand for change (see e.g. Moss 1995). There is no universal right for men to take paternity leave or parental leave. This has been left for the employers, some of whom have their own arrangements to give men, and women, more possibilities to combine paid work with family responsibilities.

In both countries, it has also been emphasised recently that parenting should continue after the divorce or separation of parents. In Finland, there have been attempts to get men who are not living with their children to become more involved in their daily life, not only to carry the financial responsibility. For example, in the Children's Act in 1984 a new arrangement for 'shared custody' was introduced in the case of parents' divorce or separation. Prior to this, only one of the parents (usually the mother) could get the custody and the other one (usually the father) had to pay maintenance for the child. The new ideal is that parental responsibilities, not only financial but also practical, still exist and continue after divorce or separation, and that the father shouldn't be separated from his children. It is also defined as a child's right to have contact to both of her or his parents. Shared custody is nowadays very much recommended by social workers who deal with custody cases. In practice, however, the new system has been far from unproblematic, and in some cases it has caused bitter fighting between former partners. It also forces them, whether they like it or not, to maintain contact with each other and to continue their relationship not as partners but as parents. (Kurki-Suonio 1992.)

paternity and parental leave, as well as men's participation in child care in general, varies according to their age, place of residence, education and social status. Young, well educated men are most likely to take the leave. (Säntti 1988, 11-16 and 1990, 7-12.) The numbers have remained very much unchanged the last 10 years.

In the UK also, new arrangements have been introduced in the case of parents' divorce, but they very much emphasise the financial responsibilities of the absent parent (Child Support Act 1991). According to Jane Millar, the state in Britain is looking for ways to strengthen and enforce the financial obligations of non-custodial parents. At the same time it maintains traditional family and gender relationships even after couples have separated. According to Millar: "The separated family is treated almost as if the relationship had not broken down at all. Thus the men are to fulfil their traditional role as financial provider and the women are to fulfil their traditional role as mother." (Millar 1994.) In both countries then the tendency is increasingly to encourage to maintenance family relations after separation, with the exception that in Finland the father's rights and responsibilities are defined more widely, not only in terms of financial maintenance but also of practical parenting.

The ideal of shared parenthood is also present in maternity and child health care, both in Finland and in Scotland. The fathers' role becomes topical mainly in two different contexts: in sharing the experience of childbirth and in participating in practical child care. Men themselves very rarely defined their own role. Instead, it was defined by women, both as partners and as professionals. On the other hand it was also very much left as the women's responsibility to change men so that they fit these new ideals of fatherhood.

Sharing the experience

During the last two decades the father's participation in child birth has become socially accepted, indeed it is almost a new social norm. Child birth was also the context where

fatherhood and woman's pair relationship most often became topical in maternity services. Health professionals discussed with women whether their partners are willing to participate in parenthood classes during the pregnancy and in child birth.

Parenthood classes are organised both in Scotland and in Finland in order to give pregnant women, and their partners, advice and information in pregnancy, child birth and child care. In Scotland, however, the timing of the classes, whether they were in the daytime or in the evenings, divided them to women's classes and couple's classes. In Lochend the women only day group was quite small, whereas the evening group for couples was much more popular. In Strathdee there were only afternoon classes for women with the last session directed at couples, and some evening sessions for couples, which were more like lectures than small groups. In the Finnish city, Tehtaala, there was only one type of class organised in the evenings, which was very much directed at both partners. Also the content of the Finnish classes showed that they were meant to be attended by couples. In one evening the topic of the class covered themes like 'changes in a pair relationship' and 'becoming parents'. In Scotland the same kind of issues were occasionally mentioned, but they were not as explicitly made a special focus.

In Finnish maternity care the change in child birth practices from 'women's business' to 'a family event' has been actively supported and produced. Leena Valvanne, a well-known midwife, could be called 'the mother' of 'family birth' and parenthood classes in Finland. In the 1960s she brought the ideas of 'painless child birth' and fathers' participation to Finland from her visits to France, Holland, and the UK. In her memoirs she writes in a very colourful way about the heated debates that this new idea caused in

those days⁴. At the beginning there was strong opposition from midwives, doctors, the media, as well as from fathers themselves. Gradually, the doors of hospital maternity units opened to fathers, even if the debate continued till the 1980s. (Valvanne 1986, 205-244.) But men couldn't be let into maternity units without preparation. Participation in parenthood classes was seen as a necessary requirement for their admittance. In maternity centres, there had been mothercraft classes organised at least since the 1940s, and since the late 1960s these gradually became open also for men.

When this new idea was first launched in Finland, the partner's participation in child birth was seen as a method of 'pain relief' for women. Men, as well as women, were taught the right breathing technique in order to assist the woman to act correctly during the labour. Nowadays, there is less emphasis on right techniques. Instead, midwives in maternity centres stated that the classes are meant for both women and their partners, not only because of the labour and delivery, but also because of their pair relationship and their future role as parents. Even the name of the classes has been changed from child birth preparation to parenthood education, and their content has widened from pregnancy, childbirth and mothercraft to include family relations and changes in family life after the baby is born.

We always inform the clients that the classes are meant for both, and that it would be good, if the father could be present at every session. Of course, some of the things are

⁴ However, another midwife, also in her memoirs, tells that the idea of fathers' participation wasn't that new. It had just disappeared when childbirth was moved from the home to hospital. According to her, at the time when home deliveries were more common, fathers were needed to assist the midwife, to boil her water and hold the lamp. She also writes how sometimes she kept a father in the room in order to give him some 'sex education', reminding him that there shouldn't be a new baby every year. (Luoto 1991.)

concretely only for the mother, but anyway. In that way, those things become more shared between the couple, and it is certainly easier for the father to share the experience, and also to support the mother. Then, some sessions are really meant for both of them, like when we discuss about becoming parents and about pair relationship. We especially wish that they both come to that session, otherwise it is partly wasted, if there is only the mother listening.

Finnish midwife C

I think the meaning of parenthood classes is, first of all, to give them some basic information. Of course, they know quite a lot already, but there is quite a lot of information about labour and delivery. And then, that they are here together, people in the same situation, couples. It is quite important that they come together, they sit here together and hold each other's hands, and talk to each other. That is a good start.

Finnish midwife I

In Finnish maternity care, pregnancy and child birth is seen for first time parents as the time when a couple becomes a family. At this point their pair relationship, its emotional basis and quality, takes on a special meaning. The birth of the first baby is seen as a fulfilment of the couple's life together, but at the same time as a risk to their relationship. After the child is born they are not anymore two individuals living together, but two parents who are both expected to work for their family and the child. Health professionals in maternity and child health centres expect both the woman and man to reconsider their lifestyle and the changes that are necessary after the baby is born. Instead of their paid work and own hobbies, they should now both concentrate more on the baby, their home and family life. The ideal seems to be a couple who, through discussion and with mutual agreement, change their lifestyle according to the new situation, from an individualistic to a more family centred lifestyle. A well functioning, heterosexual, equal pair relationship and shared parenthood are very much the ideals that are expressed in Finnish maternity care. This is an idealistic view of family life, which ignores its problems, conflicts and gender inequalities.

In the UK men's participation in parenthood classes and childbirth became more common very much at the same time, maybe a little bit earlier than in Finland⁵. It has been suggested that in the UK women themselves have been the primary motivators in this change (O'Brien & Jones 1995, 30). Also health professionals expressed more the 'customer demand' for more couple's classes and men's involvement in childbirth, than the active encouragement of men on their behalf. They expressed the view that women should have the choice to attend either women only classes or classes for couples. They did not see men's participation as entirely positive but in some occasions they emphasised that it might prevent women from talking about issues which are seen as private and intimate.

The other main change during the time that I have been here is that more and more men wish to be involved in the education and also involved in parenting. So the classes have increased quite dramatically in size although the content hasn't particularly changed, it has been refined to allow for men being in the group. For instance we don't now play with dolls, we don't play with dolls or breasts now when we are talking about breast feeding, we just tend to talk about different aspects of the subject and a women only breast feeding workshop is held at another time for those women who are interested. We also don't show bras and sometimes don't talk about different aspects of the pelvic floor because men do get quite embarrassed, so you have got to watch the embarrassment factor, although they want the education they don't necessarily want the education in the public arena.

Scottish midwife 10

Certainly in the classes we try and make them (men - mk) feel more part of it, which is a criticism of (partners) not coming during the day. We did do a bit of a research project

⁵ It is interesting that one of the countries where Leena Valvanne visited in 1964 was England where she stayed for three weeks observing both home and hospital births and parenthood classes and visiting several hospital maternity wards. She tells in her memoirs that preparation for child birth was much more advanced in England than in Finland, that there was both 'traditional' preparation and parenthood education for both parents. (Valvanne 1986, 208-209.)

about two years ago to find out primarily from women that came in the afternoon. So we asked them, it was just a small thing, did they want partners to come in the afternoons, if they had the option. At the moment we don't provide the option, we keep 6 classes and the last class is for partners to come along and then offer the alternative in the evening should they want something a wee more consolidated. We did however ask them if there were classes provided or groups provided in the afternoon for partners to come along to, would they anticipate that they would want to come, and we had to go with the majority who said no. It is still a one off criticism you know that we make them exclusively for women in the afternoon, but to be honest women are actually more fluent, in how they feel and exactly ... they are also thinking about, they don't mind sharing something with the women and then at one class, a one off with the men, it is different.

Scottish midwife 11

In Finland women sometimes complain that it makes them feel guilty if, for whatever reason, they don't have a partner with them in parenthood classes. It is a strong norm that a couple should share the experience of pregnancy and childbirth, and participation in parenthood classes is a concrete representation of this sharing. In Scottish maternity care the content of parenthood classes is directed more at women than towards couples, even if couples' classes are widely available. There is no such heavy emphasis, as in Finland, that couples should attend the classes together and men's participation hasn't brought any major changes to the content of the classes. Health professionals also recognised that all pregnant women don't have partners, or that some of them prefer to discuss pregnancy, childbirth, and motherhood with other women instead of their partners, at least in a group, where there are other men present.

A mother's helper

In both countries health professionals shared the view that men are different today than they were a few decades ago. They are not only more involved in pregnancy and child-birth but also in everyday child care⁶. The health professionals I spoke to saw this as positive development. There were, however, differences in the reasons why men's involvement was seen as beneficial, and in how much it was emphasised in maternity and child health care. In Scotland, more than in Finland, there were also negative comments about men and their family role. In neither of the countries men were expected to take an equal responsibility as parents. Instead, they were described as supporting, helping and participating fathers, or in contradictory negative terms.

It could be argued that in Finnish maternity and child health care women both as partners and professionals have taken an active role in producing and supporting men's parenthood (as also in social work, see Forsberg 1995). In their encounters they are defin-

⁶'Real' changes in men's participation are difficult to measure. In both countries, some changes have certainly occurred during the last few decades, although there are somehow contradictory views of how remarkable these changes really are. For example, Daniel Wight (1993) did an ethnographic case study of a small former mining village in Central Scotland in the early 1980s. His study tells about strict gendered division of labour. Nearly all domestic labour was the responsibility of women. On the other hand, Julie Smith (1995) suggests that a remarkable change has happened in Britain during the last forty years. According to her survey 39 per cent of women who had their children in the 1950s, but already 82 per cent in the 1990s, said that they had received help from their partners in infant care. In Finland, even if it is very common for mothers of young children to work full time, they still use much more time in child care than men. (Tietoja naisista ja miehistä 1987, 28; Koski-Hyvärinen & Puttonen 1987; Naiset ja miehet Suomessa 1994). There are also differences in the content of time used for child care. Women are mainly responsible for the daily routines in child care, and also for the contacts outside home. Men use more time in activities like playing or taking children out. (Koski-Hyvärinen & Puttonen 1987, 34-53.) In the UK the results are very similar (Wetherell 1995, 221-224).

ing how men should be. On the other hand, women are expected to educate men in parenthood. Men should be encouraged and praised, they should be given opportunities to learn, and they shouldn't be blamed for their mistakes. From time to time professionals reminded women that they should give men opportunities to participate by not keeping the baby too much for themselves. Somehow they were blaming the woman if her partner didn't participate enough.

Postnatal visit in maternity centre. Woman has left the baby with her husband at home. She is in a hurry, because it is soon time to feed the baby. The midwife asks her if she has got any time at all for herself, if she has been out alone without the baby. Woman says that she has, but she says this hesitatingly. Midwife reminds her how important it is for her to get some time of her own, and tells her to leave the baby sometimes with the father. "He can do everything else except breastfeed". Woman says that her husband is taking care of the baby a lot.

After woman has left, the midwife is still wondering to me that she was so busy. According to her, some women just don't trust their partners in child care. She says that sometimes she would like to say quite firmly to some women during the postnatal home visits that she should let the father take care of the baby more. She has enough time to do her fair share after he has gone back to work. She continues that sometimes she can see very clearly that the father would like to do more, but his partner won't let him.

Tehtaala field notes 85

It could be argued that it has become a woman's new responsibility not only to take care of her children, but also to build up a relationship between father and child by giving him opportunities to spend time with the child and encouraging him to participate in pregnancy, child birth, and child care (Juusola-Halonen & Lundström 1982). This educative task might even increase, instead of decrease, their own work load. It might also make women feel guilty if they can't manage to reach the ideal of shared parenthood in their own family life. The main issue is not that a woman needs somebody to share child

care and domestic work, but to get men involved for their own and for the child's sake: to give men a chance to enjoy their children rather than to allow women time away from parental responsibilities.

