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UNDER-UTILISATION OF MATERNAL AND CHILD HEALTH CARE

BY

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A THESIS SUBMITTED TO THE COUNCIL FOR NATIONAL ACADEMIC AWARDS IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE DEGREE OF DOCTOR OF PHILOSOPHY

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ABSTRACT

The central aim of this study is to identify and describe the experiences of first time mothers who are underusers of child care clinics. An attempt is made to counterbalance the tendency of researchers in this area to be judgmental of underusers who "neglect" their children, and their own health care needs, by reporting the mothers' views of the child health services in their own terms.

Underusers within a certain Health Authority area were identified using a purposely developed Index of Uptake. The achieved sample of predominantly working class mothers constituted a group of people who are particularly difficult to research. It is believed that success in locating and eliciting evidence from this group was in itself an important contribution to the research literature.

In depth interviews were undertaken, and the data analysed in two ways; (1) A subsample, made up of those having made least use of the services available to them, was analysed interpretively to provide detailed material of an idiographic kind on the lifeworld of the person and the place of medical care within it; (2) All interviews were subjected to content analysis to provide a more general picture of mothers' experiences of health care provision.

The main findings include the following; (1) The particular population studied had a generally low level of usage as assessed by the index, but use of specifically medical provision was greater. A process of rational decision making is implicated. (2) Accounts of underusers' experiences highlight as a central theme the mothers' vulnerability to personal undermining by many aspects of health care provision.

The thesis concludes with a discussion of the approach which health care providers adopt towards underusers, and argues that there must be an explicit recognition of the point of view of the clients if the services are to reach this deprived segment of the community. Such recognition is rarely found in research or comment on the problem of underusage. In fact apparently irrational and blameworthy behaviour by underusers can be rendered explicable when considered in the light of the individuals' perceptions and experiences, and this leads to a serious questioning of the utility and appropriateness of the negative judgements made of them.

PREFACE

This thesis arose out of a research project initiated by a concerned Area Health Authoritiy's senior nursing officers, who wanted to try to improve the uptake of their child health services. Given its genesis in a managerial perspective, the researcher found it necessary to both clarify and substantially alter the terms of reference within which the study was to be conducted. This was a time consuming and delicate process, which was likely to (understandably) irritate a number of those involved in the research; academics whose preference was for positivist methods of enquiry, senior managers in health care, a part of whose role it is to protect their professional employees from unfair criticism, and under users of the services who resist unwarranted intrusions into their lives.

Originally the study set out to compare users and underusers of the services on what were regarded as salient features, in order to account for underusage. On contact with the research literature and pilot interview data, the research aims were redirected to fill a more fundamental gap, a systematic and comprehensive understanding of the underusers experience, directing specific attention to the underusers' perspective. They had neither been identified accurately enough, nor specifically facilitated in articulating their views. The aims of the research became in one sense more limited in scope, but considered a prior and necessary step, to find out how and in what ways underusers construed official health care provision and their place in relation to it.

Conducting the research and producing the finished work has been a personal ordeal for the researcher. The most difficult aspect was visiting the poverty stricken in their homes, a deeply distressing experience, followed by the difficulties involved in securing the participation of underusers in the project. Treating the qualitative material collected in a way which did justice to its richness and maintained the rigour necessary in academic work was made possible by Peter Ashworth's innovative work in qualitative methods and enthusiasm for his discipline.

Next was the difficulties involved in trying to finish the work after the finances ran out, taking numerous temporary posts to finance the completion of the work. Each new job meant the write up was set aside, and picked up later, which has culminated in the significant time delay between the start and finish of the work.

These difficulties were not helped by the Polytechnic's thoroughly inadequate support for research. The lack of secretarial backup, equipment, an informed and motivated research community, library facilities and limited access to buildings all contributed in their own ways to the researchers view of the project as an ordeal.

The finished product would never have been completed were it not for the material help and personal support (quite outside of their professional obligations) which was consistently and willingly offered by those who appear in the acknowledgements.

A version of the discussion of interviewing which appears in chapter three has been published under the title "Interviewing the Downtrodden" in A. Giorgi et al 1985 Qualitative Research in Psychology, Duquesne University Press, Pittsburgh, USA.

It proved necessary to bind the thesis in two volumes, as the appendices are rather bulky, due to a) the amount of data involved in qualitative work, which it was felt necessary to present in order to give the reader the opportunity to consider the process by which the results were obtained, and b) the extensive tabulation of results which would have made the text difficult to read if presented in the chapters.

Teresa Hagan

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CONTENTS

CHAPTER 2: STUDIES OF UNDERUSAGE

CHAPTER 4: MAIN STUDY: IDENTIFICATION OF UNDERUSERS OF SERVICES

CHAPTER 5: MAIN STUDY: CONTENT ANALYSIS OF INTERVIEW DATA

CHAPTER 6: MAIN STUDY: UNDERSTANDING UNDER USAGE: THE UNDERUSER CASE STUDIES

CHAPTER 7: DISCUSSION

VOLUME 2 APPENDICES

CHAPTER 1: THE WIDER CONTEXT OF UNDERUSAGE

1.1 INTRODUCTION

This study is concerned with the under usage (including non-usage) of child health services by primiparous women during the first year of a child's life. An important feature of child health care provision is its system of clinics which exist to monitor the health and developmental progress of infants and to provide an advisory and supportive service for mothers. Much concern has been expressed by the DHSS, among others, about the poor attendance of certain mothers at these clinics. Those groups of people who make least use of the health care services in general can be regarded as those most in need of help (Hart, 1978).

There are a number of related issues which have added impetus to a concern with underusage, broader features of the social context in which such problems occur, which will be reviewed before turning to a consideration of the studies of underusage itself.

1.2 THE CONTINUING CLASS INEQUALITIES IN HEALTH STATUS

People in the lower groupings of the Registrar General's classification (IIIB through V) are more prone to fall ill in the first place, tend to wait for longer periods before seeing the doctor, and tend to participate less in preventative health activities (Black, 1980; Townsend 1974; Baric 1967).

Class differences in incidence of ill-health are not limited to physical matters. Thus higher rates of depressive illness are evident among working class mothers with young children, (Brown, 1975). Similarly, health differences between social groups are not limited to morbidity and mortality. They run the gamut of physical attributes upon which estimates of normal 'healthy' development are made, e.g. persistent class-related differences in birth weight and in height and weight of school children (Ashford, 1970; Davie, 1972; Streather, 1979). Many workers have drawn attention to what appears to be a widening of the gulf, with the poor becoming progressively poorer in the morbidity and mortality contexts (Black, 1980; CPAG, 1978; DHSS, 1977; Graham, 1984; Lister, 1978; Madeley, 1979; OPCS, 1971; Smith, 1974; Tod, 1964). The reports differ little in their overall conclusion and the situation does not appear to have varied over many years. Graham's (1984) recent review of the position of families in poverty confirms what has been a consistent trend: those in classes IV and V suffer much worse health problems than those higher up the social scales.

1.2.1 The widening gulf in health status

Although maternal mortality has continued to fall as a whole, the differences existing between social classes have widened. The very young mother, the unmarried mother and mothers in social classes IV/V exhibit a disproportionate share of perinatal morbidity and mortality. A particularly striking feature of current infant mortality is that mothers in class V are almost twice as likely to lose a baby as are mothers in social class I. This difference has been stable for twenty years but now appears to be widening further (Black,1980; OPCS,1971).

1.2.2 Poverty and health

The poor, in particular, face many problems which affect their health status. For the poor a new baby can impose an intolerable financial burden, (Graham 1984; Chamberlain, 1975; Ong, 1985; Oakley, 1976; and Burghes, 1980).

Doyal (1983) identifies the kind and pace of work which women do which makes them more vulnerable to ill health. In poverty they can suffer dampness, overcrowding and a chronic lack of basic amenities.

Holman 1978, describes the restricted life style of the poor, who depend on borrowing money, second-hand clothes and suffer the constant threat of frequent crises in housekeeping problems; all efforts to escape these coming to nothing more often than not. They can be overwhelmed by feelings of anxiety, worry and inferiority, causing extreme states of stress, known to be associated with poor health (Totman 1979, p.22ff).

Burghes (1980), in concluding research on the very poor families attending Family Service Units, shows the most frequently mentioned emergencies were costs concerned with ill health or death. Often bills were paid at the expense of the families' health. They could not buy nutritious food regularly, missing meals entirely was commonplace, whilst the families were confined to poorly heated and furnished houses, lacking the clothes and money to go out anywhere.

The quality of housing and heating one can afford has persistently and consistently been a major determinant of health (Tinker, 1981).

Even getting the welfare to which they are entitled is not easy for the poor. Holman (1978, p,222ff) outlines the ways in which they are known to have been subject to humiliations and punishments rarely if ever experienced by others.

The lower social classes continue to be less healthy than their higher social class counterparts.

1.3 "INVERSE CARE LAW"

Statistics derived from a number of studies suggest a 'lower' standard of health in inner city areas predominantly occupied by socioeconomic groups IV and V (DHSS, 1977; Spencer, 1978b). Certain areas of the country would appear to be 'medically deprived', since the existing services are unable to cope adequately with demand, whilst others have a relative abundance of medical resources (Black, 1980; Townsend, 1974). Here provision is by no means related to need. Hart's 1978, 'inverse care law' states that,

> "...the availability of good medical care tends to vary inversely with the need for it in the population served, i.e. there tend to be more family doctors, fewer patients and more teaching hospitals and specialist services in those areas where there are more middle class people, than in poorer areas where morbidity is higher."

This appears to be borne out by data available regarding general practitioner lists in industrial and other areas, with the tendency for middle class patients to be on relatively small lists, or on the lists of more highly qualified doctors, with easier access to diagnostic and/or other special therapeutic facilities. At the same time, health problems do not simply 'go away' in the absence of

appropriate provision. McConachie's (1977) Nottingham-based study showed that the same proportion of consultations for various health problems exist in 'deprived' areas as in 'non-deprived' areas. However, it is precisely in such areas where consistent and continuous medical care is of obvious importance, that locum and deputising services are most in evidence (CCHS, 1976).

1.3.1 Life chances of the poor

Inequalities of health care provision and/or impact are perhaps most strikingly reflected in statistics relating to 'life chances' of children as a variable factor between regions, localities and social classes (CCHS, 1976; Cloake, 1979; Griffiths, 1979; CA, 1975). Thus, in effect, socially disadvantaged families appear to suffer double disadvantage due to the relative paucity of the health service resources available to them. One reason posited for lack of necessary reform of service provision is the 'very limited protest' exhibited by clients in receipt of maternity and other community-based services, due to the relatively transient nature of the client role. (Logan, 1971).

1.4 INEFFECTIVE USAGE OF SERVICES

One consistent feature of official health care provision is the skewed take-up of available care in favour of the higher socioeconomic groups in the population (Baric, 1967; Jefferys, 1971). All groups in society do not access the services with equal facility. A common interpretation postulates 'culture lag' as a major factor, where barriers in client/professional communication are posited as due to the degree of 'social distance' existing between the working class patient and his professional carer. In particular the association

between formal educational achievement and use of services in general remains pertinent across many areas of health and social service provision, allowing some to assume that the lower socioeconomic groups are almost beyond reach,

> "The working class patient has difficulty in understanding and remembering medical terminology, written instructions and in the application of logical thinking." (Baric, 1967)

Although one may not want to go along with such a partial verdict, it cannot be denied that there seems to be a real 'cultural' gap between certain client groups and the official care agencies.

1.4.1 Cultural gaps between clients and their carers

The working class under user is considered to hold attitudes and orientations to health care which do not promote participation in preventative procedures, being irresponsible, unable and/or unwilling to take responsibility for themselves, regard events to be outside their control, as living in the present and not looking toward the future in a provident manner. These and related attitudes of 'vulnerable' groups have been cited as contributory to the problem of unequal access to/and use of services, reflected in late or inadequate take-up (Baric, 1967; Jefferys, 1971). Oakley (1976) found the 'essential' difference between the parents of babies who had died and those of others to be their attitude towards, and use of, health services in general; they seemed to be unable to avail themselves of the help afforded by the services when this was most needed. Jay (1980) notes that 'at risk' mothers tend to find that "the beds have all been booked by the time they come round to thinking about it".

There is a significant negative correlation to be found between perinatal mortality rates and the chances of being admitted to a teaching hospital for one's confinement. Babies most 'at risk' are less likely to be delivered in the 'better' hospitals (Griffiths, 1979). For particular minority groups, religious laws and ritual observance may pose considerable problems regarding maternal uptake of services (Kitzinger, 1977; Lemu, 1980; Sanderson, 1974; Tribble, 1978).

On some measures, it appears that the lower social classes are making more use of a given service, e.g.there is an increase in GP consultations as one moves from class one to five (Forster, 1976). But when sickness is taken into account, the advantages for the lower social groups suggested by consultation alone are eliminated or reversed. There appear to be various rationing devices which the service itself sets up in order to cope with excess demand.

1.4.2. Infant mortality and utilisation

Infant and perinatal mortality figures show a steady fall in the United Kingdom. Variations between different areas and socioeconomic groups persist, although here too there are encouraging signs, as some of the avoidable factors in infant mortality (e.g. asphyxia before and during labour) have been identified, (Chamberlain, 1975, Vaughan, 1979).

International comparisons were, however, disquieting with death rates of children between birth and one year of age showing differences between countries much greater than could be explained by different methods of recording.

During the decade 1960-70, whilst the infant mortality rates of France and Holland continued to decline in a fairly uniform way, those of the United Kingdom came relatively almost to a standstill. Emery (1976) writes,

> "Clearly something has gone wrong. Whilst it is generally accepted that international comparisons must be interpreted with caution when one looks at causes of death, the least treatable (i.e. congenital deformities) in the UK lie completely within the same range as those in other countries; whilst with the most treatable (ie infections) a completely different picture is seen, with UK mortality more than ten times that in Holland, for example. There is nothing to suggest that clinical diagnostic acumen, standards of training, or accuracy of registration of deaths in Holland differ from those in this country; and no evidence to suggest that the general nutritional states of the countries differs markedly, or that we are subjected to different strains of viruses or bacteria."

Emery's Sheffield-based study demonstrated the presence of a significant percentage of young children dying at home from apparently treatable diseases. There were a significant number of 'theoretically preventable' deaths presenting as cot deaths; the symptomatology of children who died and those who subsequently recovered being essentially similar. Thus the problem was seen to be one of variation in handling of similar disease situations rather than one involving 'symptomless' children. The study highlights the need for effective early monitoring of all infants to ensure an appropriate intensification of care in cases where special risks are detected.

His study prompts Professor Emery to ask four 'critical questions' regarding utilisation of child health care services:

1. Are our parents deficient in health education?
2. Do parents attempt to obtain medical help as readily here as they do in other countries?
3. How easy is it for them to obtain help at any time?
4. Are our parents supported in their primary health care well enough?

1.4.3. Inadequacies on both sides

McWeeny's (1977) controlled study of mothers of children suffering cot deaths raises some interesting and important issues regarding the part played by use or non-use of available services as a determinant of infant survival. Here the essential differences between mothers of cot death children and of surviving children apparently did not lie in such widely-assumed and well-researched factors as housing, legitimacy, socioeconomic group normally associated with raised infant mortality rates. In these respects the two groups of mothers were virtually identical. Critical differences were however observed between the two groups in the following areas:

a) Perception of disease/illness:

In both parental groups' recall of child symptoms (in the case of mothers of cot death children during the last three weeks of the child's life, and in the case of mothers of surviving children during an analogous period), there were no observed differences either in the severity or duration of symptoms reported. Differences lay in the relatively high 'alarm

threshold' of the mothers of cot death children and in their relative inability to interpret the meaning of the signs and symptoms.

b) Activation of services in crises:

Here parents of surviving children had felt concern, had summoned help with confidence and had met with a positive response, culminating in the admission of the baby to hospital. By contrast, parents of cot death children presented a picture of wavering and uncertainty, hesitation about summoning the doctor or inability to contact him. This was thought to have evoked negative responses by the services, with the responsibility for requesting a follow-up visit too often left with parents inadequate to deal with the eventuality.

c) Use of services in general:

Almost half of the dead babies had never been taken to an infant welfare clinic at any stage. Their mothers had made little use of antenatal services and were highly likely to have 'defaulted' from attendance at post-natal appointments. They expressed negative feelings about their general practitioners, and hesitation about consulting them. These mothers cited 'hasty' receptionsits, rigid appointment systems, inability to use or lack of access to telephone, 'awkward' time of day and previous experiences on approaching the services, as inhibiting factors. The

> mothers were frequently unknown to their family doctor, and occasionally not even medically registered. The Health Visitor had made fewer visits to these babies, and the mothers tended not to know who she was, or how to contact her.

Here again, the major problem is located in patterns of utilisation of the services, with 'inadequacies' involving both parental responses and the services themselves.

1.4.4. The social and economic context of health and illness

The causes of ill-health, premature death and low standards of health evident in the lower socioeconomic groups cannot be looked at in isolation from the inequalities of the rest of life (Townsend, 1974). Factors playing an important role are well documented: eg housing, levels of pollution, rates of unemployment (Dornhurst, 1967); educational deficit, inadequate nutrition, 'low' standards of family care (Chalmers, 1980; Court, 1977; DHSS, 1977; Smith, 1974; Syme, 1976). A Scottish health services study found that infant mortality rates were directly proportional to percentage overcrowding (Richards, 1971). Chazan (1976), in his study of early identification of children 'at risk' in relation to problems of adjustment, expresses a view held by many that:

> "...preventive measures short of major social reforms can have little effect on the problem",

arguing that expectations of significant progress in the absence of such far-reaching programmes are unrealistic. Such workers believe any effort not aimed at major social change to be an 'inadequate and inconsequential attack' on the problem. McKinley (1972a) asks:

> "Even if the services were used, would it make all that much difference if the major factors which lead to a poor outcome in pregnancy are primarily societal in origin?"

Here the contention is that health care makes its maximum contribution when linked to wider social and economic policies which together can increase family support (Lister, 1978). Only a combined approach by housing, health education and social services can begin to eradicate the causes of disadvantage (Ennals, 1978). "Reduction of social disadvantage such as poor housing, inadequate nutrition, inadequate disposable income is not a separate issue from that of reducing infant mortality and morbidity rates - it is the same issue" (Oakley, 1976 and 1980).

There are those, then, who do not consider underusage to be of central importance in the determination of a child's health status, any contribution being relatively cosmetic in the face of continuing patterns of disadvantage which militate against the lower classes chances of improving their health. Others share her reserve, e.g. Draper (1973) advises "the lowering of death rates cannot be assumed to be a universal or absolute goal of health planning".

Even though women are persistently encouraged to be convinced of the need to be dependent on medical care,

> "No research has been conducted that could establish a causal relationship between poor or non-existent antenatal care and perinatal mortality" (Oakley, 1980)

The issue of underusage of medical services as the factor to be held responsible for poor health has not gone unquestioned.

Despite the undoubted truth of the need for general political will to overcome the complex problems of poverty, it may still be the case, that the delivery and acceptability of health care provision could be improved by a serious consideration of the clients viewpoint.

1.5 PROFESSIONAL PERSPECTIVES ON THE PROBLEM

Current trends in health care are towards an increasingly autonomous role for the consumer in managing her own health affairs and maintaining contact with appropriate services where necessary. In this context, issues of under- or non-utilisation assume considerable significance for consumers and service providers alike.

1.5.1. The current emphasis on prevention

A wider conception of health has been adopted by the World Health Organisation, with the wide-sweeping goal of positive physical, mental and social well-being rather than the absence of disease (Townsend, 1974). The notion of preventive health care is one which aims to ensure that children reach their full potential for growth and development. Many future improvements in health are thought to depend on changes in behaviour of client groups, 'healthy' behaviour entailing an increase in individual responsibility for personal health status.

In 1977 the DHSS, in conjunction with the British Medical Association, issued a circular to doctors, encouraging them to 'promote self-care and illness management' amongst their patients. These recommendations imply a coming change in the structure, organisation and philosophy of the health service - welcome in itself but not unproblematic (Spencer,

1978a). It is difficult for the public to recognise a focus for the intentions of 'preventive' medicine and professionally it is a far more difficult concept to translate into everyday tasks (McConachie, 1977).

The emphasis on prevention of ill health has particular significance for the child health and maternity services where it makes up the main focus of care efforts. The benefits both in terms of financial savings and minimising human suffering are well articulated (BMJ editorial, 1976), the aim being to tackle some of the social and environmental sources of ill health rather than its expensive consequences.

There are also consequences for the consumer role; the nature of service provision and the way in which health care is presented to the public. At least two aspects are worthy of mention in relation to the voluntary take up of care. Consumers are required to take responsibility for their own health, most notably in terms of adopting 'healthier' ways of living which link the idea of individual causation and moral failings to a person's health status. Issues of blame and choice are raised.

The main focus of change has been located in the individual rather than the environment, as this seems to be the easiest, cheapest way to bring results. Coward (1984) voices some concern about this narrow focus as do many others; she points out that even though it is recognised that illness and depression have social causes, discourses on health still emphasise the individual body where change can come

> "Health is presented as something which calls for individual hard work, not social solutions."
>
> "In this way exhortations to good health become exhortations to take control of one's life."

It can also encourage "blaming the victim" which, if it is to be avoided, requires the careful evaluation of factors responsible for ill health. It cannot always be assumed that clients have control over all aspects of their lives.

Dingwall (1977), amongst others, comments that there is, "still no attempt to change the social and political causes of ill health, with the blame put firmly on the sufferer's shoulders". Rigler (1982) concludes that "most health problems are beyond the control of any individual" rather matters relating to economics and social policy are of most importance. Other commentators go further when articulating the assumptions held about medicine and health, eg Doyal (1983) draws attention to the medical emphasis on individual causation of ill health as inappropriate, biased and preserving of inequality. She warns of the tendency to blame the victim that such a model encourages. If ill health can be explained in terms of individual moral failings, then the victims can be blamed for what has happened to them:

> "'Way of life' factors identified as contributing to ill health are interpreted narrowly and selectively and usually emphasise the individual's own responsibility."

Such a rationale leaves the social and political structures of society unchanged and unquestioned.

The social relationships involved in the provision of health care do not encourage self-reliance and responsibility. According to Doyal they can appear bureaucratic, hierarchical and authoritarian, so that patients lack autonomy and power within the system and are subject to professional interpretations of what they need.

Doyal's (1983) historical account of the birth and development of welfare services in Britain shows that women were blamed for bringing ill health on their own children, with unsanitary habits, going out to work, unsuitable clothing, inappropriate feeding etc. Such issues are still hotly debated today. The significance of inadequate and overcrowded housing, below subsistence level wages and women's need to work to survive were all obscured.

On the one hand, then, this could lead to the censure of persons who fail to keep healthy (despite good advice) and on the other hand it may lead to better informed, more questioning and discriminating consumers who can make demands on the services rather than merely having their needs served as carers see fit. Both features are of special importance when considering the key role of voluntary uptake in preventative care.