It has been argued that in psychological research fatherhood is nowadays understood in more positive terms than before. It is not seen anymore as 'a problem of the missing father', but there is now more emphasis on the relationship and communication between father and child, and on the meaning of this relationship for the man's own well-being. (Huttunen 1994.) To some extent this seems to be the case also in maternity and child health care. Today, in some areas in Finland the Mannerheim League for Child Welfare, and also some maternity centres, are even organising classes and discussion groups for men only in order to give them opportunity to share experiences and discuss fatherhood (Isät esiin 1998).

In Scotland, health professionals also underlined the importance of shared parenthood. In concrete situations it was, however, more a question of practical help in situations where it was difficult for a woman to cope on her own than of father's emotional and constant involvement. Professionals asked women, for example, if the partner does some housework or takes other children out from time to time, in order to give the mother some time to rest. If the father was present during the home visit and was, for example, feeding the baby, health professionals made positive comments about that. They also might ask men who came to the baby clinic, whether they were taking part in child care. The child's father was, however, only one person among others who were expected to help the mother. Furthermore, there were hardly any comments about women's role in changing men's behaviour.

In Finland, partners are seen as the main source of social support and practical help in child care. The pair relationship is also seen in a very positive way. In maternity and child health care male partners are very much described in positive terms both by their female partners and by professionals. For example, mothers were often very eager to assure the professionals how much the father was taking care of the child. Men were seen as present, interested, involved and supportive, even if sometimes inexperienced and clumsy in handling small babies.

Finnish health professionals very rarely made any negative comments about men. An exception to this was one occasion when the health nurse in a child health centre started to talk with a woman client about her violent husband and what kind of a decision she was going to make, whether to continue the relationship or not (Tehtaala field notes 235). Even in this situation she avoided naming the problem as male violence, blaming the man and talking openly about this topic. Instead of talking about the man's violent behaviour, she asked more ordinary questions about problems in their pair relationship and the father's participation in child care. Also outside the client situations negative comments about women's partners were exceptional, instead there were positive comments like 'this is a very nice couple' or 'she has such a supportive husband'.

These kinds of negative comments were not very common in Scotland either. However, I would argue that in Scotland the messages about men's role in family life were more mixed. Ideally, men's participation in child care was supported, but at the same time it was recognised that this was not the reality in many of the families. Men were seen either as unable, for example because of the long working hours, or unwilling to participate in family responsibilities. Traditional cultural values and gendered division of la-

bour where men have had a marginal status in everyday family life were still strong. Men were more often seen as irresponsible, demanding services instead of helping women with the housework and child care, or even as rude and violent. In couple of occasions professionals told pregnant women, whose partners had left them, that it is so easy for men to withdraw from their responsibilities, something which women can't do. Also when they were talking to me about the reasons why women don't breast feed, one of the reasons they mentioned was the negative attitudes of the partner. They told me about men to whom women and their breasts are sex symbols, meant for them, not for the babies. Another, somewhat more positive explanation was that men feel they are left out from child care, if they can't feed the baby. Men were not exactly described as persons who are responsible and capable enough to share parenting with women.

The next long quotation is an extreme and exceptional example of the negative comments about men and their family role, but it very clearly presents a picture which is very different from the ideal of a helping, supporting and participating father. It also states how helpless health professionals see their own role in changing men, or helping women to change their lives.

It is usually in the postnatal period you find that you have to find a balance between suggesting to somebody who already does nothing at home, suggesting to that person it would be a good idea if they helped. There appears to be almost a cultural attitude there that it is women's stuff and you try to convey the message that it is actually human stuff for both parties but some people just don't want to know. ... Some of them (women - mk) are frightened of the men in their lives, and you go into a house and if you are not welcomed with a warm greeting and you perhaps have a lady who has had a caesarean section, I have seen this umpteen times, or somebody who is in a lot of pain, and you need something and you say, could you maybe go and get me some nappy changing stuff and the man will completely ignore you. I think you would need to be an idiot not to realise

that that wasn't a good opening for any conversation ... and you can get people who I would class as rude behaviour, but it is just the way they live. And it is a strange thing to go into a house where you can witness the timorous behaviour of the woman, who appears quite subservient to the man and the man doesn't acknowledge your presence. It is a bit uncomfortable, so what you do at that point you just adjourn to a bedroom out of the way where you can relax because the women won't open up in front of the men. I think another thing that you realise when you consider this, not everybody is like this, but you might go in on the 4th or 5th postnatal day and find a stitch line completely burst because the man has decided to have intercourse. That is pretty brutal. I would say I have seen that maybe a couple of times a year, and other men, it is almost like oh well I will wait until the six weeks are passed, but you will have situations where you know that happens, and there can be evidence of assault and there is not a great deal you can do because in a lot of these cases the women themselves accept that as a normal part of the relationship that they have with that person. I might not approve of it but there is very little I can do to influence it unless she specifically seeks my help which they don't do. You come out of situations often thinking, oh dear, but your hands are tied. What you have got to realise it that you are not there as a marriage guidance counsellor, you are there as a midwife to fulfil a specific function. ... I would say a high percentage of cases families are happy but we do see very, very unhappy situations and we really aren't in a position to influence it and what you have got to be very careful of is that you don't actually create a problem for the girl.

Scottish midwife 8

This description of women living in oppressive or even in violent pair relationships is in a clear contrast to the ideals of an equal pair relationship and shared parenthood. The midwife does not even call women's partners fathers but refers to them as 'that person' and 'the men in women's lives'. During the last few years in Scotland domestic violence has very much been raised as a gender issue, as male violence against women and children, especially in the Zero Tolerance campaign in posters and in television (Cavanagh & Cree 1996)⁷. Although this was a very marginal issue in maternity and child health

⁷ In the Autumn 1998 Finland has followed the Scottish example and the National Research and Development Centre for Welfare and Health and the City of Helsinki have jointly launched a similar campaign.

care, mentioned only in few instances, 'the dark side' of family life was recognised more among Scottish health professionals than among their Finnish colleagues who very much operated with the positive image of the pair relationship and gender relations. In Scotland instead, shared parenthood is much less the context where motherhood is discussed by the health professionals.

Lone mothers

In both countries, a remarkable number of families are headed by a lone mother and the number has been increasing in recent years. In Scotland, according to the 1991 Census figures, one-parent families account for 21.5 per cent of all families with children and the vast majority of them are headed by a lone mother (One Parent Families Scotland 1998). In Finland the number of lone mothers has also increased. In 1996, from all the families with children under the age of 18 15.8 per cent were families headed by a lone mother and 2.2 per cent headed by a lone father (Tilastokeskus 1998). Even if these numbers are not remarkably different in the two countries, the social situation of lone mothers and the public debate around lone motherhood is very different.

According to Jane Lewis, in Britain from the 1980s onwards one of the most heated debates in relation to family life has been about lone parent families together with the responsibilities of the 'missing fathers' (Lewis 1993). Lone-parent families headed by women, especially never married single mothers, are seen in public debate as a threat to

traditional family values and as a financial problem for the state (Millar 1994).⁸ Divorced or widowed women and affluent single mothers have very much been excluded from this debate. The political and public climate has made single motherhood first and foremost a moral issue in the 1990s (Mann & Roseneil 1994).

In the British discussions lone motherhood is also often connected to teenage pregnancies. Teenage mothers are not only seen as a problem because of their young age, but also because they are often single mothers. Teenage motherhood as a social problem has had a great deal of public attention in Scotland in recent years. At the same time, the expansion of sex education for young people is often opposed, because it has been argued to encourage young people to have sex too early.⁹

In Finland there has been less public debate on lone motherhood and not such a strong connection is made between lone motherhood, social class and social problems as is the case in the UK. In Finland also the economic situation of lone parent families has been seen as fairly good compared with many other countries, because lone mothers maintain

⁸According to Jane Millar the British post-war social security system was founded on three assumptions; full employment, male breadwinners and stable families, where the main form of financial family support was expected to be male wages. This has meant that lone mothers are often trapped in poverty and dependent on state benefits. In 1989 in the UK 72% of lone mothers were on income support. Jane Millar, like many other British researchers, has criticised that instead of blaming individual mothers, what should be tackled are the social reasons of poverty among lone mothers. (Millar 1994.)

⁹ In Scotland pregnancy rate among teenagers is almost three times as high as it is in Finland, 45.6/1000 teenage girls in 1993, whereas in Finland it was 16.9 in 1991. Another difference is that in Finland most teenage pregnancies, especially in the youngest age groups, are terminated, which is not the case in Scotland. (Teenage Pregnancy in Scotland 1994; Gissler & Hemminki 1994.) In Finland, teenage motherhood as a social problem has been hardly recognised at all in public discussion or in social and health services. This is probably partly because of the different numbers in teenage pregnancies and pregnancy outcomes, but also because of the different social atmosphere.

themselves and their children with their own earnings, working full time, and the welfare state has made it possible for them to combine motherhood and paid work. (e.g. Forssén 1997.) In this respect, lone mothers are no different from other women with young children.

However this is not to imply that lone parent families are not seen as a problem at all in Finland. Growing up in a lone parent family is often seen as a risk for children's normal development or as an explanation for their social, educational and psychological problems. Still, it could be argued that in Finland in the 1990s rather than lone mothers being viewed as a special problem they are seen as one example of the increasing diversity of family forms in general. Since the 1960s cohabitation has already become very common and also a socially accepted and officially recognised family form in Finland, and from the 1980s onwards there has been a lot of public (media) attention on reconstituted families as a 'new' and increasing family form (Ritala-Koskinen 1993). There has been a growing demand that all different family forms, married and cohabiting couples, reconstituted families and even homosexual couples should be treated equally, for example in legislation. In 1991, a Committee was set up by the Ministry of Justice in order to assess how the family is defined in different aspects of legislation. The purpose of the assessment was to standardise the law in relation to the family. The Committee found it impossible, however, to give any universal definition of the family. (Perheet ja laki 1992.)

In Finland there has been a public debate for and against the traditional nuclear family. It has been argued that the nuclear family holds an overly dominant ideological position in society, even though it no longer corresponds to the way in which many people are

actually living their lives. There are also supporters of the nuclear family who have argued that other family forms, such as lone parenthood and cohabitation, have been made financially too attractive, in the taxation and social security systems, compared to marriage. (Forsberg et al 1991.) Although there are contradictory opinions in this debate, it shows that lone motherhood is nowadays more socially accepted as a family form among others and not so much seen as a special social problem.

Correspondingly, in maternity and child health care in Finland there is more discussion about changing family forms and family relations than about lone motherhood as such. Midwives mentioned single pregnant women very much as exceptions in maternity care. There is also some confusion about who should be defined as a single mother, where the line should be drawn, because for the health professionals being unmarried, or even living apart, doesn't necessarily mean being a single mother.

At the moment I don't have any single mothers. Except one, how should I put this, who is partly alone, because her partner lives abroad. Of course, from time to time, there are mothers whose relationship is somehow unstable, or the partner is a foreigner and lives abroad, and can't get a permit to stay here permanently. These kinds of cases I have from time to time. It brings its own problems to the pregnancy. But, really, for a long time I haven't had any mothers who have no support at all from the child's father, who are all on their own.

Finnish midwife E

Instead of talking about single mothers who are alone right from the beginning, Finnish health professionals were talking more often about divorced or separated mothers, or parents, and about their new families. What was seen as problematic by the professionals was not so much lone motherhood or parenthood as such, but changing and complicated family relations caused by separation and new relationships of lone parents, espe-

cially of mothers, with whom the children usually live. Family relations were defined both in terms of biology and by cohabiting, and often the situation was looked at from the children's point of view. What was seen as important is continuity, both the continuity of biological family relations and the continuity of the parent's new relationship.

INT: Do you have many lone parents among your clients?

HN: No. I don't know if it's that cohabitation has become more common which has meant that there are not so many lone parents. Of course there are always some of them. But often when there is a divorce, very soon there is a new father figure or mother figure. This kind of periods of lone parenthood are not necessarily very long.

INT: Are there any special questions that come up with them here, or that you see as important to discuss with them?

HN: At least I always say, from the child's point of view, that every child has the right to have the father and the mother. That's what I have said. It is the most important basic principle which I want to emphasise. And I ask if the child has been meeting her parent, whether it is the mother or the father that is missing from the family, whether meetings are organised. And also that the child has somebody else as a father figure or a mother figure. Quite often this kind of a father figure is missing these days.

Finnish health nurse J

INT: You already mentioned, that nowadays there are more step-families? What are the issues that you have come across in your work concerning step-families, or that your clients discuss with you?

MW: It could be that these things are not discussed at all, but if I feel that I can ask. ... I have quite directly asked, for example, how often they meet the children who are not living in the family. And how it works out if the distances are great. Just at the moment I have a family where the father's children from his ex-marriage live quite far away. This mother says that it is so exhausting, she is not always willing to go, and this causes conflicts between them. And the other thing is that these children come here every other weekend, and it causes so much extra work for this mother. ... I think these are quite big problems. If you think, like in this family, that there is one child from the mother's ex-marriage who lives with them. The mother drives him every other weekend to see his father, who lives far away from here, and it is hard especially now when there is this new baby. Then there are the father's children, three of them, who come to meet their father,

often one at a time, but sometimes two of them might come at the same time. ...I think it helps when we talk about these things, although there is really no concrete help to offer, except maybe to suggest that these meetings could be organised differently for a while now when there is this new baby. These things we have discussed, and also about relationships between the children, and how they take this new baby.