1.5.2. Focus on the client perspective

There has been a notable growth in the breadth and prominence of health related research and comment on women's experiences of medical care, drawing more attention and serious consideration to the kinds of problems and issues which affect women in particular. Special attention is given to the form of social relations to be found in the delivery of care (Hales, 1982 p.21ff). Another important strand has

been the research based commentaries on motherhood as experienced today where the political, social and moral implications are explored (Graham, 1984; Oakley, 1979; Oakley, 1980; Comer, 1974). All have contributed to a concern with taking seriously the perspectives and particular problems of women.

1.5.2.1. Growing appreciation of women's concerns

Research and commentaries committed to the interests of women draw attention to features of the social world which are regarded as deleterious to their welfare. For instance, mothers' responsibility for the successful development of children has been seen as over-emphasised in recent work.

Individual mothers are seen as increasingly being held responsible for the welfare of their children, with concepts such as maternal deprivation being commonly invoked to explain a wide range of children's problems (Rutter 1972). Mothering and how this should be carried out has been the focus of a wide range of research and comment whereby;

> "no other area...has had so much attention...or exposed to the interference of self styled experts" (Comer 1974)

In his review of research on mothers, Schaffer (1977) draws a similar conclusion, that it has involved too exclusive a focus on the bond with the mother.

The presumed inevitability of child rearing as being the natural responsibility of the biological mother has been questioned by many writers. However, the work of Bowlby (1947 and 1969) is still identified as having an important and detrimental influence on conceptions of good mothering, despite his assertions having been heavily criticised and discredited. Issues of over and under mothering are still being measured and prescriptions arrived at. As a result Comer (1974) feels that the responsibility for mothers remains awesome, her research shows how delinquency is still popularly attributed to mothers who want to work outside the home. They are regarded as 'cold, selfish and deviant', whilst other factors are overlooked.

1.5.2.2. Features of provision

Certain features of medical provision and care have been identified as exerting a deleterious influence on women's experiences of health care. Doyal (1983) Mednick (1975) and Oakley (1980), draw attention to the ways in which women are demeaned and denigrated within modern medical ideology and practice, by having stereotypical attributes accorded to them. They were considered to be possessed by affect; incapable of rational or analytic thought, not worth the time and energy required for good patient care and finally scheming and opportunistic (Doyal 1983).

In medical encounters, both 'common sense talk' and technicalisation were found to undermine women's confidence and encourage a passive patient role. Over 90% of Oakley's (1980) sample reported irritation

to be the typical medical reaction to their mentioning their other obligations and it was widely reported that they were not listened to but merely typified as naturally maternal and as such had stereotypical mothering concerns attributed to them and taken for granted.

Such analyses stress the growing awareness that medical practice functions as a social force helping to shape the options and roles available to those who seek care.

The professionalisation of maternity care in general from this perspective is regarded as having removed the capacity for autonomous control from women to medical experts. (Oakley 1980; Bardwick 1980; Raymond 1979; Dingwall 1977).

Dingwall (1977) reviews the many studies which have drawn attention to this distinctive feature of the contemporary approach to parenthood: the reliance on specialist knowledge gleaned from outside the family context. This is provided through contact with socially appointed experts and the proliferation of books, magazines, leaflets, TV and radio. The guidance contains scientific theories drawn from empirical research on patterns of child rearing but also most importantly a distillation of cultural understandings about the nature and management of children.

Historically, women have had limited access to scientific knowledge on child bearing, there having been a general prohibition against the dissemination of information to lay audiences. Tracing the historical changes in the character of advice about motherhood, Dingwall (1977)

found that hints and advice soon gave way to laws of health and 'commandments'; the difference in vocabulary reflecting a more fundamental change in approach from an emphasis on self control to one upon medical control. Where the power lies to define needs and provision requires careful scrutiny, because professionals are assumed to have special knowledge upon which to make decisions for society.

Boulding (1966), in his analysis of the concept of 'need', alerts us to the danger of an unthinking adherence to professional's conception of need, as when contrasted with that of demand, the helplessness of the customer becomes clear. The vexed and worn question he raises can be found running throughout the research and debate on underusage; whether one should deny consumer sovereignity as the price of the relief of indigency; that the poor must have what professionals think is good for them whether they want it or not.

This central question has been related to research on underusage reviewed in later sections, as solutions vary in to the extent to which they advocate enforcement of professionally conceptualised need. Whether or not the question of rights is addressed explicitly, each one can be identified according to the position adopted in relation to it, as the consequences for consumers are important.

1.5.2.3. Motherhood as a difficult life change

Motherhood has been identified as a potentially difficult period for women, whereby they are vulnerable to physical and mental health problems. Graham (1979) found in her sample of 230 mothers that many experienced health difficulties in the early postnatal period. The physical trauma of the birth followed by the tasks of early baby care

and housework, with the demands of feeding at night and soothing night-crying accentuating fatigue and exhaustion. Those experiencing particular social problems (eg of a financial nature) appeared to be most prone to health difficulties.

Many studies point to the relatively high incidence of depression among new mothers, the suggestion being that, unless effectively countered, the experience of child-bearing and early child-rearing may have a negative effect on their mental health. (CCHS, 1976; Gove, 1977; Jacobson, 1965; Pitt, 1968, 1981; Richman, 1974, 1976; Tod, 1964). Gove (1977) found that married women having a job outside the home exhibited better levels of mental health than those who did not go out to work. Women with young children exhibit particularly high rates of depression, whilst the highest rates of all are exhibited by working class women with children under six years of age (Richman, 1976). The Court Report notes that some 16 per cent of mothers with young children are diagnosed as suffering from some degree of psychiatric problem (CCHS, 1976, Pitt, 1968).

Rossi, 1968, cited in Oakley 1980, in a review of the literature focusing on the effect of parenthood on the adult, concludes that the major effect of maternity is the "negative outcome of a depressed sense of self worth". The research consensus is that young mothers form an exceedingly vulnerable section of the population.

Oakley 1980 concludes that emotional lability is so common in the puerperium as to be regarded as normal. Her analysis also revealed a

more complex picture of depression than has hitherto been realised, (p.14ff offers a full account of the distinctions drawn). Most significantly, only two persons could be regarded as having no negative mental outcome.

The mental health problems have been linked to certain features of medical provision; life circumstances such as poverty and the contraction of a mothers social life; and the cultural idealisation of motherhood.

Bell (1982), Pitt (1981) and Oakley (1980) all found features of medical management of womens pregnancy and birth experiences to be associated with negative emotional states and in some instances depression. The overall conclusion was that the great psychological, emotional and social meanings which are an integral part of child bearing are neglected in the pursuit of what were regarded as physiological goals.

In her study of the incidence of depression among low income mothers, Bell (1982) found that current life circumstances were powerfully related to psychological wellbeing. Those in her sample who did not explicitly make a connection between their mental problems and environmental difficulties blamed themselves entirely for their problems and were more likely to suffer complete breakdown. Thus the physical and emotional health of mothers has become a focus of concern.

Gove (1977) describes the coping problems faced by new mothers. Social contacts are necessarily curtailed both by child care

activities and by giving up regular employment in order to have the baby. Lack of time to oneself, lack of adult interaction and resultant loneliness are commonly experienced. In Graham's (1979) sample, loneliness affected half the maternal sample at five months post-natally. Extended family relationships in general and close mother/daughter relationships did not appear to solve the social-interactional problems faced by many young mothers.

Comer (1974) and (Women's Monitoring Network) (1985) describe the ways in which the romanticising of motherhood leaves women vulnerable to depression, whilst Pringle (1977) and others concur, stressing the importance of realistic preparation for parenthood specifically to counteract idealised notions of mothering which can encourage women to feel they are not doing well enough. Oakley (1980) concludes that it is this cultural idealisation of motherhood which poses the greatest dilemma. 84% of her sample felt they had romanticised beforehand and were now suffering from the identity strain of such a transition, having to reorganise their assumptive worlds to replace false notions.

Graham's (1984) work stands out as unusual in its detailing of the daily life of a mother, this usually being subsumed or glossed over under very general and vague headings such as 'caring' or 'housework'; both of which tend to be denegrated, overlooked or romanticised. With great respect and sensitivity towards her respondents, she outlines what 'caring' entails. Providing for health for her family a woman must maintain a materially secure environment which is warm and clean, purchase food, and orchestrate social relations. Nursing the sick

combines feeding, laundering, shopping and preparation of comfort. As mothers they teach about health through the transmission of their culture covering (among other things) diet and hygiene."

Mediating with outsiders is also part and parcel of caring. The domestic routine is shown to integrate care, treatment, education and harnessing professional support. It is all about reconciling and meeting many and varied commitments, containing demands and conserving supplies to ensure that needs and ends meet. Coping with crises is commonplace and many feel they are completely answerable for whatever happens. Their love and sense of commitment can provoke anxiety that things may go wrong and guilt and self recrimination when they do. Responsibility is felt in an acute and highly personal way.

Housework is largely invisible but takes over 50 hours per week, the patterns of activity being dictated by the needs of the family. It involves both a commitment to order and routine and an acceptance of change and chaos so that, for example, a mother's diagnostic and adaptive skills have not gone completely without recognition. Spencer (1978a) has shown how quickly mothers notice changes in their babies' behaviour and appearance and how they are constantly reviewing it. In very poor families the mother's main tasks are the alleviation and rehabilitation of stressful conditions, social and clinical, which they can neither fully prevent nor cure. This can be never-ending work.

1.6. SUMMARY

From what has gone before it can be seen that a number of wider issues have fuelled a concern with underusage, as to what part it can be regarded as playing in affecting health status.

The lower classes continue to be less healthy than their higher class counterparts, a number of these people have real problems in making use of the services available, the services are inaccessible and certain clients avoid them. Some see underusage of services as of critical importance in maintaining (achieving) a healthy status, eg Emery et al (1977), whilst others see attendance as merely cosmetic, the causes of ill health lying outside of provision in impoverishing environments.

The services want to reach more people, CCHS (1970) seeing prevention as it is now delivered as the way forward. The discussion of changing consumer role raises the question as to what can reasonably be expected of a person in the pursuit of health and how effective individually changed personal habits can be in enhancing health.

The growing appreciation of women's concerns has shown the need to take seriously women's accounts of their problems, research having indicated that they have been poorly understood. Attention was drawn away from women to the services themselves and it was found that medical management itself could be a cause of problems.

There is now to be found serious questioning of the benefits of professionally inspired care, motherhood in particular having attracted many experts to set standards. This has led to an awareness of the central importance of power in the servicing sector, and how the imbalance in favour of professionals can overlook clients.

CHAPTER 2: STUDIES OF UNDERUSAGE

Though the present study is concerned with consumer responses to postnatal services, it is relevant first to consider some of the literature pertaining to antenatal care. Postnatal care and non-uptake can be seen as part of a sequence of events which begins with a mother's first recognition of her pregnancy, confirmation by her doctor, and entry to antenatal care. The links between successive stages of ante/postnatal care are clear and continuous, frequently involving the same professionals and the same settings.

2.1. STUDIES OF ANTENATAL HEALTH SERVICES

There is some evidence to indicate that under-users of the postnatal services are consistent under-users, ie the same groups make scant use of all health services not just particular ones (Douglas, 1964), whilst a number of researchers found uptake antenatally to be predictive of postnatal uptake (McKinlay, 1972a; Zinkin & Cox, 1976b). Similar problems may be identified in both spheres.

2.1.1. Lower socioeconomic groups: A socio medical problem

The antenatal services are under-utilised in a number of ways: late attendance for antenatal care, whereby a mother does not come to the attention of the health services in time for adequate care to be given; non-attendance at antenatal checks; missed appointments and low attendance rates at preparation and relaxation classes.

Latecomers for antenatal care would appear to be more 'at risk' of a bad outcome to their pregnancies, with a perinatal death rate in late bookers five times that in those who come early to the attention of the services (Pringle, 1977).

Women of lower socioeconomic status contribute the highest proportion of under-utilisers of antenatal services as judged by time of first attendance - a trend which is still in evidence, (McKinley, 1970a). From data collected in 24 areas of England and Wales during 1975, Child Poverty Action Group (1978) found that only one-third of women interviewed had attended preparation classes. Here the range was from 81 per cent attendance in social class I to 21 per cent attendance in social class V. There was also a tendency for lower socioeconomic group mothers to start antenatal care late, (i.e. after the fifteenth week of pregnancy). In her district study of attendance at antenatal classes, Perkins (1978b) found the expected class-linked decline in uptake. There is a felt need for antenatal care for these groups, voiced not only by the professionals but also by the mothers themselves. In Graham's and McKee (1979) 1976-77 survey, mothers overwhelmingly acknowledged the importance of antenatal care, citing such features as the monitoring of child development, prevention and detection of complications, and the recurrent need for reassurance as the major reasons for attendance.

2.1.1.1. Factors contributing to under-utilisation

McKinley (1970a) sees under-utilisation by certain groups as leading to long-term socio-medical problems. He reasons that non-users of the

antenatal services who experience normal parturition without complications are likely to perceive antenatal care as irrelevant and unnecessary, and to perpetuate their 'unsatisfactory behaviour' through subsequent pregnancies.

Certain groups are thought to become habituated to episodic and fragmented care, thereby creating a new and increasing socio-medical problem. It is, therefore, the attitudes of certain groups which he sees as creating a major problem. This approach appears to place reliance upon the current appropriateness of existing services, assuming that the fault lies with the consumer. The desirability, appropriateness, well-publicised or even pleasant nature of the existing services cannot be assumed. No consideration is given to possible faults in the services which may have helped create the problem of 'unsatisfactory behaviour' in the first place. McKinley is, however, well aware of the shortcomings of studies which leave the client's perspective out of account, and in fact, criticises such studies in a subsequent paper (1970b).

In a further study (1972b) McKinley examines the influence of premarital conception and of obstetric complications on subsequent delay in seeking antenatal care. There were significantly higher levels of obstetric complications in women who had conceived premaritally, although premarital conception by itself had no delaying effect on first antenatal visits. However, those women experiencing no major obstetric problems during first pregnancy tended to delay first visits in subsequent pregnancies. The sample excluded unmarried mothers and relied solely on retrospective hospital data. No rationale was given for selection of the seven types of obstetric

complications monitored. Inferences are drawn regarding the degree of 'rationality' observed in the behaviour of each maternal sub-group.

The study offers judgemental outside view of mothers' behaviour, which is viewed as irrational given their status as 'at risk' in medical terms.

2.1.2. The Client Perspective

This study provides a good example of the 'socio-demographic' approach to the analysis of under-utilisation. Major conceptual problems with the approach concern the partiality of the data, the deterministic nature of the model employed, (i.e. the women are perceived as responding in a passive manner to the play of social forces around them); and the invalidity of the criterion of 'rationality' employed. No consideration is given to what the mothers thought of the services, the nature of the services on offer.

2.1.2.1. Mothers face a conflict of responsibility

Graham (1979) characterises many proposed 'solutions' to the problem of under-utilisation as presupposing that the blame for non-attendance should rest squarely on the family, whilst adverse factors in the services are overlooked. She claims that 'Blaming the family' usually takes the form of assuming non-attenders to be 'irresponsible' and prone to risk-taking. These assumptions are questionable in the light of studies which have looked in depth at maternal feelings. In her study, she found mothers to be the reverse of irresponsible, and in fact frequently facing a 'conflict of responsibility', with uncertainty about what to do for the best. The problem is, therefore, not adequately represented by the 'unfortunate' or 'irrational'

attitudes on the part of certain under-utilising groups. Her in-depth interviews with mothers attending for antenatal checks at a hospital clinic showed high levels of dissatisfaction with the care received.

2.1.2.2. Mothers found provision disappointing

Few mothers had actually enjoyed attending or expressed the view that they had learned anything.

The general impression was of a task-oriented approach to care, with different members of staff assuming responsibility for fragments of the process. 80% said they would prefer to see the same member of staff on each occasion. Contact with staff was limited to the time taken to perform each sub-routine. The impression created was that it was staff time that was 'at a premium', rather than theirs and queueing was common in order to minimise 'time-wasting' by staff. Mothers were reluctant to ask questions and 'to waste the doctor's time', felt they were given insufficient information when they did ask questions, and thought there were 'too many there' for individual attention to be possible.

Many of the findings and proposals included in the Graham study are supported by data from small-scale studies carried out in 24 areas of England and Wales (CPAG/DHSS, 1978). These indicated that most clients tended to see use of the services as an obligation rather than as a positive experience. Dissemination of information was also seen to be problematic. Some did not receive adequate information regarding facilities available whilst a number expressed their exasperation with 'confusing' advice from different professionals.

The accessibility and timing of clinics was not ideal whilst concern was expressed at excessive waiting times and overcrowding. The continuity, completeness and availability of a woman's medical history and information on outcome of tests and examinations was lacking.

2.1.2.3. Suggested improvements for services

Suggested solutions thus vary considerably according to the type of study undertaken and the theoretical perspective(s) of the researcher concerned. Maternal suggestions for 'improvements' included the following: care to be provided within walking distance of home; reduce waiting time in clinics; more freely available information about their care; and a 24-hour phone-in service.

2.1.3. Inadequacies in provision

Some of the benefits thought to accrue from attendance are: increased understanding of terminology; increased familiarity with the hospital; assistance in overcoming the discomforts associated with pregnancy and childbirth; social contact with other mothers-to-be; and an increased understanding of the processes of pregnancy and childbirth (Gillett, 1976).

There are a number of problematic issues revolving around the evaluation of antenatal classes. Some researchers prefer to examine the extent to which antenatal classes help the mechanical aspects of childbirth, reducing the length of labour, quantity of pain relieving drugs prescribed, or frequency of forceps deliveries. Others look at the extent to which such classes may positively affect the woman's emotional experience of childbirth, increasing confidence, reducing fear, and improving the 'quality' of the experience.

2.1.3.1. Both professionals and mothers found problems with provision

Classes are so varied in presentation and content that meaningful comparisons are difficult. Women who elect to attend classes are a self-selected group so that comparative results are only meaningful for attenders of classes, however disparate these may be (Gillett, 1976). Furthermore, classes are themselves only one of a number of factors which might be expected to contribute to a 'good' outcome and experience of pregnancy and childbirth.

Perkins' (1978a, 1978b) study in Nottinghamshire found that classes were held mainly in the daytime and so made no attempt to cater for couples. They were aimed in the main at women in late pregnancy and showed little if any imaginative consideration of what a father's needs might be in relation to the impending birth. At the clinics, no provision was made for care of other children in the family who may accompany their mother, and advice to women concerning timing and content of classes appears to have been rather limited. There also appeared to be a certain lack of clarity regarding objectives of the classes among participant health visitors. The classes themselves did not seem to form a clearly integral part of supportive health service provision in pregnancy, birth and parenthood. When consumers were asked their reasons for non-attendance at classes, two major groups of problems emerged clearly cognate with problems discussed in other studies of provision. These were the dissemination of information and practical problems relating to attendance.

2.1.3.2. Dissemination of information

Certain maternal groups did not appear to know what was happening with regard to provision of classes and when they did, they were unsure of the degree of importance which they should attach to attendance at classes. Some mothers-to-be were apparently not offered any classes and sometimes, the client was not sure that she was being invited to attend. First-time clients were more likely to be offered classes than others (Perkins 1978b). Gillett (1976) found that 64 per cent of her non-attenders did not know about the service. Some did not feel the need to go, or could not be bothered as they had been before. In both studies, fewer social class V clients attended, a fact regarded by Perkins as adding to the 'vicious circle' of low uptake by certain groups. Certain groups are seen as 'non-attenders', therefore midwives tend not to offer them classes and they do not attend.

2.1.3.3. Practical problems related to attendance

Practical problems which discouraged attendance revolve around the home circumstances and siting of the service. Those with young children had difficulties finding childminders. Some found the clinic to be too far away whilst for others there was no place left in available classes. Frequently mothers were working when the classes were held. Others said they felt 'too ill' during pregnancy to go.

Data used in the studies was collected by midwives from mothers following delivery and whilst they were still in hospital. The hospital environment may not be the best place in which to ask such questions. Being questioned by a health professional closely linked with the care under discussion may inhibit mothers from being honest

about their reasons for not having attended. There are also some reservations as to the accuracy of utilisation data. However, Perkins believes that the results remain enlightening, even although the study had a design which did not allow a close examination of motivation for attendance and non-attendance.

2.2. POST NATAL STUDIES OF UNDERUSAGE

In this section, the extent of the problem of under or non usage of post natal health services is reviewed, followed by an overview of the research conducted to date, conveniently grouped according to the type of enquiry conducted. Arising from such research, various intervention strategies are suggested and these are considered in some detail, with particular emphasis being placed on the assumptions which underlie proposed solutions. There follows a critical review of the research on underusage which informed the research approach taken in this study.

2.2.1. The problem of underusage

The problem of low/non attendance at child health clinics has been well documented. Deprived area clinics exhibit a disproportionate share of non attendance, eg Spencer (1978b); whilst clinics in deprived areas were responsible for 40% of the total infant load, they contributed 54% of the total poor and non attenders (table 14). 52% of those children not seen by the medical officer was contributed by these clinics, that is 7 out of 13 as compared with 4 out of 54 in the non-deprived area clinics. Reasons were documented for attendance but no reasons for non attendance were covered in Spencer's study.

2.2.1.1. Problem Groups Identified

Immunisation of children is an area of preventative care, where the benefits are almost universally accepted but where the evidence of differential take up between social groups is clear. Most recent studies reviewed by Blaxter (1981) show that failure to immunise children is particularly marked in groups defined as specially 'disadvantaged' (Davie et al, 1972).

Blaxter's (1981) review shows that the majority of studies of clinic use have shown a reduced attendance at both ends of the social scale, there being little evidence to suggest that such inequalities are compensated for by more extensive home visiting. It is always possible, however, that lack of clinic visits could be made up by increased visits to the doctor. Where matched samples of social class 3 families were compared with those of class 4 and 5 in working class areas of Glasgow, more non attenders were found to be in overcrowded homes, with unemployed fathers and homes with social problems (eg alcoholism, poverty, delinquency). They were more frequently admitted to hospital and reported more problems to the health visitor but made fewer visits to their GP.

2.2.2. Studies of underusage

A number of studies have examined the problem of low uptake of child health services postnatally, focussing on non-attendance at child health clinics, non-utilisation of GP services and low uptake of immunisation. Attempts have been made to identify major factors responsible for low/non uptake, employing a variety of theoretical

perspectives by means of which the studies may be characterised.

The process by which research gets underway and reaches some sort of conclusion and recommendation can be seen to hinge around assumptions made at the outset. These determine the nature of research undertaken, methods adopted, the selection of relevant material and these in turn determine the type of remedy which would appear logical.

The problem of underusage has been approached in a number of different ways by different researchers. These are grouped for discussion into the major types of study undertaken.