Finnish midwife E

Divorces, separations and reconstituted families have widened the sphere of family relations. Even if a couple separates, the child's relationship with the parent living elsewhere is expected to continue. Adults, especially the mother and even the father's new partner, are seen as responsible for maintaining and supporting this relationship, even if this might cause enormous practical problems. Hannele Forsberg (1995), who has studied the ways in which fatherhood is discussed in encounters between social workers and their clients, has noted that on some occasions divorced women were encouraged to maintain the relationship between father and children, even if the relationship between the former partners had been very problematic, or even violent. Changing family forms are seen as causing psychological and behavioural problems for children, even if it is not parents' separation as such which is seen as the main problem, but more often any new relationships the mother may have. In Scotland these issues were not raised at all. There were no discussions about fathers living away from their children, or about children's need to keep in touch with them, even if divorce and separation are also common in Scotland.

In Scotland, instead of separated parents and reconstituted families, single mothers were discussed much more. Single motherhood was often connected with young age and working class background. Descriptions about single motherhood were very much problem oriented, but health professionals also emphasised that not all of them have

problems in parenting. It is also interesting that single motherhood and the problems single mothers were seen to have, were connected more with very practical issues in the organisation and management of their daily lives rather than with the missing pair relationship.

INT: Do you think they (single mothers - mk) need more from you than the others?

MW: It depends on the individual. Some of these single mums are very confident and they have brought up their younger brothers and sisters more or less because their mum has maybe gone out to work so they know what bringing up children is all about. I know it is different having your own but they seem to cope and they don't really want to come along to parentcraft education because they know how to make up bottles, they know how to bath the baby, they know how to change a nappy. It is all done on an individual basis really and how we think they are going to cope by the state of the house and things like that.

Scottish midwife 5

INT: You said that you have quite a lot of single mothers, do you find that they are a special group who need more of your time.

HV: Some of them yes do need a lot of reassurance, a lot of guidance and a lot of support. Quite a few of the single mums are very caring, very good providers and they manage very well. Some of them are just able to cope better than others.

Scottish health visitor 4

(Health visitor is talking about problems that parents might have with toddlers) But certainly there is quite a lot of behaviour problems, they will phone you up and say their child is climbing the walls or I can't control this child for some reason. So a lot of the time you can give them some management, but it is not easy. If they are in their home on their own, maybe if it is a single mother and she has got a few other children, she is maybe finding it hard to really control the child and give the child things to do, maybe what they will do is sit them in front of a television and think that will do them, but they need more stimulation.

Scottish health visitor 8

Kirk Mann and Sasha Roseneil (1994) argue that more than before there are now young single mothers who are not necessarily abandoned by the child's father or whose preg-

nancies are not 'accidents', and who, in this respect, are not victims. Instead, according to Mann and Roseneil, a significant proportion of lone mothers in the 1990s do not intend to marry and see no place in their families for a 'father figure'. There appears to be a new confidence and assertiveness among many working class women. Whether or not this is representative of young single mothers in general, to some extent it does seem to be shared by the health professionals. The main question for them is not the missing father but women's ability to cope in their daily lives.

On some occasions, especially in connection with parenthood classes, Scottish professionals expressed what could be interpreted as criticism towards the ideological basis of parenthood education, which is very much targeted at couples. According to some professionals, this seems to keep young, single women away from the classes. For them, child birth as family event is a middle-class ideal, distant from the everyday experience of young, single, working class women. Because of this it is understandable that they don't want to attend these classes where they feel excluded and inadequate. The same kind of criticism has been directed towards Swedish parenthood education (Juusola-Halonen & Lundström 1982), but in Finland there have been no discussions at all about whether there should be different groups for women in different situations.

The women only class has in fact started to evolve into a singles' class. I haven't done anything, it has just evolved itself into a singles' class and single girls have different needs, so these may well have to be looked at, at some point in the future, but at the moment I am keeping everything that is offered in the afternoon the same as everything that is offered in the evening.

Scottish midwife 10

(The midwife is talking about her role in parentcraft education) There is a community centre in one of the particularly more socially disadvantaged areas that we would like to

get involved in. Maybe even do parentcraft catering towards teenagers, young mums because you often find that young mums will not go to the parentcraft education class that is full of married middle class women, they just feel intimidated, so they don't go. As midwives we feel there is a need in our area at the moment because there is a rising teenage pregnancy rate in this particular area and we would like to get in there, but at the moment we are just working on that. Teenagers, I think they need more health education and they also need to be able to talk to someone about their fears, and if they are in a group of women, middle class women, and they are worried about having no money, they are not going to highlight that. When a woman is talking about labour, they are wanting to know, how much money they are going to get. So I think we need to have a group just of young women, teenagers, so they can come along with their friends if they want to, rather than have to sit there and think, oh I don't have a partner and things like that.

Scottish midwife 7

The way in which Scottish health professionals talked about single mothers was sometimes quite judgmental and problem oriented, but it also differs from the political debate and public 'moral panic' over single motherhood (Mann & Rosenail 1994). They are more sensitive to the everyday lives of lone mothers who are not seen as problematic only because of the missing male partner, but are assessed more according to their practical skills to cope in the everyday life with young children. In Finland, instead, a lasting, stable pair relationship is much more likely to be seen as an essential part of parenting and family life, and the whole issue of lone mothers is very much ignored.

Conclusions - what is family

In both countries motherhood is expected to take place in a family context and family support is seen as important for mothers, but what constitutes this supportive family is defined quite differently. Health professionals in Finland are working in a family oriented way where motherhood is defined in the context of the nuclear family and parenthood is expected to be shared between partners. Family form itself is not the most im-

portant issue, for example, marriage and cohabitation are equally accepted family forms. Instead, the quality of family relations, between partners and between parents and children, is given great weight, even in situations where parents and children are not living together.

In Scotland family is understood more widely.¹⁰ Motherhood is expected to take place in a permanent heterosexual relationship, ideally in marriage, but male partners are given quite a marginal role as caring and sharing parents in maternity and child health care. Shared parenthood is not the context where motherhood is discussed. Instead of the male partner, the woman's own mother and other female relatives are seen as an important source of 'family support'. Depending on the context this support can mean emotional support, teaching in domestic skills, actual help in child care, financial support or even two generations living together.

In Finland, this kind of 'family support' is seen as having very much disappeared from modern society. Rapid urbanisation which took place in Finland from the 1950s onwards has been described as a process where the younger generation moved from the countryside to the cities to live isolated, (nuclear) family centred lives in rapidly built new suburbs at the outskirts of the cities, and this 'big move' also very much cut their relations with their parents and other relatives (e.g. Kortteinen 1982). The disappearance of traditional family relations is often mentioned as a reason for the increased need for professional support and advice for new parents (Vehviläinen-Julkunen 1990, 2)

¹⁰I realised this very concretely and personally when one of the midwives once asked me about my family. I first told her that I do have a partner but no children. She wasn't happy with my answer, she wanted to know about my parents and my sisters and brothers.

Scottish health professionals described close family ties between women as an ideal situation which ensure social support and practical help for women with young children. Health professionals were also worried that in modern society the situation was changing. Again they made a distinction between middle class mothers and working class mothers. Middle class mothers were described very much with the same terms as the 'modern Finnish family', whereas the working class family was seen as more traditional where close family ties among women more often existed. Family support was seen as crucial especially for single mothers, but its importance for all women was emphasised. Even in middle class family life, male partners were not seen to have replaced family support provided by female relatives.

I think because it is quite rural and quite middle class (area) and a lot of women have moved away from their families so they don't have the back-up of the extended family. So they tend to be isolated in a way so they seem to depend more on the midwife for support. In comparison to the inner cities where maybe the families are quite close together, they have got their mum down the road or their granny down the road, they seem to get a lot more support from the family. A lot of the women in our area don't, they are just by themselves and their husband, and I think I have said before that you find that women who are very articulate, they demand more, they just need more support. Whereas, in fact, I always feel that a working class person who has nobody and has no money probably needs more support but very often, as I said, she has her family's support.

Scottish midwife 7

In Scotland the family ideal in maternity and child health care is more traditional than in Finland at least in two ways: First, the role given to the male partner is more traditional. Men are first and foremost seen as breadwinners, even if often as an unreliable breadwinner, and only very marginally as a caring father. Unlike in Finland, the changing role of fathers is not supported in family policy. Second, family is understood as an extended family, and family support provided by female relatives is seen as meaningful for moth-

ers. They can even replace missing fathers. In Scotland family is very much defined as the women's sphere and motherhood is shared with other women rather than with men.

The Finnish ideal of shared parenthood and recognition of men as fathers could be seen as more modern and advanced, but it could also be argued that this understanding of family life is perhaps too idealistic and limited, ignoring what is the reality for many women. At the same time it might be ignoring and excluding other possible sources of social support and concrete help for mothers.

CHAPTER 9

EVERYDAY EXPERIENCE AND PROFESSIONAL EXPERTISE

In this chapter I will discuss possible points of conflict between health professionals and mothers and between lay and expert knowledge relating to motherhood and child care: Whether and in what ways these conflicts exist and become visible in maternity and child health care. I haven't interviewed the mothers and asked their opinions about health professionals and services provided. Instead, I have looked at the ways in which health professionals interpret these conflicts: how they see clients who don't take their advice, who don't attend the visits or who challenge their professional knowledge and expertise.

Conflicting definitions of mothers' needs

In the introduction I discussed two different feminist perspectives on maternity and child health care and on the relationship between health professionals and their female clients. Especially the approach I named control perspective has emphasised a conflict between women's everyday experience as mothers and expert definitions of motherhood (e.g. Graham & Oakley 1981; Mayall & Foster 1989; Heritage & Sefi 1992). It has also emphasised that services that are offered do not meet women's actual need for services.

In maternity care this conflict has most often been defined as a conflict between medical and 'natural' views, or discourses (Ruusuvaori 1994), about pregnancy, childbirth, and motherhood. Feminist researchers have criticised mainly doctors and the medical model of maternity care (Graham & Oakley 1981; Garcia et al 1990; Wrede 1991). For example Hilary Graham and Ann Oakley (1981) who have studied encounters between doctors and pregnant women in antenatal clinics argue that "conflict, rather than being a peripheral issue, is a fundamental feature of the relationship between the providers and users of the maternity services." They point out that "doctors and mothers have a qualitatively different way of looking at the nature, context and management of reproduction". Their 'frame of reference', both the ideological perspective and the network of individuals who are influences upon their set of values and attitudes, Graham and Oakley argue, are completely different. According to them, doctors treat pregnant women in a narrow way as patients and the pregnancy in the same way as an illness, whereas women situate the pregnancy in the wider frame of their everyday life. They show, by using very strong and extreme examples, how doctors treated women as incompetent and ignorant, ignoring their knowledge, and refusing to give proper answers and explanations to women's questions. In conclusion Graham and Oakley state that changes of the system, rather than changes in the system are required in order to solve the conflict.

Some researchers (e.g. Laryea 1991) have shown similar differences in midwives' and mothers' perceptions of motherhood. Maureen Laryea has studied these perceptions in the postnatal period, during the first weeks after child birth. According to her, midwives used and emphasised the biological and medical aspects of motherhood, seeing it as a normal process in a woman's life cycle and an indication that she has achieved physical maturity. According to this definition the care given to women in the postnatal period

focused on physical aspects. For the mothers the meaning of motherhood extended beyond the biological act of reproduction and the birth process. They placed the main emphasis on their acquisition of a new social role. This social aspect, Laryea argues, was missing in the midwives' perspectives. According to these studies, the views of service providers differ remarkably from those of women themselves.

In child health care the conflict has been seen as one between the views of 'child care experts' and women's everyday experiences in caring for their children. Unlike in the case of maternity care, more attention has been paid to female service providers, to health visitors who have often been seen to 'police the family' (Abbott & Sapsford 1990; Dingwall & Robinson 1990; Heritage & Sefi 1992).

Several British researchers have pointed out that mothers and health visitors hold different opinions about how much and what kind of services women and children need (Blaxter & Paterson 1982; Mayall & Foster 1989; McIntosh 1992; Carter 1995). There doesn't even seem to be an agreement about who health professionals are targeting. For example, according to Berry Mayall (1990), health visitors thought they worked with mothers for the child, whereas mothers thought health visitors' and doctors' work was focused on the child. Different forms of child health work are also judged differently by the mothers. Often women seem to appreciate child health clinics more than home visiting. For example Mayall and Foster (1989) found out that although mothers accepted the principle of surveillance this did not mean that they accepted the unannounced home visits. Health visitors talked in very positive ways of 'dropping in' and 'popping in', but these visits looked to many mothers more like inspection of their child care standards.

It has also been argued that mothers, at least many working class mothers, do not see the relevance of the child health services for themselves because they understand health visitors as policing child neglect and child abuse (Blaxter & Paterson, 1982, 167-169; McIntosh 1992). According to James McIntosh (1992), working class mothers in his study identified, in principle, the relevance and importance of child health clinics and health professionals working in them, but they only considered a small proportion of the clinic functions relevant to themselves. They saw the clinics as having a substantial social control dimension. The monitoring of child abuse, neglect and maternal competence and the support offered to 'inexperienced' mothers was something that, according to them, was needed for 'others' but not for themselves. Instead, they saw themselves as experienced in infant care and already having informal support from their social networks, with no need for professional advice and intervention.

It is interesting that according to many British studies mothers seem to value much more lay advice and personal experience in child care than the professional knowledge of health professionals. Even so much so that health visitors, and to certain extent also midwives, are judged by the mothers according to their personal experience and feminine qualities rather than their professional expertise. Health visitors who have children themselves are more trusted and respected than those whose advice is seen to be based only on 'book knowledge'. Doctors, instead, are judged according to their medical expertise. (Carter 1995, 172-179; also Blaxter & Paterson 1982, 167-169; Mayall & Foster 1989, 18-20.)

All these studies seem to emphasise that there is some kind of fundamental gap and conflict between everyday experience and professional knowledge about motherhood. This

conflict is defined in different terms in maternity care than it is in child health care, but nevertheless, it has been seen to exist in both. It has also been argued that mothers use different forms of resistance to oppose professional intervention into their life, even if they do not openly challenge the professionals (Bloor & McIntosh 1990; Heritage & Sefi 1992). I will now move back to my own data to analyse whether and in what ways this conflict materialised in the various health care settings of my research.

Non-attendance as a problem

It has been a challenge for the experts to get women to use their services, to take their advice, and to forget the traditional customs in pregnancy, childbirth and child care which have been seen as misleading, old fashioned and even dangerous. According to expert opinion, pregnancy and child development should be monitored regularly in order to prevent medical, psychological and social problems and risks, or to find them at an early a stage as possible. Maternity and child health services, unlike most other health services, are 'supply- rather than demand-driven' (Heritage & Sefi 1992). It is defined by the service providers, not by the users, how much and how often they should be used. Women who do not attend antenatal visits or do not bring their children to health and developmental checks are seen as acting unwisely, carelessly and even dangerously. It has been one of the major concerns of the service providers how to reach those women who do not actively seek their services. There is, however, a remarkable difference between the two countries in the extent to which 'non-attendance' has been identified as a problem in maternity and child health care: In Finland it has been emphasised that serv-

ices are extremely well attended whereas in Scotland non-attendance has been discussed as a notable problem.

Two different forms of 'non-attendance' can be identified in maternity and child health services: first, there are women, or families, who do not use the services at all, or who use some alternative services. This group is probably very small in both countries. More common, instead, is to use the services less than is recommended in professional schedules or not to attend when invited.

There are no national statistics available either in Finland or in Scotland of how many per cent of pregnant women or children under school age are using, or not using, maternity and child health services, or how regularly they are using them. In Finland, these kind of statistics were available in child health care until 1973 and in maternity care until 1979. According to them, in 1973, 97.1 per cent of all children under one year of age were registered as clients of child health centres, and in 1979, 99.9 per cent of all pregnant women were registered as users of maternity health centres. (Suomen virallinen tilasto XI.78; Terveystieteiden tutkimuskeskus 1987.) There is, however, a reason to believe that these numbers haven't significantly changed during the last twenty years. Since the 1970s only the total annual number of visits has been shown in health statistics. There are also statistics which show the average number of visits per pregnancy. None of these statistics shows the individual variation in the number of visits among women and children. In this respect the situation is similar in Scotland. Also in the Scottish health statistics only the total number of visits or the average number of visits per client are shown (Scottish Health Statistics 1993; Provision of Maternity Services in Scotland 1994, 28).

Among professionals in Finnish health centres there was a clear agreement that non-attendance is not a problem they face in their work. Instead, they emphasised how well women or families are using the services, sometimes even more than would be necessary. Those who didn't use the services or used them irregularly were seen as rare exceptions. In those cases non-attendance was not defined as a problem in itself but as a sign of some other, deeper, social or family problems.

(They attend) extremely well, if you think that there is no law or money that oblige them to come. They remember to book visits and come tremendously well.

Finnish health nurse A

Of course there are always some families who don't regularly use our services. I have never come across any total refusals, but there are some who only come occasionally. They are often families which have many social problems. There might be unemployment, alcohol problems, maybe psychiatric problems. I somehow feel that in the middle of all these problems the family occasionally remembers that this place exists. They might book a visit, but then not necessarily come, or they only come occasionally. These are the main reasons for non-attendance.

Finnish health nurse J

During these almost ten years I have had two mothers who haven't come to the antenatal visits at all. In both cases they allowed me to do the postnatal visit. This is my experience. One of these mothers gave her baby away, and I didn't ask why she didn't come to the antenatal visits. I understood her reasons. The other one was an ordinary housewife who already had one child, and she certainly knew how this system works. When I phoned her afterwards and asked if I could come for a visit, she said 'please come'. She didn't say why she hadn't come, and I didn't ask. I wanted to respect her opinion, because there was nothing wrong after all. I don't have any other experiences. I have never been in a situation where I have had to chase somebody up to come for a visit. Usually mothers phone you, if they are not able to come, and they book a new appointment. And I have the feeling they are quite happy to come.

Finnish midwife E

The view that non-attendance is a problem only in rare cases, among 'families with social problems', is shared by official health policy reports. The Committee for the Development of Maternity and Child Health Care emphasised in its report in the mid-1980s, in relation to parentcraft education, that "The families which are most in need of support are most often found among the group of people, whose own activity, motivation or mental capacity is not strong enough to participate" (Neuvolatoiminnan kehittämistyöryhmän muistio 1984, 115). One group of women that has received a lot of attention, although defined as quite small and marginal, is women with alcohol problems. Their problem is said to be not only drinking in pregnancy but also non-attendance in antenatal care. (Jaakkola 1988.) Non-attendance, for whatever reason, is seen as a sign of personal, social or mental problems, not as a clients' choice.

Professionals in Scotland, unlike their Finnish colleagues, often mentioned non-attendance as an everyday phenomenon in their work. They also used home visiting as a method of reaching women and children who didn't attend the clinics.¹ Non-attendance was maybe slightly less of a problem in child health care than in maternity care, because the work of health visitors is in any case so much based on home visiting, which is a more definite way of contacting clients. They mentioned it as a problem mainly in relation to developmental assessments which are usually done at the clinic, and should be done at certain ages according to a fixed schedule.

The quite high level of non-attendance could be noticed even by observing the clinics. It was not unusual that no more than half of the invited clients arrived, and health profes-

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sionals used a lot of time just sitting and waiting. One of the health visitors told me that for some time she used to use double booking in order to avoid the waste of time. If it was bad weather, a busy Christmas season, or a nice summer day, health professionals expected even fewer clients to attend. Non-attendance or 'late booking', coming for the first antenatal visit later in pregnancy than recommended, have been seen as problems also in official health policy documents and in health service research (Porter & Macintyre 1991, Reid & McMillan (no date); McIntosh 1992). There have been some concrete attempts to solve the problem by making clinics more accessible, for example by bringing them geographically closer to the users (Reid 1983).

According to the professionals in Scotland, as well as policy makers and researchers, it is most often working class, often single women living in deprived areas, who fail to attend the clinics. Again non-attendance is connected with social problems. Using this background knowledge and their work experience, professionals almost expected some women not to attend. On the other hand, they didn't see non-attendance only as an individual failure, but emphasised also practical problems, such as long distances, lack of transport and problems in travelling with several young children. In this respect they were understanding of women's reasons for not attending, whether or not these were their 'real' reasons. At least they gave morally and socially acceptable excuses for women (Strong 1979, 48-49).

It is much easier in an area, for example in the suburbs, certain suburbs where everybody is on the telephone, everybody has got a car, they can come and use the services. You must remember that GPs are not zoned here, we cover huge areas and when it is a cold day like we have got today and if it was immunisation and for a young person with two children and using public transport, it is not always easy bringing them over. So you have

to allow for those and try to give the mother appointments at the date which would suit them because it is not easy to come with very young families, public transport and the cold and with the financial constraints they have. So the targets, as we call it, that those things should be looked at as well because it is very important perhaps to see when we devise systems what is, is it feasible, is it achievable, and is it achievable in the time because they have so many other concerns and worries. Scottish health visitor 5

Using my data it is difficult to comment on whether women used non-attendance as a form of criticism and resistance towards expert intervention, definitions of their needs, or quality of services. However, in Scotland, women who were most likely to be blamed for non-attendance, are also those whose parenting skills are less likely to meet the professional standards of motherhood. From their point of view, it might look rational to avoid professional surveillance (see also McIntosh 1992).

Health professionals in Scotland were partly blaming individual women for non-attendance, but they also emphasised that services should be organised in a way that would make it easier for women to use them. Still, they did not seek the reasons in the content of the services, as some researchers have done. For example, Maureen Porter and Sally Macintyre have argued, based on several studies on antenatal care, mainly on medical consultations, that antenatal care does not meet the psychosocial needs of pregnant women. Nevertheless, according to them, women attend the clinics extremely well, even if they are not sure if it is worthwhile. They conclude that “the ‘problem’ is not high rates of defaulting, but the quality of care offered.” (Porter & Macintyre 1991; also Oakley 1992.) In the 1990s, this feminist critique has also reached the official health policy in the UK. Especially in maternity care in Scotland, the ‘individual needs and wishes of women’ is mentioned today as one of the main objectives in developing the services (Provision of Maternity Services in Scotland 1994, viii). Still, it could be asked

whether this is more official rhetoric than a principle which has significantly changed professional practice.

Competing with the grannies

As I discussed in the previous chapter, health professionals emphasise the importance of 'family support' for mothers. In Finland this help and support is expected to come mainly from male partners, whereas in Scotland female relatives, especially woman's own mother, are seen as an important source of 'family support', advice, social support and concrete help. This 'family support' shouldn't, however, threaten the legitimacy of professional advice. Men were not seen as a major threat in this respect: especially in Finland fathers themselves have become targets of professional education along with mothers². In Scotland instead, female relatives, especially women's own mothers with their knowledge from their own life experience, were often seen as a competitive source of advice. In the Scottish maternity and child health care grandmothers were also concretely much more present than in Finland, where they were occasionally discussed but hardly ever met. In Scotland, grandmothers came with their daughters to antenatal clinics, to parentcraft classes, brought children to baby clinics, or they were met during the home visits.

Health professionals in Scotland emphasised that mothers should teach their daughters basic household and child care skills. It was assumed that, ideally, these skills are 'in-

²In Scotland, however, health professionals sometimes blamed the negative influence of male partners e.g. in relation to women's unwillingness to breastfeed.

CHAPTER 9

EVERYDAY EXPERIENCE AND PROFESSIONAL EXPERTISE

In this chapter I will discuss possible points of conflict between health professionals and mothers and between lay and expert knowledge relating to motherhood and child care: Whether and in what ways these conflicts exist and become visible in maternity and child health care. I haven't interviewed the mothers and asked their opinions about health professionals and services provided. Instead, I have looked at the ways in which health professionals interpret these conflicts: how they see clients who don't take their advice, who don't attend the visits or who challenge their professional knowledge and expertise.

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In the introduction I discussed two different feminist perspectives on maternity and child health care and on the relationship between health professionals and their female clients. Especially the approach I named control perspective has emphasised a conflict between women's everyday experience as mothers and expert definitions of motherhood (e.g. Graham & Oakley 1981; Mayall & Foster 1989; Heritage & Sefi 1992). It has also emphasised that services that are offered do not meet women's actual need for services.

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As I discussed in the previous chapter, health professionals emphasise the importance of 'family support' for mothers. In Finland this help and support is expected to come mainly from male partners, whereas in Scotland female relatives, especially woman's own mother, are seen as an important source of 'family support', advice, social support and concrete help. This 'family support' shouldn't, however, threaten the legitimacy of professional advice. Men were not seen as a major threat in this respect: especially in Finland fathers themselves have become targets of professional education along with mothers². In Scotland instead, female relatives, especially women's own mothers with their knowledge from their own life experience, were often seen as a competitive source of advice. In the Scottish maternity and child health care grandmothers were also concretely much more present than in Finland, where they were occasionally discussed but hardly ever met. In Scotland, grandmothers came with their daughters to antenatal clinics, to parentcraft classes, brought children to baby clinics, or they were met during the home visits.

Health professionals in Scotland emphasised that mothers should teach their daughters basic household and child care skills. It was assumed that, ideally, these skills are 'in-

²In Scotland, however, health professionals sometimes blamed the negative influence of male partners e.g. in relation to women's unwillingness to breastfeed.

herited' from one generation of women to another, that girls learn cooking, cleaning, household budgeting and child care in their own homes, from their own mothers. It was seen as problematic if these skills hadn't been learned, either because there are no longer such big families where these skills could be 'naturally' learnt or because their own mothers didn't have these skills either.

To some extent, professional advice is seen as an alternative to these inherited skills. Not only in Scotland but also in Finland, the disappearance of traditional family relations is often mentioned as a reason for the increased need for professional support and advice for new parents (Vehviläinen-Julkunen 1990, 2). Health professionals in Scotland also saw themselves, and other professionals and agencies, acting as some kind of 'mother substitutes' who had to teach these skills if they were missing. (Edwards 1995; McIntosh 1992).

Parenting skills to my mind is things that tend to be passed on before, from say the grandmother onwards, how to cope with children, childhood diseases, feeding, how to cope with the other stages of say when they become toddlers. Now these things used to be passed on say from grandmother to daughter and so on and people were able to cope, most of the people were able to cope with that. Now many of them don't see those, so many children really, in small communities. You find they have a problem of knowing what is involved in child care. Most of the things they look at in glossy magazines and the babies look lovely, no problems, wonderful babies and then when they have sleepless nights and they have other things like colic, perhaps temper tantrums things like that, they find it very difficult because they have never really faced it before. So these are all to me the kind of problems and I feel very strongly a sense of commitment to helping them to cope with these and learn because these are, to be a parent is really a learning skill and I think that is quite important that they learn the skills and I feel a great part of my job is to help them to do this.