2.2.2.1 Sociodemographic studies

The approach most frequently adopted is that of identifying groups who can be considered to be 'at risk' or unlikely to make use of the services available. In this type of research, 'users' and 'under-users' are compared according to their sociodemographic characteristics. Often the researcher then suggests reasons for the 'unsatisfactory' behaviour exhibited. 'Explanatory factors' are guessed at and presented in an exposition often containing moralistic judgmental decisions on the part of the worker concerned (Selwyn, 1978; Steele, 1966). For example, in the work of McKinlay (1970a) certain economic, biological and social factors were identified which pointed to those social groupings most likely to under-utilise the services: mainly multiparous mothers whose husbands were employed in manual work, married women with children conceived premaritally and unmarried mothers. This type of research mainly reveals relationships between under-utilisation and the various attributes of social status, eg occupation, income level, education, residential location. As

McKinlay points out, these gross relationships have already been established conclusively enough and further identificatory work of this nature would add little to what is already known about under-utilisers.

Collver et al (1967) sought reasons for low rates of attendance by interviewing patients after delivery and before discharge in the hospital context. A further important factor in this American study was obviously the cost involved in attendance. He checked records at a post-partum clinic to identify mothers who attended in a search for 'predictor factors' of attendance. Major question areas concerned factors such as age, marital status and religion. Collver also looked at 'size of community of childhood' and attempted to relate it to attendance (no relationship was found and it is not clear why such a possible link was initially hypothesised). The study concludes that postnatal attendance is determined by 'objective' factors such as age and marital status, as expressed intentions on the part of the mothers added no further precision to predictions of attendance. It is argued that these 'objective characteristics' produce 'dispositions' on the part of the woman either to attend or not to attend; whilst such characteristics also call forth differential treatment in the system. Religious affiliation is also thought to be linked with attendance, Protestants tending to attend more frequently than Roman Catholics in the antenatal period but not in the postnatal period, though no explanation is offered as to why this should be the case.

There are a number of methodological difficulties with this study. Mention has been made of the timing and location of interviews as being less than ideal. There is also a certain ambiguity regarding what is meant by 'attendance'. No consideration is given to a number of factors which are possibly of equal or more importance in determining levels of attendance, eg continuity of care or the lack of it, maternal perceptions of care received. One is left to wonder why a group displaying certain 'demographic characteristics' should make less use of the available services than others, what services were available to these mothers, what the quality of the services was like, and so on. As with other studies of this type, the individual element of decision-making on the part of consumers appears to have been left totally out of account.

McKinlay's (1972b) study of postnatal attendance attempts both interpretation and explanation by relating the social attributes of some under-utilisers, to prepare a composite picture, employing a sample controlled for social class membership to highlight intra-group differences. He found the lifestyle of his under-utilising group to be typically unstable and mobile. They tended to marry earlier, and to have been married for less time before the birth of their first child, than was the case for the utilising group. They tended to move house frequently, often renting accommodation in the same house as one of the parental groups. They tended to have a more fatalistic attitude to life and did not display as much forward planning as did the utilising group. McKinlay concludes that

> "...under-utilisers appear to sustain a crisis existence, constantly threatened by lack of permanent accommodation, overcrowding, marital instability and financial difficulties, frequently compounded by family sickness, accidents or other untoward social events such as imprisonment. Given the continual need to cope with such major life problems, planning ahead was hardly relevant for these families."

As in antenatal studies previously discussed, McKinlay gives no consideration to the form in which 'care' was delivered, its appropriateness or otherwise for the target groups, or of the opinions of the mothers themselves regarding the care. They are viewed as a group of 'very unsatisfactory' mothers who, it is assumed, ought to make better use of the services currently offered to them.

Some authors have characterised this type of sociodemographic research as 'blaming the victim', leaving out of account the characteristics of the care itself. McKinlay himself has noted a dearth of research into the quality of medical care delivered, with many researchers concentrating on primarily quantitative aspects. The studies attempt to identify 'at risk' groups, e.g. of developmental delay (Zinkin, 1976b), cot death (Selwyn, 1978), failure to 'manage' the child adequately (Frommer, 1973; Lewis, 1972), but do not enquire specifically into the reasons for non-utilisation.

As an adjunct to a study of the work of health clinics, McConachie (1979) visited 23 non-attenders and asked them three short questions, about underusage, health visitors and immunisations. Although a majority expressed approval of the clinic, they did not attend because they received help from elsewhere (GP, hospital or own mother) and felt no need to go. Those who did not approve of clinics thought they

were no help at all. Those who had never thought about going merely reiterated this. Whilst in general health visitors were well spoken of, their help was not missed or sought after. The report recommends an increase in home surveillance by both clinic doctors and health visitors of their defaulters, bringing the service to them. The times clinics are held could be more mindful of mothers' other duties and the confusion surrounding immunisations should be cleared up by doctors speaking with one clear voice. The reasons offered by those interviewed are very bald and dismissive indicating a reluctance/lack of opportunity to discuss the matter further.

In another study (Chazan, 1976) the reasons for non-attendance were similar to those found by McConachie (1977); out of 76 underusers visited, 25 stated they had other small children and it was too far to go, 22 claimed they never went to clinics. Others had other problems such as illness in the family or child, which prevented them from going. Again there is a bald list of simple reasons for non usage offered. In particular, what a person means by claiming never to go to clinic, defining it as an irrelevance to their lives, requires further investigation.

Emery's work (1979) on the identification of some infants at immediate risk of dying unexpectedly would seem to concur with that has gone before. All children are scored at birth and by the health visitor at one month, on a system developed to identify those requiring attention. The scored 'at risk' register is used to direct primary care services to those most in need. The results so far have been promising in that children in need of hospital care have been picked up. Redirecting resources in this way skirts around the problem of

underusage by taking the service to the mothers, a fuller understanding of under-usage is not gained.

Burkel (1983) identified high risk mothers and related usage to social network information. The problem was identified as due to a lack of congruence between lay and professional attitudes and values. The high risk mothers tended to act in accordance with the advice of kin and friends, and their sense of competence as mothers was directly related to underusage. It was concluded then that families were offering a competing service, "modelling and sanctioning" behaviour and the solution was seen as identifying neighbourhood opinion leaders and intervening in this way. A need was also acknowledged to improve the congruence between lay and professional values and attitudes.

This study raises numerous questions. Under-users were again missed out by sampling procedures as those who refused referral into the study were not pursued. The study relied on self reported frequency of attendance in order to classify participants and mothers were identified as 'at risk' on the basis of the programme's own measures of "inadequate parenting, child abuse and neglect". Interestingly one feature used to identify the target group as at risk was poor kinship support, lack of group membership and frequent moves, which casts serious doubts on the validity of the study's main conclusion, that neighbourhood kin and opinion leaders were leading these mothers astray.

There are some important gaps in this approach. Where no attempt is made to contact under-users themselves and discover their reasons for underusage, many possible factors are left out of account. One can never be sure, for example, if the clientele are even aware of what services are on offer. Hart (1979) reports the holding of a public meeting in order to give an idea of what a health centre is about and what is provided there and discovered a very low level of public awareness.

Graham (1977a) bemoans the bias in research towards demographic predictive studies, whereby we know relatively little about the realities of child rearing as women see and experience this in their daily lives. Research has relied heavily on traditional quantitative techniques, fixed choice questionnaires, personality inventories, in order to mediate the attitudes and experiences of informants, rather than procedures which allow for more flexibility and negotiation in the meanings and categories of results.

The results which ensue from traditional approaches are too simplistic to be very informative. For example, the research leads to a distinction between mothers in terms of 'planners' and non-planners, i.e. the feckless and the organised. This apparently clear cut distinction (McKinlay, 1972) disappears on further analysis. Planning is treated as a central and taken-for-granted facet of mothers whereby they are supposed to need to adopt a conscious and instrumental orientation towards the future. However, for many, events 'just happen' and only retrospectively are they given order and consistency. The rigid classifying of responses does not really capture the nature

of what is going on. In McKinlay's 1972 study, even 'planners' contemplated abortion and adoption, and the overall similarity in attitudes between the two groups were more significant than the differences. The planned parenthood ideal then, is not lived as such, and may obscure areas of real difficulty and conflict for those who try to live up to it.

2.2.2.2. Social/Psychological studies

The second major type of under-utilisation study may be described as social/psychological in nature. In this type of study, the client's motivations, perceptions of care and educational attainments are emphasised as explanatory variables affecting take-up. Some studies of this type emphasise the role of negative or inappropriate attitudes on the part of the consumer, whilst others focus on information deficits. In the former case the under-utiliser is considered to be alienated from the services, to have negative attitudes towards them; whilst in the latter case the under-utiliser is seen as not understanding enough about the importance of the services and the long-term benefits of preventive health care, to act accordingly. These two themes of alienation and information deficit are often linked and discussed together as being of significant importance to the problem. For example, one study of disadvantaged families showed mothers in the sample as seeing health centres predominantly as hostile places, where 'needles' are given, and where children are more likely to be given infections than to be protected against them. (Wilson 1973). This may reflect the widespread practice of taking children to the clinic because of ill-health for which treatment will be required, even though this is not its primary function.

The dichotomy of responsibility whereby clinic medical officers exercise a purely advisory function as against the combined advisory/therapeutic function of the general practitioner could be both confusing and time-consuming for parents. This broad distinction may not be well understood and it is questionable how effective preventive and developmental surveillance can be when unsupported by immediate access to any necessary medical treatment. This situation is illustrative of the view advanced in the Court Report, where it is suggested that:

> "They (the parents) are faced with a conglomeration of professionals, the majority working in separate uncoordinated services, with limited roles and limited communication with each other..."

so that the inappropriate attitudes of consumers may be a direct product of the delivery of child health care, its administrative and organisational aspsects, although this is rarely spelled out.

Acton (1978) indicates that there is a resistance to attendance affecting some groups throughout their lives and that those attending during the first few months of a child's life most quickly lose interest if their confidence is not reinforced. The problem here seems to be one of disenchantment with the services offered, so that initial reluctance to attend, even when overcome, may reassert itself. Acton refers to 'resistance' on the part of some groups, indicating an 'inappropriate' attitude on the part of parents, due possibly to one or more of a number of factors including personal alienation, lack of

perceived usefulness or appropriateness of the services, and negative attitudes towards health care. Conversely, regular attendance can be correlated with positive attitudes towards health care (Hulka, 1971).

It has been suggested that a considerable amount of dissatisfaction with the maternity and child health service revolves around professional attitudes to maternal requests for information, e.g. women asking for more information in order to assist them in making appropriate decisions regarding care of their children being met with resistance or negative attitudes on the part of health professionals (Micklethwaite, 1978). As is the case with antenatal care, many mothers tended to see attendance at postnatal clinics as an obligation rather than as a positive experience. Some express feelings of inferiority, others feel 'out of place' in the clinic, and single mothers are especially reluctant to attend (Bramall, 1978).

Other studies have been concerned with information deficits and have regarded this as of primary importance. For example, concerning uptake of immunisation, a report of the Child Poverty Action Group comments:

> "It was apparently those with clearest information about the relation of the service to health, and with the clearest concept of the effect of actions today in relation to benefits in the future, who had made most use of the service." (CPAG/DHSS, 1978)

Here the problem is seen as one of inadequate education - possibly partially due to patterns of service delivery - and ignorance on the part of the parents as to the necessity for preventive measures. The tacit assumption appears to be that anyone who possesses this type of information would be only too happy to use the services - a

problematic conclusion, if the attitudinal material of previously-discussed studies is taken into account.

The suggestion has been made that health care uptake and social class membership are linked in the sense that lower working class groups do not manage to act as consumers in the normal sense of the word, that is, by actively exploring and utilising the various options available. Here the problem is seen as inherent in the inability of certain consumer groups to initiate care, or to conform to the expected role of a consumer (Logan, 1971) and it has already been noted that some support exists for the notion that certain parental groups are incapable of initiating help when it is needed (McWeeny 1977). Where the need for individual initiative is reduced, eg as in the case of computer-controlled immunisation programmes (CPAG/DHSS, 1978), a significant reduction in differential take-up between socioeconomic groups was noted. This finding might be thought to support 'information deficit' theory, as some consumers may have been unaware of the service prior to receiving computer invitations to attend, or may not have realised its importance until that time, or may have responded positively to the receipt of a written invitation. There is a need for more work in this area, since it cannot simply be assumed that non-utilisers prior to computer-assisted immunisation programmes were inept individuals, incapable of taking personal initiatives in child health care. However, firm knowledge of disease and illness states and related understanding of medical and health care have been

linked with positive attitudes to the child health service; and the converse, presumably with a tendency to unfavourable attitudes. For instance Smith and Kaner (1970) found those mothers who had less knowledge of disease and illness to have more unfavourable attitudes towards official child health care.

Whether such a causal link between knowledge and usage can be made remains to be seen, it being entirely plausible that those who make use of the health service and hold favourable attitudes towards child health care would be expected to display appropriate knowledge of medical matters gleaned from contact with service personnel. It would form part of their reflective rationale for usage, not necessarily there in the first place and being a reason for usage, as is most often assumed. Simply noting the presence of usage, favourable attitudes towards official health care provision and some appropriate grasp of medical matters and linking them in a causal framework is an entirely circular exercise.

McWeeny's (1977) study shows up the inadequacy of a simple sociodemographic approach, finding the essential differences between the mothers of cot death children and those of surviving children to be quite distinct from such factors as housing, RG category membership etc. The two groups were virtually identical in these respects. They differed in their perception of disease; thus the parents of cot death children were considered unable to interpret the meaning of symptoms and to have relatively high alarm thresholds, as measured by the time elapsed between recognition of symptoms and summoning help. McWeeny found a picture of uncertainty, wavering and hesitation about summoning the doctor and judged the parents to be inadequate to the

task. They expressed negative feelings towards their GP and found the services in general inaccessible. In this study, then, the clients' view is given an airing and the services are at least questioned; it is not assumed that they are adequate at the outset. The services had responded negatively and inadequately to the approaches of these parents, hasty receptionists and previous offputting experiences with service personnel contributed to the problem. The clients did not know either their GP or health visitor very well, had been visited less and had been turned away before from the services. They had lost faith in there being any readiness to help them.

Jeffery (1971) sees the attitudes and lifestyles of the working class as rendering them unable to make use of the health service. They are described as irresponsible, unable or unwilling to take responsibility for themselves, regard events to be outside their control, live in the present and do not look to the future in a planned or systematic manner. All of these negative characteristics of the working class are supposed to account for their inadequate take up of health care. They are judged by the yardstick of a middle class professional and inevitably found to be lacking.

The same kind of explanation is offered by Baric, who postulates culture lag as the major factor accounting for the skewed take up of care in favour of higher socioeconomic groups. Barriers to communication are posited as due to the degree of social distance

between the working class patient and the professional carer. The patient is regarded as quite stupid, having difficulties in 'the application of logical thinking'. The evidence for such conclusions is sparse and totally obscured by the moralistic, judgemental overtones.

The attitudes and views of life held by the multiply deprived are clearly thought to add to, if not be solely responsible for, their health problems. Williams (1982) asserts that they hold ridiculous (folklore) beliefs about their bodies, which are regarded as mysterious and potentially dangerous things. They have low self esteem and so do not cherish their bodies, being content to accept less than perfect health. The adjustments they make to being deprived are held responsible for a good deal of violence and hostility, "often blaming professions for their deprivation". The problem is seen as a lack of communication between client and professional, compounded by a lack of power, drive and ambition from clients who have learned to accept their place without further question. These communities are regarded as those where "health is least valued" and the solution is to make families stand up for themselves.

Aitken-Swan (1977) summarises personality deficiencies thought to be evident in underusers of the health service. They are unable and lack the motivation to limit family size, being judged ignorant of and apathetic towards family planning. She sees the "well developed sense of apathy and fatalism" as a form of adaptation to powerlessness. It is thought that it is more usual for women in low socioeconomic groups to deal with a problem as it arises rather than prevent it (Chapter 5, p.211ff), whilst sympathy is regarded as one of the games such people

can play to get their own way. This is admittedly unfair to those who are not adept at establishing brief interpersonal relatonships but the "duller" patients, i.e. the unmotivated women, are thought to require doctors to be much more active in influencing the attitudes of their patients. After cataloguing such a negative picture of these people, the reader is cautioned to beware as it is acknowledged that such conclusions may be prematurely pessimistic in the light of our ignorance of what makes a service attractive to the individual woman.

Such a pathetic picture can be contrasted with any number of others who perceive quite different persons suffering from deprivation, eg Pahad (1982) found those who did not attend clinics to have very good reasons for not doing so, they were beset by other worries and demands which made keeping appointments out of the question. Parents often blamed for the mismanagement of their children's problems are found to be doing the best they can under the severe circumstances in which they live and all expressed deep concern about their children's health and welfare.

The Well Women's Clinics' (1982) own research found that women expressed satisfaction with the health service mainly because their expectations were very low.

Friedson (1960) points to the difference in what a professional and a lay person would consider to be good practice and the fact that these

are likely to be very different and almost certainly powerful determinants of usage. There is, and always has been, an association between formal educational achievement and use of preventative services, but the relationship cannot be written off neatly by disparaging the uneducated as ignorant and therefore unable to communicate with the intelligent professional. There are a myriad of factors responsible for difficulties in communication between groups having different values, life styles and manner of communication. To judge one as the more desirable mode and negate the others is merely to express one's own opinion. It is by no means uncontentious that professional values and styles of communication are the better or more desirable which all should adopt. The problem is more complex than that allowed for by this type of analysis. Crystal (1976), when looking at sociolinguistic problems in doctor/patient communications, suggests that jargon is unnecessarily used and the divided opinions among doctors causes confusion for patients, whilst Tanner (1976) notes that building rapport in relationships is a complex matter.

Shuy (1974) stresses how few people have the ability to expound their state in a logically precise and well-sequenced manner. It is not simply a question of a class divide, but these kind of communication problems cut across class boundaries and relate more to the differences between having a professional training and the lack of one. He stresses the importance of expectations, eg people being used, or unused, to asking questions and answering them in clear cut

terms. Most people, it seems, begin at random and introduce a range of observations as they come to mind.

The association between beliefs and behaviour has received much attention in this area of study, with questionable usefulness.

Wurtele (1982) is one example of a testing of the relationship between health beliefs and stated intentions and behavioural predictions. The study tried to predict non compliers in order to follow them up; but it was found that general beliefs were not predictive of cooperation with service provision. Sharp et al (1983) investigated the relationship between symptoms, beliefs and use of services among the disadvantaged. The expressed attitudes favoured usage, seeing it as a good thing which, however, had no effect on uptake. The whole of patient compliance research is replete with similar conclusions (see Hagan (1979) review paper), stated beliefs and intentions bearing little relation to subsequent behaviour in any simple way.

Lipton (1974) asked parents to give their opinions as to what they expected to occur at a clinic for children with developmental problems. They found that most parents felt they lacked the expertise necessary to answer the questions. They did not want to comment on the clinic or procedures. This uncertainty was expressed regardless of class or ethnicity. The authors explain that their questions were in a sense redefining the traditional consumer role in a manner that was totally new and surprising to many parents. They then offer two explanations; that lower class parents were unable to state their case

whilst the middle class ones were unwilling to step outside the consumer role. Merely to establish that parents rarely have firmly established attitudes as to how and by whom health care should be delivered is instructive.

Berkanovic (1974) offers a much more sympathetic and balanced account of how culture can affect utilisation behaviour. The cultural values represented by the health service can be supportive, neutral or antagonistic to those of any target group it serves, so that psychological costs can be involved. The need is stressed for an examination of the human meaning of health services, in view of the inadequacies of the so-called 'hard' indicators. As a guide, three points of study are suggested: misfitting expectations, different priorities and vulnerability to personal assault. Encounters with health carers can imply threats of victimisation, punishment or ridicule. Threats of failure are highly probable in the face of strongly sanctioned but socially/physically impossible behavioural demands. Evidence is presented which shows that the social preferences of physicians and nurses are important determinants of a patient's fate. Cartwright (1964) demonstrates, for example, how lower socioeconomic group patients are much less likely to receive detailed explanations of their conditions. A later study, Cartwright and O'Brien (1976), indicated that little has changed. Middle class patients still receive longer consultations with their GPs, receive more advice, social chat and discuss a wider range and number of problems. Doctors tend to cut short working class patients, feeling they ask about inappropriate problems. This quantitative study

measuring conversation time, minus silences, and telephone calls, however rigid shows that patients are routinely treated quite differently along class lines to the detriment of the lower socioeconomic groups. To look at the quality of encounters would require more qualitative approaches to identify awkward or easy silences and what kind of treatment such people feel they are offered.

Green and Evans (1984) contribute an important consideration to the debate surrounding usage of service facilities, although their work was related to the uptake of on-demand relief service for handicapped children, their insights are of relevance to this study. It was commonly believed prior to the setting up of the service that it would be abused, yet they found their problem was one of underusage, not overuse. The parents' dilemma surrounding usage was that of accepting help. They felt that they should be doing all the caring and should moreover be seen to be doing it. Their own sense of competence came under threat if they needed to accept help. As one person put it,

"If I can't cope then I'm not a good mother."

In nearly every case the parents' emotions and sense of responsibility were the regulators of use.

The mere provision of service then is not a straight forward matter at all. Parents find that the services lead them to question their own competence, their needs and the compatability of their self-image with accepting help. Parents were not, moreover, unrealistic or over-sensitive about such matters; it can be noted that the service fully anticipated abuse and were surprised to find underuse to be the major problem. Service providers do have clear cut ideas as to

appropriate usage behaviour on the part of clients, and it is to be expected that parents will make efforts to avoid being caught 'wrong-footed'.

This study remains quite unique in its sensitive awareness of this regulator of usage. Reluctance to make use of other services has never been viewed in this light except perhaps alluded to by Graham (1979) in her identification of a conflict of responsibilities in her sample. Oakley (1980) found notions of personal failure to be linked to the need for medical care.

When interviewing mothers some five months after the birth of their child, Graham (1979) found a critical factor affecting uptake and satisfaction to be the degree of maternal uncertainty regarding the role of the clinic and of the Health Visitor, and confusion about the division of responsibility between them and other health care agencies. She describes three major differences in the problem postnatally as compared with her findings on antenatal attendance:

1. Frequency of expressed dissatisfaction with clinics and health visitors had declined

2. Dissatisfaction was now expressed in a different way, ie by non-attendance and/or under-utilisation

3. The source of the dissatisfaction had changed from antenatal confusion/unhappiness about the way in which the care was organised and delivered, to a generalised uncertainty about what the service was for, and why they should attend (ie confusion regarding the role of/need for the services).

Here primiparas and breast-feeding mothers saw the health visitor as most helpful. The most interesting class-related trend was a good initial attendance and apparent initial satisfaction by mothers in lower socioeconomic groups, with a subsequent failure to return and a drop in satisfaction levels after the first few postnatal months. It seems that mothers both attended and appreciated the clinic if: (a) they saw it as both relevant and important, and (b) they perceived its role as not easily fulfilled elsewhere. A critical question would, therefore, concern maternal perceptions of the health visitor's role and of her relationship to other sources of health education and advice. Mothers saw a wide range of functions for the child health clinics, eg weighing children, discussing baby's progress, discussing problems, meeting other mothers, buying milk and baby foods. Regarding maternal attitudes to health visitors, the psychological and practical importance of their work was acknowledged by many mothers. Those who neither attended nor 'appreciated' the health visitor had doubts about these functions. They saw clinic roles as better performed elsewhere, eg they weighed their babies at the chemist's, discussed progress and problems with their own doctor, and saw their friends as a better social outlet than casual clinic acquaintances. Another very significant factor affecting uptake and satisfaction was the experience of one or more 'distressing' incidents. These incidents were invariably ones in which the mother was made to feel guilty, inadequate or embarrassed because of her apparent inability to care for her baby.