Scottish health visitor 5

Some of them (single mothers - mk) yes, have very good family support, some of the single mums they have extended family within the village who are very supportive. There are others who don't have the same amount of support and they have to rely on day nurseries and social work department, family aids to go in and offer support and really teach these girls how to provide basic food and that sort of thing. Where, if for a reason, they don't have their mother there to guide them. Scottish health visitor 4

James McIntosh (1992) suggests in his study about the use of child health clinics among working class mothers in Glasgow that also women themselves might use the clinics as an alternative to more informal type of support. Those mothers who said they hadn't got enough help and advice from their family, attended the clinics more often compared with the mothers, who said the support had been adequate. However, only a minority of women used the clinics as a resource for assistance with problems associated with parenting or the health of the infant. Instead, the vast majority of visits were done for routine purposes, for weighing the baby, immunisations, and developmental assessments.

It is somehow contradictory that in Scotland, at the same time as grandmothers are seen as an important source of social support, advice, and concrete help for mothers, they are also described as 'bad influence'. There seems to be a conflict between expert knowledge and lay knowledge in child care (see also Mayall & Foster 1989; McIntosh 1992). Professionals presented themselves as experts who have the correct, most recent knowledge and information, but grandmothers were seen as a more powerful influence with their old fashioned and even harmful advice which their daughters were more willing to follow. This conflict was most obvious in baby feeding. It also seem to have long historical roots in child welfare work. Jane Lewis wrote about health visiting in the early decades of this century: "The health visitor was supposed to counter the influences of hostile, old fashioned grandmothers and interfering neighbours who might favour the

use of unhygienic long-tubed feeding bottles or dummies.” (Lewis 1980, 106.) Health professionals I studied, almost a hundred years later, complained that mothers tell their daughters not to breastfeed, to start solid food for the baby too early, and to feed children with food that is unhealthy for them.

Yes, it (poor diet - mk) is kind of a circle really because nobody gets out of it really and it is really, – their mother will tell them – oh, it doesn't matter if you give them cow's milk, I gave you cow's milk at two months and there was no problem with you. Or, I started you on solids at 6 weeks and there was no problem, so it is all attitudes and beliefs, so when the health visitor comes in and says don't give them that, they are too young, but there has not been any problem with their mother giving them that so they don't – it's breaking down that attitude and telling them, well, there are problems associated. You may not see them now, but you will see them in a few years to come.

Scottish health visitor 2

They have a lot of problems with feeding that you have to discuss. Also infant feeding practices have changed a lot in the last 20 years and a lot of these wee girls tend to take their advice from their mother. Now when their mother had a baby it was quite normal that you started a baby on solids at about 6 weeks or even earlier for some of them so it is quite important that we get that message across to them quite early, the reason why we don't think that is a good idea nowadays. Otherwise granny will suggest and the girls will go with it.

Scottish health visitor 6

MW: Girls do run their home in much the same way as their mothers have done and it is trying to break that down. When we offer them parentcraft classes, for example, they will say they are not going to bother because their mothers have said it is a waste of time.

INT: These generational ties seem to be very strong here?

MW: That's right, it is very strong in this area really, because a lot of our patients they have still got mum staying round the corner or granny two corners away. Sister lives up the street and they all do the same thing. So it is grannies we would need to get at.

Scottish midwife 3

The conflict was most obvious with working class families, among the very same group of people whose close family ties and family support, in other context, was very much idealised. There was no uniform way to define the meaning of the relationship between mothers and their adult daughters. In any case, whether it was seen as good or bad, its importance was never denied.

The notion of negative familial influence is not a new one. It materialised very clearly - and in a much deeper and more serious sense than just in terms of competitive views over baby feeding practices - in the public political debate over the 'cycle of deprivation' which arose in the UK in the 1970s. Crescy Cannan (1992) has analysed this debate. According to her, Sir Keith Joseph, as Secretary of State for Social Services, used the term in his speech in 1972 arguing that particular families produce subsequent generations of maladjusted people. As methods of handling the problem he proposed the extension of family planning to reduce the numbers likely to be recruited into the 'cycle of deprivation', preparation for parenthood, casework with emotionally deprived adults, play groups to stimulate the development of the young, and finally, an overall strengthening of family life. The term became widely used by child care organisations and professionals who also took action in order to break the 'cycle'.

The political anxiety over the 'cycle of deprivation' also produced research on the topic, funded by the Department of Health and Social Security. As a part of this research programme Mildred Blaxter and Elizabeth Paterson (1982) studied attitudes towards health and health care in two generations: mothers of young children in the 1970s and their mothers who had had their children in the 1950s. The grandmothers in the study all belonged to the lowest social classes and they all lived in one Scottish city. Researchers

were interested if there were similarities in the attitudes and in the actual health and health behaviour of these two generations of women and their children. In conclusion they wrote that “no consistent relationship could be found between the attitudes of mothers and daughters, despite the close relationship characteristic of the sample. It appeared that inter-generational changes - inextricably bound up with changes in life-style and circumstances, changes in the provision of services, and general changes in public attitudes - were more important than direct familial transmission.” (ibid. 183). Also in their study, however, health service providers described grandmothers as the most powerful source of influence and lay advice in these families, and as their biggest problem to get expert advice accepted. This view is still very powerful among health professionals in Scotland.

In Finland this kind of a conflict very rarely came topical in maternity and child health care. On those few occasions when it did, it was because mothers complained to health professionals about the grandparents' behaviour, for example that they give sweets to the children, although parents themselves try to avoid them and won't accept it. There has also been an ongoing debate, for example in women's magazines, about mothers and mothers-in-law who are interfering too much in the family life of their adult children. Professionals in Finland didn't need to compete with grandmothers, instead mothers were even seeking support from the professionals against them.

In Finland, female clients are very much on the same side with the health professionals. From time to time there are complaints that the professional advice women get is too strict and offers them no alternatives, that there is only one right way of doing something at the time which every mother is expected to follow. In spite of the criticism, Fin-

nish women seem to be satisfied with the services, but also expecting a lot from the health professionals (Kaila & Lauri 1992; Hokka & Suhonen, no date). If women are opposing the information and advice given by the health professionals, their conflicting knowledge is more likely to come from books, journals, and the media, not from the traditions of their own mothers.

Demanding clients

Women who take the advice of their own mothers rather than that of health professionals are seen as difficult clients. But there is also another group of clients who are seen as difficult, or rather as demanding and challenging, namely well-educated, professional, middle-class women. On some occasions they were seen in a positive way, as a challenge which makes professional work more interesting and worth doing, in others they were seen more as a nuisance, causing difficulties and extra work. Most often, however, both aspects were present when professionals described the 'demanding clients'.

According to Finnish professionals people in general have more knowledge nowadays about pregnancy, childbirth and child care, they are better educated, they read books and journals, and watch television. The information they get elsewhere also makes them expect more information from the health professionals. Sometimes professionals found it difficult to answer these demands, or they thought that the expectations of the clients were too high.

If I think about the work of health nurses at the child health centre, there has been an awful lot of pressure to change the ways we are working. There are an awful lot of demands. We should run different groups, we should know all the special diets, and so on. I have received a lot of criticism that I don't know enough about all these alternative trends, Steiner pedagogy and vegetarian diets and that sort of thing, that I haven't been able to advise the parents properly. Even if I have sent them to a dietician ... but according to them I should have given them more leaflets and books and telephone numbers, and so on. Child health centres are more and more criticised in the papers and women's magazines. Of course, it's good that you don't become stuck in a routine in this work, but ... Sometimes I just feel that I can't enjoy this work anymore. There is only the pressure and anxiety that comes from the society and from our clients. But still I think this is work I want to do.

Finnish health nurse A

One of the Finnish midwives spoke at great length about the pressure she experiences when running parenthood classes, the pressure that comes both from the employer and from the clients:

I think that families nowadays have really high expectations. Pressures are really enormous, it (parenthood education - mk) should cover everything. When clients have been asked, there has been criticism of all sorts, why didn't they tell about this and that. Somehow, I often feel, that I can't give enough, that I'm not able to prepare these modern families for childbirth, that it is too heavy a burden and responsibility just to carry on my own. I would like to share it with the hospital staff. Now we have to carry the full responsibility. ... I have been thinking many times when there has been this kind of criticism, which has often been like 'I didn't get anything'. Just recently there was a journalist or somebody in the local newspaper, who said that she didn't get anything out of it. I would like to ask that person if it's really true that she didn't get anything. Anyway, it is not the midwife who is going to give birth, I can't give anybody a ready made package, it is that person herself who has to prepare herself. It is not something another person can do. What I can do is to deliver small pieces of information which she can then use.

Finnish midwife E

Even if the Finnish health professionals emphasised that parents in general have more knowledge and they want more information, they mentioned 'educated' mothers or

families as clients who are the most demanding and most critical. They even mentioned some professional groups, such as journalists, teachers and doctors, as the most difficult clients. Sometimes they told me concrete examples of their 'difficult cases':

The first client this morning didn't arrive, so the midwife and I had time to chat. She tells me about this client who didn't arrive. She says that she is a medical student, who used the services irregularly also during her first pregnancy. She is quite irritated when she describes the woman to me as somebody who thinks she knows everything, but doesn't know after all. In her opinion, the woman is not even suitable to become a doctor. She also tells me another example about a woman, a journalist, who actually belonged to another health centre, but wanted to change here, because she couldn't get along with her midwife. According to her the woman had many kinds of demands. For example, she had prepared a long list of what she wants or doesn't want to be done when she goes to hospital. She continues that the woman had said that she will go back to work right after the baby is born, that she would get crazy at home, and that she doesn't want to breastfeed. In the end, she says, all that changed when the baby was born. When she had done the postnatal home visit, the woman had been very maternal, she had been breastfeeding, and hadn't said anything about going back to work. Tehtaala field notes MW I

Some of the health professionals in Finland complained that their work had become more demanding because of the increased knowledge base of their clients, but these really difficult clients were mentioned as rare individual cases. In Scotland, professionals again made distinctions between different groups of clients as to how demanding they were. On the one hand, there were clients who were not interested, whose visits were very short or who did not even come regularly, who did not ask questions or demand any alternative services. On the other hand, there were clients who were active, who knew what they wanted, who used more time because they had more questions to ask. The response towards 'demanding clients' was somehow contradictory. The line between showing positive interest and being too demanding was sometimes quite nar-

row. Women have the right to be demanding, but they are also time consuming clients, maybe even taking time from other clients, and asking a lot of expertise from the professionals. When talking about 'demanding clients' professionals constantly compared them with women who were the opposite.

They (women in one of her areas -mk) are educated, they know what they want, they know what is available to them and you can't not give that to them. Whereas the ladies in another area, I had to be telling them what was available to them and that they could have it and make sure they got it. I was constantly feeding them the information, whereas here ladies they have got the information, so they are questioning me on it as to if they felt that from somewhere they didn't get it. Whereas in the other area I was having to be the one that gave them the information and they were very accepting and thought that they got so much, whereas quite often ladies in this area they know what they are entitled to and want it. They are very much so more demanding, I don't mind that because I feel that that is their right and it is such a special time being pregnant and I think to have gone through that nine months and feel that you haven't been happy with it is very sad. It should be a really, really special time and you. It should be rewarded as such whether it is in the type of care you are receiving or however. Scottish midwife 4

I have some people who aren't interested in labour and we try and encourage them to go to classes and they will say, well it doesn't matter I am just going to lie and scream, they don't want to know. And you can have other people who come with a list of questions and take up a lot of your time at every stage of antenatal care. And very often you are just going over the same things over and over again, and I think that has a lot to do with their anxieties about how they will perform in labour. Some can worry too much about it and it completely spoils their pregnancy experience. Scottish midwife 8

Sometimes women's demands were seen as enormous and even unrealistic. One of the midwives told me a 'moral tale' of a woman who was too demanding and who finally got her 'punishment' for that:

I mean as midwives you can assess, and if we have got 15 mums, you could probably almost choose the ones that are going to have epidurals whatever ... should they need them, and you can also choose the ones that are likely to have difficulties because they have got such idealistic ideals of what is going to happen when they are labouring and how this wee child is going to do absolutely everything that they have read in the book that it says. So you can almost pick them out, and this particular lady at the time was quite challenging and had been challenging to all the midwives. She was always a bit disgruntled every time she came up for a visit. She was never a happy person. But she was primarily getting an optimum service of a group of midwives looking after her, then delivering her and then going home, so she had quite a good bite at the cherry to say, that people from outlying areas aren't offered that. ... So she was challenging in the fact that I already knew of her because she always asked about different things every time she came up that were maybe a wee bit controversial. I don't know why she did it but it maybe just made her feel better. ...When I spoke to the community midwives, I said to them this was what she was like, is there any underlying cause why she should be like that. But they still never found out, she never ended up getting a domino³ because she ended up having a caesarean section.

Scottish midwife 11

The midwife is drawing a picture of a 'demanding client' who wanted to be in control of everything. who wanted special services and who challenged the professionals with her endless questions. According to the midwife she already got the best possible service, much more than most women are able to get, and still, she wasn't happy. Finally, she ended up having a caesarean section, a medical intervention, against all her wishes and expectations. Again, there is a contradiction: women are expected to be active and to seek information, but, according to the professionals, too much 'book knowledge' can also be harmful.

³Domino means a model of maternity care where a midwife or a small team of midwives undertakes antenatal care and the community midwife attends the mother in her home until labour is well-established. At this point the midwife accompanies the mother into the maternity hospital and continues to care for her

It has been one of the main arguments in feminist critique that, especially in medical maternity care but also in medical practice in general, women as clients don't get their voice heard, they are not given opportunities to ask the questions they want to ask, and because of that they don't get enough choice, information, advice, and social support they would need. (e.g. Porter & Macintyre 1991; Oakley 1992, 21-43). Midwives in my research emphasised that they want to encourage women for actively expressing their wishes, asking questions, and making choices about their care, as long as they don't cross the border of getting too demanding.