The problem of under-utilisation of general practitioner services stemmed from a confusion about when it is legitimate for a mother to

call upon her doctor's services. This was especially marked in the case of emotional problems such as depression. Fifty-five per cent of Graham's maternal sample reported having suffered from depression at some stage, yet two-thirds of these had received no medical advice or treatment at all. Non-consultation was due to uncertainty regarding the nature of symptoms and reluctance to admit to what many mothers regarded as an 'irrational, silly' state, and perceived by them as a stigmatising condition.

As a result of her findings, Graham considers the current concern with the supposed social and psychological characteristics of mothers who fail to attend to be misdirected. As a first step, she feels that attention should be focused on the delivery of the service itself, and not least to the question of where the emphasis in provision should be placed; eg on the more specifically medical supervision of a mother and child, or on the emotional/supportive side of postnatal care. Medical benefits may be obvious for an attender but their uptake could be prevented by the absence of supportive features in the form of emotional support and reassurance.

Graham's work has provided a number of insights into the problem of low uptake, which have been considered in the planning and design of the present study. However, her findings are limited to the users of one hospital-based child health clinic and the nature of her sampling procedure precluded the inclusion of profound under-utilisers of the service - a group of particular interest within the focus of the present study. Similarly, the Graham study was carried out

prospectively, with interviews conducted at three-monthly intervals during the data collection phase and it is entirely possible that the study itself may have influenced take-up in the group under study, an effect avoided in the present study by adopting an immediately post-first-year retrospective approach.

A number of workers have expressed concern regarding the negative, judgemental manner in which mothers have tended to be treated in studies of under-utilisation. Oakley (1976) comments,

> "In every study of patients' attitudes which I have seen, the desire to do one's best for the child is sincerely and spontaneously expressed"

and Graham stresses the major themes underlying women's experiences of motherhood as being those of responsibility and uncertainty, ie their concern to promote and to protect the healthy development of their baby, and their feelings of uncertainty about how best to ensure this.

The view is widely expressed that research should now take into account these more positive considerations of a mother's roles and responsibilities.

Blaxter (1981) points out that underusage exists side by side with commentaries which suggest that the same group of families 'take advantage' of the NHS and over use primary care. It seems then that whatever their behaviour, it is inappropriate and somehow culpable (p.168ff). She also notes that it is a simplification of human

behaviour to assume that rational behaviour results from perfect information and 'correct' values. Unapproved behaviour may be neither irrational nor the product of ignorance.

2.2.2.3 Geographical Approach

The third type of research approach regards relative proximity of services as a main determinant of under-utilisation and seeks to demonstrate that this is the case (Collver, 1967; Lister, 1978). Using geographical proximity to source of care, Collver computed a "measure of accessibility", described as an "a priori measure of exposure to the opportunity to attend", whilst the "relation between accessibility and attendance is to be found empirically to determine a prediction of the probability of attending clinic." As the verbal responses of these mothers were not predictive of their actual (subsequent) behaviour, not too unexpectedly attendance rates were found to increase in areas where more clinics were available.

Lister (1978) stresses the inaccessibility of clinics and suggested taking the services to those who do not attend and increasing domiciliary visits and weekend clinics.

Although there is evidence to suggest that some mothers do have problems in getting to clinic due to distance, there is little evidence that this in itself necessarily produces lower rates of utilisation (McKinley, 1972a). It will obviously have some relevance but may be considered as a further problem faced by some mothers in addition to those previously outlined.

McKinley (1972a) states the main reservation regarding this approach; the little evidence to show this to be a main determinant.

2.2.2.4. Specific deficits approach

A number of researchers have indicated the importance of the quality of service provided as primarily affecting take-up rather than external factors such as socio-ecocnomic group (Graham, 1978; Jenkins, 1978; Robinson, 1978). Some consideration has been given to the service facilities themselves as not being conducive to regular attendance; e.g. lack of play space for other children, lack of changing space for babies, lack of refreshment facilities after a long wait, lack of privacy with mothers feeling embarrassed for whatever reason, lack of social clubs and/or functions where those experiencing similar problems could chat and offer each other support. Thus the clinics themselves have been regarded as unattractive places to visit, with lack of facilities contributing to dissatisfaction and reluctance to attend on the part of the mothers.

Retraining and redirection of personnel

Doctors and health visitors have been judged to be inadequately trained for their work in the prevention services (Illingworth, 1979; DHSS, 1978; Oakley, 1976; Steiner, 1977; Perrium, 1979). Both could be given more training in human and communication skills (DHSS, 1978; Zola, 1973) and refresher courses to bring their knowledge up to date and to include welfare rights information. It is thought that not enough general practitioners undertake this child health work because of lack of training, financial inducement, facilities and time (Steiner, 1977). There is an almost unanimous call for more and better trained health visitors (Reid, 1978; Emery, 1976a; Dunn, 1979;

Court, 1977) and some redirection of their activity towards high risk children. Their skills are too often being used for help of a kind more properly expected of social workers and this increases their uncertainty regarding their role on the part of the profession.

Delivery and timing of clinics

Transport is recognised to be a problem and the remedy suggested is the siting of facilities around places where the disadvantaged do go, eg casualty departments (DHSS, 1978). (This was treated in more detail in 2.2.2.3.) Mobile clinics are to be encouraged (CHC, 1979) to reach more underusers, whilst attention has been drawn to the problems of health visitor attachment to general practice or geographical placement in order to reach more of the population. The Court Report (1977) finds the changes towards general practice attachment has made the task of the health visitors, of locating and offering help, even harder whilst continuity of care has been eroded, those attending their local health clinic being unlikely to see their own health visitor.

The timing of clinics has been regarded as restrictive (DHSS, 1978) and it is thought more sessions should be held in the evenings and at weekends whilst mothers could be granted time off work to attend. It is repeatedly suggested that appointments could be introduced to reduce waiting times which are without exception a source of complaint. These were found to average 110 minutes in one Newcastle study (Steiner, 1977). In view of the evidence which reports high consumer satisfaction with the drop in, informal set up, opinion remains divided (Morrell, 1972).

Facilities at clinic

Many suggestions have been made to improve the clinic environment. Play space and materials, changing rooms, refreshments, private cubicles and the setting up of mothers' clubs have all been raised and discussed (DHSS, 1978). The attractiveness of clinic premises has come under scrutiny (CHC, 1979), their impersonal officious character and drab paintwork.

Suggestions have also been made as to how the service could be more of a positive experience for mothers. Problems revolve around the dissemination of information, conflicting advice from different personnel, poor continuity of care, less than adequate availability of doctors at clinic, minimal social worker involvement and lack of discussion groups of any sort (DHSS, 1978; CHC, 1979; Dunn, 1978). Perrium (1979) and other advocates of well women clinics insist on personnel having time and patience to cater for mothers.

Special services are thought to be needed to deal with particularly vulnerable groups, eg schoolgirl mothers, the handicapped and those appearing on at risk registers (CHC, 1979; DHSS, 1978). There has also been much discussion of a 24 hour phone-in service.

Communication and integration of services

The communication and liaison between health carers at all levels has been found lacking, requiring restructuring and modernisation of records and administration. Computers could be used to ensure automatic follow up and accessibility and completeness of records (DHSS, 1978). The lack of consultation between health and social services has called for more integration (Steiner, 1977), whilst it is

generally agreed that lack of coordination between these services has been wasteful and confusing all round (Court, 1977), as has that between hospital and community services.

The present state of child health records is regarded as a reflection of the divided history of the services, lack of standardisation and coordination leading to incomplete and inaccessible records. It is concluded in Court (1976) for example that there are far too many different types of clinical records used in the child health services and this in itself presents an obstacle to the integration of care, preventing complete coverage of all children and the tracing of defaulters. Information available to mothers is regarded as totally inadequate, conflicting and unsettling (CHC, 1979) and a call is made for professionals to get together and present a united front.

Thus nearly every facet of the existing service has been found wanting and requiring change and improvement if those not reached are to be brought within the service. Caution should be exercised in the adoption of any of these proposed remedies as present data and understanding of underusage is an insufficient basis on which to determine superior forms of care.

2.2.3. Solutions to the problem of low/non usage of services

Professionally inspired solutions to the problem of under/non usage can be found throughout the literature, based on research or personal preferences of the authors. It would seem instructive to look at the underlying explanations of underusage which lie behind each one, whether these are explicitly stated or not.

Solutions to the problem of underusage can be seen to be a direct product of the research undertaken. If misconceived, they can be expensive mistakes and will not only not work but could make matters worse, being both ethically and technically ill conceived.

2.2.3.1. Positive discrimination: the designation of health priority areas

The sociodemographic approach leads logically to the designation of health priority areas to serve these groups, encompassing both discrimination and labelling. The positive discrimination very prevalent in the literature at present, whereby resources are directed to these groups, requires careful scrutiny to ensure that the intervention encourages attendance rather than coercive measures.

A considerable development of home-based mobile clinics seem desirable in themselves, embodying the ideal of the services going out 'samaritan-like' to those most in need. However, there is no reason to believe that groups hostile to stationary clinics will make any more usage of mobile ones offering similarly unsatisfactory services. Their decision to avoid provision is overlooked, rather than taken seriously and averted.

Improving the delivery of services assumes too readily that the services are adequate as they stand, but that they are just not reaching those in need. This attitude could lead merely to 'more of the same', without any serious consideration of client needs as defined by the clients themselves.

2.2.3.2. Changing client behaviour patterns

The apparent apathy of the poor is thought to be a reflection of their feelings of powerlessness and low self esteem. Their normative expectations are unlikely to encourage uptake; the poor are accustomed to and accepting of poor health. Thus intervention is geared towards individual health education. However, changes in client behaviour are unlikely to make a very significant impact on the incidence of ill health whilst so many of the health disadvantages which are class related remain outside the control of individuals.

The focus on problems of management posed by 'difficult' clients leads to a solution being sought in the personal characteristics of such people, which can be measured e.g. the extent of the client's knowledge has been measured usually in terms of what the professional feels they ought/need to know, and personality traits or attitudes have been identified, which are found to be inimicable to effective performance as a client. There is an implicit comparison with an ideal client whereby the nonconformer is portrayed as deficient in some way, irrational and requiring change. This tends to lead to policies which seek to change, educate, compensate and even suppress the client's choices.

To see underusage as dispositional then is to ignore the plethora of research and comment which shows how powerful social, economic and medical contexts can be in shaping a person's experiences (Oakley, 1980).

2.2.3.3. The cash incentive approach

The cash incentive idea is also gaining adherents in the popular literature, its most well known exponent being Pringle (1977) who sees the financial inducement as of paramount importance and suggests that the government makes payment of child benefit dependent on take up of services, as in the rest of Europe. This deceptively simple solution has not gone unopposed.

Billingham (1979) expresses grave concern at the suggestion of witholding benefits in order to secure attendance. The adoption of such a policy may inhibit any further investigation of late or non-attendance for care and takes attention away from possible deficiencies in the service on offer. Furthermore, it could increase discrimination against the most vulnerable sections of the community renowned for low uptake. This concern is echoed by Burkeman (1980) who questions the comparisons with France (where cash incentives are used) as being unrealistic. The better rates of uptake in France are thought to stem from better care, not from witholding benefits. Such a scheme would in effect punish some mothers for the choices they have made, assuming them to be totally irresponsible in spite of any real evidence to that effect.