Women who do not ask difficult questions and who accept the 'ordinary' services that are available are easy clients, but at the same time they are often judged to be careless, not even wanting to receive information and take the advice. Professionals emphasised that they try to give them the same information as for the others, but in practice the more active the clients are, the more information they get, and the more alternatives they have. This was the case also in child health care, but there the situation was more complex. Mothers or parents who are active in contacting the professionals, bringing their children to the clinic, and asking questions, get more time and information. However, in child health care more attention is paid to those children and their mothers who are seen to be 'at risk' or 'in need' of the services, whether or not they actually seek them (Blackburn 1994, 21).

In the case of the 'demanding' clients, who are usually well-educated, professional, middle class women, there is no conflict between the 'traditional, old fashioned' lay

there, delivers her baby and takes both home after 6-8 hours. (Provision of Maternity Services in Scotland 1994, 66.)

knowledge and the expert knowledge of the health professionals about pregnancy, child birth and child care. Rather, there is a conflict between two 'modern', alternative forms of expert knowledge, two different forms of 'book knowledge', which don't always match. Johanna Ruusuvuori (1994) has identified and analysed two different discourses of child birth which she has named as the 'medicalised discourse' and the 'counter discourse'. In the medicalised discourse child birth is seen as an event controlled by the medical profession, knowledge, and technology, whereas in its counter discourse it is seen as a 'natural' and 'active' event controlled by the woman herself. Women she interviewed about their child birth experiences used elements from both discourses. I would argue that these two discourses are actually both expert discourses. The counter discourse has been introduced by female experts, and by some men, some of whom also identify themselves as feminists. The counter discourse borrows some of its basic ideas from what is seen as women's traditional way of giving birth, but still the natural child birth is introduced as a modern, advanced way, as a new technique which also has to be guided by experts.

'Demanding clients' in my research, according to the professionals, demanded both more medical interventions, such as tests, screening and pain relief in labour, and more alternatives for the medicalised forms of care, such as midwife only care and home births. They were also those women who were more likely to seek alternative services such as parenthood classes and breastfeeding counselling provided by voluntary organisations e.g. the National Childbirth Trust (Carter 1995, 223). In Scottish maternity care during the 1990s, women's demands for alternatives and choice, have been recognised also in official reports and in actual service provision (Antenatal care 1995; Provision of

maternity services in Scotland 1994). It is recognised that women have the right to be demanding. Still, in practice, their demands are seen in contradictory ways.

Forms of resistance

Michael Bloor and James McIntosh (1990) have studied the surveillance of clients and their ways of resisting the surveillance in two different contexts: in health visiting and in an institutional setting, in a therapeutic community. According to them, in both settings surveillance is a necessary precondition for conduct. In health visiting the techniques of surveillance are more limited than in a therapeutic community and, at least in principle, clients have wider possibilities to resist them. They identify five different forms of resistance: collective and individual ideological dissent, non-cooperation, escape or avoidance, and concealment. According to them, all these forms except the collective ideological dissent, were used by the clients of health visitors. Clients can either challenge the legitimacy of health visiting discourse, exercise covert non-compliance with the health visitors' advice, not attend the clinic or not answer the door, or tell health visitors the kind of story they want to hear.

John Heritage and Sue Sefi (1992) have also paid attention to these kinds of hidden forms of resistance in health visiting. They recognised three different ways in which mothers responded to the advice given by health visitors: marked acknowledgement, unmarked acknowledgement, and assertions of knowledge or competence. In marked acknowledgement mothers took the advice as advice and acknowledged its informativeness. Instead, the two other forms of response both contained some sort of resistance. In

unmarked acknowledgement mothers responded to the advice in ways that avoided acknowledging it as informative and overtly accepting it. In the last form of response, assertions of knowledge or competence, mothers asserted that they already knew or were undertaking the advised course of action. According to Heritage and Sefi (1992, 409): “While our data base contains only one instance in which advice is overtly rejected, only one class of receptions - marked acknowledgement - involves a full-fledged acceptance of advice as *advice*. The others, in their different ways involve resistance to advice giving.”

Using my own data, it is difficult to say how much women actually objected to professional advice because there were very few signs of overt resistance. For example, it is impossible to say whether women in Scotland intentionally used non-attendance as a form of resistance towards the services and professional advice and surveillance. Health professionals never acknowledged non-attendance as a sign of resistance. They explained it with the social problems of the client or with practical difficulties in attending. Instead of finding forms of resistance or opposition, I found it even surprising how willing women were, for example, to let health professionals into their homes or how openly they discussed even very intimate and difficult matters of their private life. What professionals in Scotland complained, however, was that some women won't follow their advice.

In my Finnish data, there are a couple of encounters where women showed mild open resistance when professionals suggested that there might be something wrong with the child:

The clients are a mother and a boy who is going to school next Autumn. He does all the tests as asked, but at the end, when it's time to give an immunisation, he starts to cry and fight back. Both the health nurse and the mother are trying to persuade him, and finally he accepts it more or less voluntarily. At the end of the visit the health nurse still asks the mother what kind of things the boy can do and if he is sociable with other children.

After they left the health nurse explains to me that she tried to be very precise because she is not getting along very well with the mother. She tells me that both the child health centre and the day care centre wanted the boy to be tested to see if he is ready to go to school because of problems, among other things, in his fine motor skills. The mother didn't want that test to be done. The health nurse tells me that the mother phoned to the clinic herself and introduced the issue in the way that they had said that he needn't come for the test. She said that the mother doesn't understand the problem as a whole. She also shows me the drawing the boy had just done and his writing, where, for example, the letter s was written the wrong way round.

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The clients are a mother and a two and a half year old boy. They are talking mainly about the boy's speech development. During the last visit, six months ago, he had hardly spoken at all. Now, according to the mother, he is using some simple words, two word sentences, speaking mainly about cars. The health nurse is showing him some pictures, asking him to name things from them, but he doesn't say a single word. Most of the time he is playing on the floor with cars, imitating their sound but only saying some very unclear words. The health nurse suggests to the mother that she could ask the doctor if it's already the time to send him to a speech therapist. "Maybe, it's too early, but it's good to ask". The mother says that also their older children had developed quite slowly. She continues, that their eldest son is now 15 and only now are there the first signs of puberty. She also says that her daughter went to speech therapy as well. The health nurse is taking back a little bit what she said earlier, and admits that maybe this is just how they develop. Then she moves to another topic

After the clients left, the health nurse says to me that his speech was really poor, usually at that age they are talking all the time. She also says that she is going to mention that to the doctor anyway and to ask her opinion.

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In both situations, the health nurses suggested that the child's development should be examined more closely by the experts, a psychologist or a speech therapist. Both moth-

ers, instead, wanted to avoid this kind of interpretation. According to their everyday experience of living with and caring for their children, there was nothing wrong with them. The second of the mothers even referred to her experience with her older children. Health professionals in these situations didn't want to confront the mothers openly. Actually, in the first extract above, the conflict between the health nurse and the mother didn't become overtly visible in the encounter itself. Instead, the child was strongly resisting immunisation, as children often did⁴. The conflict was only explained to me afterwards by the health nurse. In the second case the potential conflict was present, but was carefully faded away. It was quite common that professionals didn't want to make problems visible to the clients if they could avoid it (Kuronen 1994b). The rule of politeness and normality acted in both ways in hiding and fading away the possible conflicts.

According to Bloor and McIntosh (1990), staff counteraction is difficult in health visiting towards this kind of clients' covert resistance. They have no right of access to the covert activities of their clients as the staff has in institutions. They may also be unaware or unsure that concealment is taking place and therefore unable to proceed against it. Even if health professionals are aware that things are being concealed from them, 'politeness' may prevent them from attempting to counteract it. Covert resistance is also difficult to study: how can a researcher recognise it if it's not made visible.

⁴ Children's resistance was usually ignored or seen as 'natural' both by the health professionals and parents and often children were either forced or persuaded to obey.

Conclusions - Conflict or contract

According to Nikolas Rose (1989), in the modern society the direct state control has been minimised and replaced by self-governing. Instead of direct engagement by the state, parents are encouraged to seek help from professionals. “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.) If that is the case, the Finnish society could be described as more modern, a society where mothers, or parents, have accepted the legitimacy of expert knowledge and learned to seek help from the professionals. Even Arvo Ylppö, the ‘founding father’ of the Finnish child health services, in his memoirs praised Finnish women for their willingness to take expert advice. According to him, “elsewhere people are more bound by the tradition”. (Heydeman 1980, 26 - translation mk.) In Scotland all mothers haven’t defined motherhood as a ‘problem’ where they necessarily need professional intervention. Even the professionals I talked to, more than their Finnish colleagues, stressed that at the end it is mothers’ own choice whether to follow expert advice or not.

It is an interesting question why Finnish mothers seem to be more willing than Scottish mothers to accept professional intervention and follow expert advice. There is maybe no single right answer. One explanation could be maybe found in the relationship between the state and people’s everyday life. British researchers have emphasised the moral control of family life and direct control of families with social problems as a principle of the British welfare state and contrasted it with the wide support for family life and active family policy in the Nordic countries (e.g. Rodger 1995). Although in both countries

maternity and child health services are universal services for all pregnant women and families with young children, in Scotland they might still carry, at least to some extent, the negative stigma of state intervention. In Finland, maternity and child health services are seen as a part of the universal, public social and health services, at the same way as, for example, public day care services for children or home help for elderly. Using these services is not seen as stigmatising or controlling but as a social right for all citizens (Sipilä et al 1996). The popularity of maternity and child health services in Finland is understandable in this social context. Historically, getting mothers to use the services has also been a long enlightening project where even financial rewards have been used.

Another explanation could be found closer to professional practices in maternity and child health care. As discussed earlier, in Finland, more than in Scotland, all the elements of control have been faded away from the work of health professionals: open discussion on difficult and delicate issues is avoided if the client is not active in taking them up, and professionals do not attend clients' homes without invitation and agreement with the client. In Finland the positive image of maternity and child health centres, as 'normal services for normal families', is actively created and maintained in everyday practices of maternity and child health care.

CHAPTER 10

CONCLUSIONS

When hearing the subject of my research the first question people usually ask is: which one of the systems is better, the Finnish system or the Scottish system of maternity and child health services. This is maybe very natural and understandable question in relation to comparative research. Implicitly or explicitly, the practical and political aim of comparative research, especially in the field of social policy, is often to find models of policies or service provision in one country to learn from the experience and develop the system in another. I have, however, tried to avoid answering this question because I think it is impossible to give a simple answer and because it hasn't even been the main focus of my research. I do have, of course, my own personal preferences, but instead of ranking the systems as a whole, there are some elements I do like and don't like in both systems. I also think it is difficult, if not impossible, to find scientifically argued criteria to make this kind of judgements because the systems are deeply rooted in a certain historical, cultural and social ground. They can't just be taken out of their 'home' environment and 'planted' to another. This is something that is often ignored in international comparisons.

In this final chapter, instead of making judgements of superiority of the two systems, I will return to my original question: how maternity and child health care as a profes-

sional institution of the welfare state define and organise motherhood in its daily practices, and how these definitions vary across social and cultural contexts.

The social organisation of motherhood

Following Dorothy E. Smith (1988, 157) I am arguing that beginning from the local and particular, from the everyday practices of the health professionals in maternity and child health care, provide more general understanding of the social relations that organise motherhood in these two societies. In conclusion I will discuss the different levels where motherhood is socially organised and constructed, and how these levels come into being in the everyday practices of maternity and child health care.

I have identified four levels where motherhood is socially organised in this context and named them as interactional level, institutional level, welfare state level and socio-cultural level. Interactional level has been the main focus of my research. It is the level where health professionals and mothers actually meet each other, where they discuss and negotiate standards of proper motherhood. By institutional level I am referring to the organisational context where health professionals do their daily work and where woman enter when they become clients of maternity and child health care. It is referring to the definitions of professional qualifications and relations, to the hierarchical relations and the division of labour within the organisation of health services, to the national and local rules and regulations organising service provision, as well as to the knowledge base of health professionals. The welfare state level includes policies and services that create the conditions under which mothers, and fathers, are acting as par-

ents (Björnberg 1992,12). Family policy measures, or the lack of them, are then highly significant e.g. existence and conditions of maternity, paternity and parental leave, financial support for mothers or families with young children, child care arrangements and other measures that allow women to combine motherhood and family responsibilities to other areas of their life, most importantly to employment. Finally, there is socio-cultural level which is highly important but also most general and abstract to identify and define. It includes social class and gender systems as well as historical and cultural tradition, customs, and ways of thinking in a certain society.

What is missing in this classification is the everyday level of motherhood, the level where mothers are living their daily lives and caring for their children. A part of this everyday level is, however, included in what I call the interactional level: it is an essential part of the everyday mothering in the modern Western society that it takes place in co-operation with different experts and professional organisations. Overall, it is a characteristic of these four - or five - levels that they are not separate but interrelated. Interactional level has been my 'point of entry' (Smith 1988) to the other levels which are recognisable and existing in it. Professional advice giving for mothers in maternity and child health care does not take place in isolation, but in a particular organisational, social and cultural context. I will now discuss some of my main findings and make connections between the different levels.

Family oriented versus women oriented work

There is a clear difference between the two countries in who are defined as clients in maternity and child health care: In Finland it is families, in Scotland women. The difference in orientation is more rhetorical than factual: in both countries professionals most often meet women and are working with them. It has, however, factual consequences.

In Finland there is a strong family orientation in the work of health professionals (see also Forsberg et al. 1994). Family in this context is seen as a nuclear family, a heterosexual couple with their children, where parenthood is shared between partners. Both women and men, or rather 'families', are defined as targets of professional advice, although men more often indirectly, through their partners. It is also characteristic to this family orientation that families are seen as equal, well-functioning units. Quality of family relations, the relationship between partners, and the relationship between parents and children, is given an important meaning. Instead, power relations, gender and generational inequality in families is very much silenced and ignored.

In Scotland professionals are more clearly concentrating on women, even if men are accepted into clinics, parenthood classes, and labour ward at the same way as in Finland. Men as fathers are still very much missing in professional discourse. Instead of gender equality it assumes separate spheres of women and men in families. The core of families for health professionals are women and children and men have only a marginal importance in everyday family life, except maybe as breadwinners. Unlike in Finland health professionals in Scotland are also discussing the 'problem with men': men are

more often described as marginal in women's lives, incompetent, unreliable, missing or even rude and violent towards women and children. Instead of their male partners, women are seen to get help and support from other women, either from their female relatives or from health professionals. Family is not the context where motherhood is defined. Instead, professionals discuss women's and children's life, women's needs, wishes, and problems.

The difference in professional orientation in maternity and child health care is in accordance with the family policies and gender systems in the two societies. In Finland, unlike in the UK, men as caring parents are recognised also in legislation on paternity, parental and care leave. One of the principles of the Finnish family policy and the welfare state has been to support gender equality in families as well as in the society as a whole. But gender equality has much longer roots in the Finnish society. It goes beyond the welfare state to the agrarian society where women and men have both worked hard side by side. Even in the travel literature written since the late 18th century, a feature that surprised and fascinated many English authors was the position and social activity of the Finnish women which was even seen as a sign of democracy and civilisation of the nation (Halmesvirta 1995).

Gender equality really became an issue in Finland in the radical 1960s. According to Raija Julkunen (1994) a gender equality organisation 'Yhdistys 9' (Association 9) was a representative of the new radical, modern ideals. The objective of the association was women's emancipation but its members were both women and men. What was new in its aims was the demand for a changing role of men, for example a demand for paternity leave which was achieved in the late 1970s. Women's equal participation in the labour

market was defined as one of the corner stones of women's emancipation and a working mother was the ideal woman of the time - as still very much is. What was requested to gain the target was both public day care for children and participation of men in child care and housework. (see also Jallinoja 1983.)

What has been characteristic to the Finnish equality policy and women's movement is that it has been based on the ideal of similarity rather than difference between women and men. In the 1960s problems in women's position were understood as a conflict between the traditional and modern society rather than a conflict between women and men. Man was seen as a norm which women should gain. It was assumed that women and men should work together to change the society more equal. The ideal of similarity has also influenced the language use changing it to more gender neutral¹. In Finland, instead of women, we often talk for example about persons, parents, spouses, and families. (Julkunen 1994; see also Honkanen 1993.) The same gender neutrality in language and the ideal of shared parenthood can be found in the family orientation of the health professionals in maternity and child health care in Finland.

In the UK, what has been criticised by many feminist researchers is the traditional family model which is embedded in the British welfare state system (e.g. Lewis 1992; Millar 1994). This model is based on separate spheres and responsibilities of women and men in the family, and in society as a whole, where women are seen as unpaid carers and financially dependant on male breadwinners. Distinctness of male and female

¹Compared with many other languages greater gender neutrality is a linguistic characteristic to Finnish language. For example, in Finnish there is only one word 'hän' for he and she referring to both sexes.

spheres is also present in maternity and child health care in Scotland: pregnancy, child birth and child care are women's issues where men have a very marginal role. It is also important to remember that, unlike in Finland, in the UK there is no legislation that would recognise men as caring parents, even if there has been a lot of discussion about it recently. In this respect professionals in both countries work very much on the conditions provided by the welfare state. For example, in Finland where men are given more possibilities to spend time with their children it is also supported and encouraged by the health professionals. In Scotland where this opportunity does not exist it was not an issue in maternity and child health care either².

In order to understand why family orientation and discussion about fathers are missing in maternity and child health care in Scotland another explanation could be found in the feminist movement and feminist discussion in the UK. It has more than in Finland emphasised difference between women and men and women's oppression in personal life, in such issues as, for example, reproduction, sexuality and male violence which are seen as women's issues, or feminist issues, rather than issues of gender equality.

I would even argue that, to some extent, Scottish health professionals I met had a feminist orientation in their work even if the term feminism was never mentioned. What I mean by feminist orientation here is that, at the same way as in feminist social work discussion (e.g. Brook & Davis 1985; Hanmer & Statham 1988; Dominelli & McLeod 1989; Philipson 1992), health professionals saw themselves working with and for

²During my data collection in Scotland I met a couple of men who asked me about paternity leave in Finland. They would have been clearly interested in having that option.

women, paying attention to the problems women meet in their everyday life, and sometimes acting as advocates of women for example in relation to male doctors. They also emphasised the importance of women's supportive networks rather than male partner as a companion and a main source of help and support. Only very recently it has become an issue in feminist social work discussion whether feminist social workers should also work with men. Even then the main aim is to help women and the attitude towards men is somehow sceptical, it is suspected whether men are really willing to change. (Cavanagh & Cree 1996.) In maternity and child health care in Scotland working with men is not really an issue: they are merely by-standers rather than subjects of professional interest.

My own orientation has also changed during the research project. I recognised only afterwards that when I was doing my research in Finland I was myself unwittingly committed to the ideal of shared parenthood. I expected health professionals to support participation of fathers and criticised them for ignoring men as caring and competent parents and for emphasising responsibilities of mothers, but hidden behind family rhetoric. It seems to me that, in the 1990s in Finland, fatherhood has become a bigger issue than motherhood in public debate as well as in academic research, even in feminist research. Because of my commitment and my cultural understanding it was difficult for me to recognise and admit that this was not the way in which parenthood was discussed and understood in Scotland.

It was, and still is, an ideal for me that parenthood should be more equally shared between women and men and that should be promoted in different ways in the society. But women centred orientation of the Scottish professionals has also made me ask the

limitations and disadvantages of the family centred orientation: sharing parenthood with men is not necessarily what all women want or are able to fulfil in their lives. The ideal of shared parenthood might even strengthen the nuclear family ideology where children are only expected to be born and raised in a heterosexual permanent pair relationship³.

In Finland the family form itself is not that important but rather the existence of a pair relationship. In Scotland marriage is the only socially respectable form of family life much more than in Finland and there is a strong public moral concern over what is seen as an erosion of family values, especially over single motherhood. In this respect, it is quite surprising that for the Scottish health professionals family relations of their female clients are not very significant. Women who are having and raising their children outside marriage are not blamed by the health professionals because of their missing pair relationship but their competence as mothers is assessed according to their practical skills and 'coping' in their daily lives. To put it strongly, because of their women centred orientation all mothers are 'lone mothers' for the health professionals.

Similarity versus difference of mothers

In both countries, in spite of the difference in orientation, the main interest of health professionals and the target of professional advice are mothers. In their everyday work

³Only some months ago there was a heated debate in Finland whether permanent heterosexual pair relationship should be a prerequisite for fertility treatment. It was suggested by the Ministry of Justice committee which is preparing legislation for fertility treatment that only married or cohabiting couples should qualify for it. The debate will probably continue in the Parliament, and also in the media, in a near future.

health professionals are assessing the competence of mothers against the standards of motherhood. These standards are actually quite similar in both countries: babies should be planned and wanted, but still mothers are also allowed to feel negative feelings, mothers should not risk the health of their children with their own behaviour, and they should have practical skills to care for their children in a proper way. What is different, however, is the extent to which mothers are expected to fulfil these standards and also how much they are allowed to make their own choices and decisions.

Again, there is a question of similarity and difference, not between women and men, but between women as mothers. In Finland women are assumed to be similar as mothers and as clients in maternity and child health care. They are seen as competent, knowledgeable and responsible, willing to take and follow expert advice. Differences between women are ignored. This means that mothers are not classified according to marital status, social class, race and so on. But it also means that mothers are all expected to behave according to professional advice. Mothers are told to be the best experts of their own children, but their expertise shouldn't be in conflict with professional expertise. They are not really given the possibility to make their own choices. If they do, it is often seen as problematic in professional discourse, for example, if they decide to give up breastfeeding or return back to work 'too early'. However, it is a part of the same 'similarity discourse' that mothers who are defined as having or being problems in maternity and child health care are seen as rare exceptions.

In Scotland, on the other hand, differences between women is a strong assumption in maternity and child health care. It is discussed in terms of individual differences but, first of all, in terms of social class differences. Social class is seen to divide women in a

deterministic way. It does not only determinate their economic situation, but also their life style, health behaviour, child care practices, and use of health services. It is the working class mothers who are the real problem for the health professionals, and even more for the maternity and child health care as a system. They are those women who are seen as not using the services, ignoring professional advice and not meeting the standards of motherhood. At the same time their failure is 'forgiven': they are not even expected to meet the same standards as middle-class mothers because it is seen to be the consequence of their social and economic situation or the working class culture.

In Scotland there is also a stronger emphasis on individuality. Health professionals emphasise that women are free to make their own decisions but they also carry the responsibility of their choices. Professionals do not have a great faith in their power or even their right to make women to change their behaviour. Instead, they have to accept women's decisions and also offer them different alternatives. Advice giving in infant feeding is maybe the clearest example of this. Especially in maternity care 'informed choice' and 'meeting the needs of mothers' are now two main objectives for developing the services (Provision of Maternity Services in Scotland 1994, xiii). It is emphasised that women should have the right to choose between different alternatives of service provision.

The two different ways in which differences between women are discussed in Scotland are somehow contradictory: if social class is as deterministic as understood by the health professionals, how free women are to make their individual decisions? I would argue that 'women's choice' is very much a middle-class discourse. It is mainly middle-class, well-educated women who are demanding, and getting, more alternatives in

service provision. This was recognised also by the health professionals. But women's right to choose is also used as a discourse to legitimate the existing differences, or rather inequalities, between women. Beverley Skeggs, for example, is criticising cultural studies as well as feminist research that the concept of difference has, in many places, come to stand in for inequality (Skeggs 1997, 7). She is referring especially to postmodernist theorising which, according to her, "imply that there can be a voluntary free fall through the social positions that are available to people to inhabit" (ibid. 12). Health professionals are not postmodernists in that sense. They are well aware of the economic restrictions that working class women meet in fulfilling the standard of motherhood. They see women's possibilities to change the situation limited. Instead, they accept different standards for middle-class and working-class motherhood.

Again, beginning from the local and particular provide more general understanding of the social relations that organise motherhood in these societies. It shows the importance of social class differences in Scotland in dividing women's everyday life and their experiences as mothers, and as users of maternity and child health services. Even if the distinctions made by health professionals are maybe too rigid, simplifying and moralising, social class differences can't be denied.

Finland is less a class society than Scotland⁴. In Finland there has been a great faith in upward social mobility and equality between different social groups especially by means of providing equal opportunities to education. Equality is understood in terms of

⁴It is often argued that Scotland is a more equalitarian country than England. According to David McCrone this is, however, merely 'the Scottish myth' with very little factual evidence supporting the argument (McCrone 1992, 88-120).

regional equality, gender equality as well as social class equality. As shown in the historical chapter, health services and health education have also been used as a means to both educate and unify the nation. In social sciences in Finland, social class was used especially in the 1970s as a Marxist concept, but has since then very much disappeared from the academic discussion. In feminist research social class differences in motherhood have only been studied from a historical perspective, as a phenomenon of the late 19th and early 20th centuries (e.g. Markkola 1994; Nätkin 1997). Nor has there been such an 'underclass debate' as in the UK (see e.g. Mann & Roseneil 1994). Only very recently, mainly as a consequence of the economic recession and the high unemployment rate of the 1990s, this kind of debate has been raising its head also in Finland. Or more precisely, some features of the underclass debate can be identified in the discussion on 'problem suburbs' which argues that social problems have concentrated to certain urban areas, to the quite recently built housing estates at the outskirts of big cities (see Roivainen 1998). In the early 1990s when I collected my Finnish data this discussion hadn't reached the health services, but the situation might be changing.

Control versus women's agency

In the introduction I identified two different feminist discussions and perspectives that could be used in analysing the relationship between mothers and health professionals and the role of maternity and child health services in women's everyday life as mothers: the British (or Anglo-American) discussion which has emphasised the controlling role of the state and different experts in women's lives, and the Finnish (or Nordic) discussion which is talking about 'woman-friendly welfare state' and women's role as actors

in creating it. In conclusion it is now time to ask: To what extent it is relevant to understand health professionals as control agents? Or should they, instead, be seen as female actors who have created their own space within the health service system expressing women's specific interests? Furthermore, is it so that in Scotland the system is controlling women more than in Finland as could be assumed on the basis of feminist discussion?

First of all, my answer is that this distinction is too sharp and dichotomous and doesn't make justice to the diversity of the everyday practices of health professionals. The distinction is maybe more relevant to describe the characteristics of the welfare state systems as a whole than a specific institution and certain professional groups, although even then I suspect that the situation is more complex than that.

What could be criticised in the British control discussion is that it has ignored the rather independent role of female health professionals, midwives and health visitors, in maternity and child health care. Feminist research on maternity care has mainly concentrated on medical care⁵. The role of midwives as service providers has either been ignored or they have been seen as handmaidens of the doctors, subordinate to the medical profession without any independent role. Health visitors, on the other hand, have been seen as control agents of the state policing the families and especially mothers, although it has been admitted that they have no direct means to control mothers and force them to follow their instructions (e.g. Dingwall & Robinson 1990; Heritage & Sefi 1992).

⁵I have deliberately excluded medical care from my research, although the distinction I have made between advice giving and medical care is somehow problematic and not always very functional.

Based on my results also a different interpretation can be made. Health professionals in both countries work in a hierarchical health care system where doctors are the leading professional and organisations authorities. Still, at the same way as midwives and health nurses in Finland, both midwives and health visitors in Scotland have their own distinctive role in the system. They meet their own clients usually without doctor's presence. To some extent, they are also able to plan their own schedules for meeting clients according to their own professional preferences. The knowledge base they use in advice giving often comes from medicine, but even then they do not take it as granted but modify it and put it in practice according to their own judgement and to the actual situation of their clients. As I mentioned earlier, Scottish professionals in my research were also understanding to the possible problems women meet in their everyday lives, especially to the social conditions of working class mothers, even if they were sometimes moralistic and judgmental. I have even identified some features of feminist orientation in their ways of working with and talking about their female clients.

In both countries the relationship between health professionals and their female clients seems to be open and informal. I have even named health professionals as 'professional friends' for women. Even if I have criticised that the friendly relationship is used as a professional technique to get women unveil their personal life, that it is not a 'real' friendship, there are also signs of shared experience and understanding between women. The most controlling aspect in the maternity and child health care system in Scotland is the way in which health professionals visit clients in their homes without an advance notice and agreement with clients, assuming their access to people's homes as self-evident. Even if professionals themselves interpret home visiting as good service, which it is in many respects, it has been shown in some previous studies that many mothers

find unannounced home visits as an inspection of their home and their child care standards (e.g. Mayall & Foster 1989).

I have argued that service provision based strongly on home visiting wouldn't be possible in Finland because it would be against the cultural understanding of the privacy of people's homes. Finnish mothers seek for the services more of their own free will. Still, I would argue that they have a strong moral obligation to use the services and follow professional advice. It is seen as an integral and self-evident part of motherhood and the evidence of mothers' responsibility. In that sense, I agree with the argument by Nikolas Rose (1989, 203) that the direct state control is replaced by self-governing where parents are encouraged to seek help from professionals and rely on their expert knowledge. In Finland, as I discussed above, mothers are also expected to behave in a more uniform way: women's own choices are less accepted and respected than they are in Scotland. These kinds of controlling aspects of the Finnish maternity and child health care haven't been much studied and discussed. There has been a strong belief promoted by the service providers that the Finnish system is the best in the whole world. It has been so strong that its basic principles and policies haven't been really questioned.

At the end

I'm now getting to the end of my long journey during which I have travelled both physically and mentally between two countries, two service systems, two cultures and languages. It is both sad and delightful to end the journey. It has been a real learning experience. It has made me aware of how scientific theories, frameworks of researchers, and

results of empirical research are always bound to their socio-cultural contexts. It is now much more difficult for me to accept only one right answer, only one perspective, and explanation. In cross-cultural research all these are in constant movement and transformation which makes it both fascinating and difficult.

I see cross-cultural research process being like a kaleidoscope where one light touch can change the whole picture to something different. The new picture is not better or worse, just different. Moving from one country, from one system or from one academic discussion to another can change your way of thinking and seeing things, it can change questions that are meaningful or possible to ask and answers given. In a research project, however, this constant motion has to be stopped somewhere and the research report has to be finished. Even then, it will be still changing in the hands and minds of the readers.

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APPENDICES

Appendix One:

Historical development of maternity and child welfare work in Scotland and in Finland

Appendix Two:

Guidelines and schedules for maternity and child health care in Finland and Scotland:

- National guidelines for examinations during maternity care consultations at the health centres in Finland
- Guidelines for parenthood education and preparation for childbirth in Finland
- Antenatal care plan in Scotland, Suggestion given by CRAG/SCOTMEG Working Group on Maternity Services 1995
- Schedule for child health surveillance in Finland
- Schedule for child health surveillance in Scotland

APPENDIX 1

Historical development of maternity and child welfare work in Scotland and in Finland

Scotland

- 1860s The first health visiting schemes in Britain
- 1872 The Infant Life Preservation Act in Britain
- 1904 Four milk depots opened in Glasgow
- 1906 First restaurants for nursing mothers opened in Dundee and in Glasgow
- 1907 The Notification of Births Act
- 1911 National Insurance Scheme where working women and wives of insured men received a maternity benefit
- 1915 The Extension of the Notification of the Birth Act in Scotland, local authority provision for maternity and child welfare schemes
- 1915 The beginning of antenatal care in Britain, in Edinburgh
- 1915 The Midwives Act eliminated unqualified midwives
- 1937 The Maternity Services Act in Scotland
- 1948 The National Health Service
- 1990 The National Health Service and Community Care Act
- 1991 Recommendations for development of child health surveillance in the UK by the Joint Working Party on Child Health Surveillance
- 1992 The Framework for Action Working Group on Maternity Services in the Scottish Office

Finland

- 1904 Maitopisara (Goutte de Lait) association opened the first 'child guidance centres' (milk depot)
- 1918 Unpaid maternity leave for women in manual work
- 1920 The Mannerheim League of Child Welfare was founded
- 1920 The Midwives Act requiring rural municipalities to employ a midwife (extended to cities in 1934)
Only qualified midwives allowed to practice midwifery

- 1922 First child health centre opened in Helsinki by the Mannerheim League
- 1926 First maternity health centres opened in Helsinki and Viipuri by the Mannerheim League
- 1938 Maternity Benefit
- 1944 Municipal Maternity and Child Health Centres Act
Municipal Midwives Act
Municipal Health Sisters Act
- 1949 Use of antenatal services was made a condition for Maternity Benefit
- 1963 Universal paid maternity leave
- 1972 The Public Health Act
- 1978 Paternity leave
- 1986 Parental leave

APPENDIX 2

FINLAND Examination during maternity care consultations at the health centres.

<i>Consultation</i>		<i>Week of pregnancy</i>		<i>Examinations</i>
1st	PHN, MD	F, S	8 - 12	BP, weight, gynecological status, Hb, blood group, screening for blood group antibodies, cardioplipin, HbsAg, U-gluc, U-prot, U-bact
2nd	PHN	F, S	14	BP, U-gluc, U-prot, possibly blood screening for Down's syndrome (16th - 17th week)
3rd			16 - 20	Ultrasound screening
4th	PHN	F, S	24 - 26	Routine check-up, Hb, screening for blood group antibodies (Rh-negative women)
5th	PHN, MD	F, S	28	Routine check-up, cervical status
6th	PHN	F	30	Routine check-up
7th	PHN	F, S	32	Routine check-up
8th	PHN	F	34	Routine check-up
9th	PHN, MD	F, S	36	Routine check-up, presentation, Hb, screening for blood group antibodies (Rh-negative women and Rh-positive women who have had blood transfusions or whose children have received care for jaundice)
10th	PHN	F	37	Routine check-up
11th	PHN	F, S	38	Routine check-up
12th	PHN	F	39	Routine check-up
13th	PHN	F, S	40	Routine check-up
14th	PHN	F, S	41	Routine check-up, observation of movements started, amount of amniotic fluid estimated, referral to the hospital for postmaturity monitoring
15th	PHN	F, S	Immediately postpartum	Clinical examination, home visit
16th	PHN, MD	F, S	5 - 12 weeks postpartum	Postnatal check-up, vaginal examination, Hb, U-gluc, U-prot, U-bact

Abbreviations

PHN public health nurse/midwife
 MD physician
 BP blood pressure
 F first pregnancy
 S subsequent pregnancies
 SF height measurement of the symphysis-fundal height
 Routine check-up BP, SF height, U-gluc, U-prot, weight

Finland: Guidelines for parenthood education and preparation for childbirth

The purpose of parenthood education is to help the parents prepare for parenthood and to promote a successful delivery. Parenthood is among the greatest challenges of adult life. The transition to parenthood may be easy for some, but many people feel that they benefit from parenthood education. Although women expecting their first child usually have good knowledge of childbirth, and couples rarely express a need for information, they do need support from professionals and from one another. Parenthood education groups are thus an important component of maternity care. The opportunity for parenthood education should also be ensured for minority groups, within the framework of their own culture and language.

The main responsibility for providing parenthood education rests with the midwife-public health nurse though the content of parenthood education may be prepared in collaboration with other primary health experts and with the maternity hospital. One should remember that the needs of the family are foremost. For parenthood education to be successful, it is important that the maternity unit is aware of the clinical practice patterns observed in the maternity hospital which the parents will be using, and that the families are aware of the hospital's possibilities. Likewise, the maternity hospital should know the content of the education given at the maternity units. It is good to discuss clinical practice patterns, and changes in them, e.g. during meetings between primary and specialised care.

On the basis of feedback received from parents, the education should be started when pregnancy has reached the halfway point. Parents hope to receive expert knowledge from various specialist groups about

- the course and development of pregnancy and the associated emotional changes
- the course of childbirth and different modes of delivery
- pain relief during delivery
- abnormal deliveries
- puerperium
- child care and breastfeeding, as well as
- an introductory visit to the maternity hospital and
- information about the significance of the husband's support and of other social support to pregnancy, childbirth and infant care.

During the preventive visits, it is good to discuss child care breastfeeding and care during puerperium at the very end of pregnancy and after childbirth, when the nurse of the well-baby clinic may also participate. During the introductory visit to the maternity hos-

pital, the midwives describe the care given while in hospital and the clinical practice patterns observed.

Both research and experience show that parenthood education is most successful when implemented in small groups. The recommended group size is four to six couples, giving the best opportunity for discussions. When groups are formed, it is also good to take group members' level of knowledge into account. In this way, families with a weaker knowledge base can be given the support they need, and can be helped to have a more positive birthing experience while preventing families with a more solid knowledge base from becoming frustrated. A questionnaire can be used to survey families' guidance needs. The distribution into groups and the content of the parenthood education given can then be based on the results, thereby achieving a better match with the families' needs. If formation of the groups has been successful, the groups may continue to meet after childbirth, supporting one another in problems relating to child care, breastfeeding and child-rearing.

Source:

Screening and Collaboration in Maternity Care. Guidelines 1995. STAKES

(addressograph label)

YOUR ANTENATAL CARE PLAN

Scotland

NAME:

CARE CO-ORDINATOR:

Estimated date of delivery:

GESTATION	CARER		CONTENT OF CARE	INVESTIGATION	TREATMENT	EDUCATION	OTHER NEEDS			
	GP	MIDWIFE						CONSULTANT		
6			Identify maternity care co-ordinator Physical examination if indicated	Pregnancy test if necessary		Pregnancy Book				
7	Needs Assessment									
8										
9										
10			History Height, Weight, Blood Pressure Urinalysis	FBC, Blood Group, Antibodies, Serology		Development of the fetus; Physical changes in the woman; mental & emotional issues; tests - scan, blood tests, MSAFP, role of the professionals; what might go wrong, and what to do if it does; breastfeeding; multiple births, welfare & employment issues; antenatal classes info.				
11	Booking									
12										
13										
14										
15										
16			Blood Pressure, Urinalysis	AFP Ultrasound		Revision of previous topics; type of delivery; positions for delivery; labour; interventions; pain relief/self help; relaxation/breathing/pelvic floor exercises, etc.; baby feeding; premature delivery; tour of maternity unit tests.				
17										
18										
19										
20			Interpretation of results <i>The key purpose of this visit is health promotion and education.</i>							
21										
22										
23										
24										

25									
26			Blood Pressure, Urinalysis, Fundal Height	FBC	Antibodies if Rhesus negative				Discussion of employment, social and domestic arrangements, including MAT B.1 if appropriate; revision of previous topics; preparation for hospital e.g. what to take; home safety; the new baby - handling, sleeping position, feeding, minor problems; demonstration of breastfeeding; labour and delivery - labour rehearsal; birth planning; what can go wrong e.g. stillbirth, handicap, etc; neonatal problems, e.g. jaundice, etc; postnatal problems, e.g. stitches, feeding, emotional; postnatal exercises and fitness; where to go for help - contact name of midwife, health visitor, obstetric physiotherapist, etc.
27									
28									
29									
30									
31									
32									
33									
34			Blood Pressure, Urinalysis, Fundal Height, Presentation	Antibodies if Rhesus negative					
35									
36									
37									
38		PRIMS							
39									
40		PRIMS							
41			Blood Pressure, Urinalysis, Fundal Height, Presentation						
42									

Schedule for child health surveillance in Finland

	weeks		months					years											
	2-4	1	1,5	2	3	4	5	6	8	10	12	15	18	2	2,5	3	4	5	6
Doctor			x			x			x							x			x
Health nurse	home	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Dentist or dental nurse										x	x	x	x	x	x	x	x	x	x
Screening:																			
Weight & height	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Head measurement	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Vision	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x	x
Hearing																			
Blood pressure																			
Speech development																			
Psycho-motorics																			
Psycho-social development																			
Pre-school screening																			
Immunisations	x																		
Social background																			
Health education																			
Support in development																			

National recommendations, National Board for Health 1990 (Lastenneuvolaopas. Lääkintöhallitus 1990)

Schedule for child health surveillance in Scotland¹

Antenatal period	One visit checking this period as minimum
11th day onwards	Once weekly (home) visit till 6 weeks
8 weeks	Child comes to clinic 8/52 check 1st immunisation
8 months	Hearing test & medical examination Health visitor & GP
1 year	Visit or seen at clinic
18 months	Developmental screening
2 years	Seen at home
3 years	Developmental screening
3,5 years	Vision screening
4 years	Seen at home
4,5 years	Pre-school screening

¹The schedule is given by one of the health visitors in Lochend. It only gives a broad guideline of the schedule. No national guidelines available.