Chalmers (1980) in a thoughtful review discusses and rejects the simplistic solution of financial incentives. The problem of underusage is seen as one which requires further analysis, with sensitive measures of the quality of service provision.

It is one thing to recognise that certain groups are impoverished and in need of financial help in order to cope with the burden of a child,

but it is quite another to suggest 'bribing' them to come to the clinic. The implicit meaning to clients of such a policy would need to be recognised, i.e. that they are at fault and need to be punitively forced into realising their responsibilities.

2.2.4. General comment on research

Overall, the research on underusage is inadequate in a number of respects. The sociodemographic type studies typically collect statistical data and inferences are drawn about usage. There are major conceptual problems with the approach; and data chosen for consideration is not always given a rationale. The reliance on 'objective' data, as explanatory or identificatory tools, disregards the subjective factors which must be of some importance to the understanding of behaviour. The studies have not attempted any evaluation of the adequacy of provision, from the client view. Having arisen predominantly from 'at risk' type research, the aim is to identify likely defaulters early on so that intervention can be targeted. By its very nature this type of research tends to be identificatory rather than deepening understanding.

When assertions are made about the underutilising group they tend to be rather sweeping generalisations such as irresponsibility and lack of planning (McKinley, 1972). When judged by the criteria of a professional yardstick most members of the lower socioeconomic groups are found wanting.

The sociodemographic and social/psychological approaches both offer cultural explanations of underusage, claiming that the poor have developed ways of coping which have become so inbred and extensive as to constitute a culture within a culture. Such explanations combine social, economic and psychological traits, eg lack of integration in major societal institutions, not sharing the values of society, poor family organisation and damaging attitudes such as helplessness, dependence and inferiority complexes.

The main solution then is seen as one which would make the parents fully functioning parts of mainstream culture, changing their parenting practice through professional intervention to break the mould. Studies adopting this approach, although plentiful and holding considerable sway in popular thought, are imprecise. It is not clear how and in what ways the myriad of social, psychological and economic factors are linked or which if any are present at any one time, or what weight is to be attached to them. Many studies of the poor, reviewed by Holman (1978) for example, have found them to be not so very different from the rest of society, sharing most common cultural orientations in society, merely lacking sufficient means to take a full and active part.

In the socio-psychological approach it is clear where the fault is felt to lie by the type of research undertaken, which mainly sets out to determine what it is about this group of people which makes them behave in such a self harming manner. Thus there have been attempts to devise methods of measuring 'mothercraft' and accepted standards of

health by monitoring, for example, the length of time which elapses between a mother's recognition of symptoms in her child and concern as shown by summoning medical aid (McWeeny, 1975). Others have tried to measure physiologically a mother's sensitivity to her infant's behaviour, thought to regulate care-giving responses (Wiesenfeld et al, 1978).

The approach treats underusers as what Holman (1978) calls 'problem persons'; such people are seen to have multiple problems, poverty being only one of them. The reason for their behaviour is psychological, something within the person which - "got them in this situation in the first place". For example it has been asserted that childhood deprivation leads to an abnormally functioning adult. This line of reasoning has come under a lot of criticism (see Clark & Clark, 1972), lacking clarity, specificity and most often seeming tautological. The other main suggestion, that this group displays an immature feckless approach to life, has not been convincingly demonstrated.

The specific deficits approach assumes the solution lies in more technical expertise of delivery.

The needs of the organisation can be shown to supercede the consumers' needs (see Graham, 1979, ante natal and maternity provision assessment), most often professional interests gaining priority. Solutions address themselves to delivery, ways in which to reach their own professionally designed goals.

Robinson (1978) sees the major problem as the encapsulation of the

client and professional in sharply differing subjective worlds exacerbated by the gross power imbalance between them. The professional is blocked from an adequate view of his client's world and is moreover able to impose his own definitions while ignoring or reinterpreting those of the client. Research on clients' views of provision are very few in number and rarely receptive or open ended enough, most often circumscribing areas of relevance through premature categorial analysis.

Too often studies assume the appropriateness of existing services and the fault is implied to lie in the non-user when more often than not we are never sure if they were even aware of services on offer. Knowledge of provision cannot be assumed, Gillett (1973) found that 63% of non attenders did not know enough about the service to make use of it and Perkins (1978b) offers some evidence to indicate that services are differentially offered to mothers, most of whom indicated their willingness to attend had they been sure they were being invited. Often they were not sure what degree of importance to attach to attendance.

Some researchers can be regarded as critical and derogoratory towards under-users. Underusers' rationality is questioned on the grounds that they fail to comply with a normative model of attendance with little consideration being given to what they might have to say about provision. Studies which have looked in depth at maternal feelings have found without exception that mothers express an overwhelming sense of responsibility and desire to do what is best for their children.

The ante natal studies reviewed indicate that women feel they are rarely if ever treated as intelligent equals by health carers. The lack of respect complained about is particularly pertinent for working class mothers. Oakley (1980) notes that they are more likely to be labelled mentally deficient in case notes (page 33ff) and not taken seriously. Women are assumed not to know what is in their own best interests.

The higher rates of morbidity and mortality among working class women have brought considerable attention to the behaviour of the mother and concepts such as deprivation and deficiency are used to describe their standards of care. This can be contrasted with Graham's (1984) work in which she outlines ways in which mothers work tirelessly to secure health for their families even though they are seldom regarded as health workers in any significant sense. More often than not mothers are construed as barriers or facilitators to the health work of professionals.

The quality of social relationships involved in the delivery of health care has been examined. Doyal (1983) notes that the inequalities in power, knowledge and status which usually exist between clients and professionals are at their greatest with working class patients and this could have deleterious effects on their subjective experiences of medical care.

Given the lack of critical scrutiny towards provision, under-users are almost always thought to be wrong and should therefore be made to change their ways for both moral and practical reasons.

The efforts to change the mothers themselves, their views on services, priorities, prematurely assumes there to be no good reasons for non-attendance. The poor attendance at clinics is rarely considered as an indictment of the services, as mothers voting with their feet, but seen as a problem in the mothers themselves.

The seeking of defaulters and compilation of at risk registers with the concomitant negative appraisal and inevitable discrimination has come under attack since its inception. The notion of positive discrimination cannot be accepted at face value as the best way of tackling the problem, despite its well meant conception. It reflects a patronising and discriminatory practice of forcing people to accept/make use of services 'for their own good' There are many who do not think attending at clinic would make much impact on the poor health of these groups, (Townsend, 1974; Black, 1980).

It is moreover by no means clear that advice and surveillance at clinic produces any significant improvement in health behaviour. Oates (1973) found a large proportion of attenders at clinic to be giving their babies feeds of incorrect strength despite having been given correct feeding instructions. There is plentiful evidence to indicate that there are large areas of ambiguity for patients in the carrying out of what seem to be straightforward medical instructions (Riley, 1966). Despite such considertions, there are those who would like to push harder in this direction, e.g. Kegeles (1983) reviews the many programmes which have aimed at encouraging women to carry out desirable 'health' behaviours, ranging from mass communications to group work methods and concludes that much more penetrating methods need to be adopted (e.g. behavioural therapy) to bring about the

internalisation of such behaviours.

One glaring omission is the absence of any attempt to explore in depth the perspective of the under-user. A more open and receptive method of enquiry may be necessary to avoid the bias and distortion evident in studies reviewed.

Graham (1979) has shown that the life situation and problems of a mother are not well understood/appreciated by the service providers.

Most often **the profound under-user is omitted from research** because of the sampling method chosen, which means that most of what is known about clients' perceptions of provision is not pertaining to under-users at all. For example, those studies which took place on clinic premises are of relevance to users, albeit reluctant ones. They at least appeared in clinic, if not very often. Twomey (1975) administered questionnaires to those at clinic in order to find out their reasons for usage. The majority who chose to take part claimed to have come for weighing, immunisation or a general talk with the health visitor, most often making favourable comments about clinic staff. The questionnaire was limited, offering a number of precoded answers to be ticked and very few chose to add comments of their own, others have poduced very similar results, (e.g. Durham, 1977).

The subjective views of clients are often overlooked; it being rare to find maternal perceptions of care included in the research. As Blaxter (1981) concludes in her review, there is a particular need for a study of the way in which patients, especially the mothers of young children, use primary care. At present the picture is very confused.

The consumer's view is most often left out of account altogether or sought as an afterthought to more 'objective' statistical data gathering (McKinlay, 1972). It seems that in general their views as a useful source of information are not held in particularly high esteem, having little to add to an understanding of the problem. This is implicit in those studies which omit any consideration of their views but is more explicit in others. (Collver (1967) states that mothers' expressed views add nothing useful to the prediction of usage, their expressed intentions and beliefs bearing no relation to subsequent behaviour.) Those who do not make any use of the services being just as likely to express favourable attitudes towards the services as those that do use them.

Those studies which catalogue satisfaction and dissatisfaction with provision tend to be simplistic, sterile and fragmentary, revealing nothing of any underlying logic behind the client's views. They are notoriously difficult to operationalise in research, not least because people's feelings about encounters with professional carers are complex and many sided, and rarely amenable to simple classification systems. Graham (1977a) has shown, for example, how clear cut distinctions disappear on further analysis, blurring the initial categories to the point where the distinction is no longer useful as an explanatory variable.

Fitzpatrick (1983), reviewing research on satisfaction, concludes that one major problem has been the tendency to trivialise what matters to patients by trying to get attitudinal sets and establish associations with particular groups. He calls for increased sensitivity towards

the kinds of responses consumers offer, indicating the sheer reluctance on their part to make bald criticisms, any negative comment always being highly qualified with added disclaimers. Robertson (1981) expresses the view of many when ruling out clients' perceptions of care as being useful as a measure of the effectiveness of health visiting as "their perceptions are bound to differ".

The majority of studies reporting mostly satisfied consumers take this to be indicative of a dispositional state encompassing a generalised positive orientation to future health care encounters. Such an assumption has never been tested and other evidence suggests declared attitudes and subsequent behaviour to bear little obvious relation to one another. The association between high satisfaction and social categories, eg middle class persons, is not particularly consistent and breaks down when more specific questions are asked about specific aspects of care.

Even where attitudinal studies have been carried out they have not explored the consumer view in any depth, rather their reported lifestyle has been scrutinised. Where lower social class members have been interviewed, they do not do well at all, in that what they say is subject to the researchers' own judgement which sets out to look for causative factors, be they perceptual or motivational in character, which are then contrasted with more desirable ones.

Chalmers, (1980) and Oakley's (1980) attempt, to move to a broader explication of women's reproductive experiences, conclude that even the patient-oriented studies have a common basic lack; a repertoire of first hand accounts from the reproducers themselves. (See Oakley 1980, page 90ff

In this work, her aim to elicit women's own accounts of reproduction as the chief research goal and of allowing them to shape any interpretative theories generated is laudable; however she selected out the under-users, late bookers and unmarried mothers. This was a deliberate ploy in order to exclude pronounced medical problems and to ensure a degree of 'cultural homogenity'. Despite attempts to reflect the socially mixed catchment area of the hospital she ended up with 93% middle class respondents. Again the major gap in research to date is emphasised: the need to concentrate on the under-users themselves.

Under-usage has not been particularly clearly defined in past research. It can mean any number of things all of which have very different consequences and pertinence. Not all types of under-usage are as serious as others, eg non-attendance at ante natal classes, general practice surgery, hospital out patient clinic, post natal clinic, developmental check ups, immunisations, advisory contact with the health visitor.

Researchers have in fact been asking a number of related but quite different questions. Non-attendance at clinic is not, for example, synonymous with neglect, although most often it is treated as such. In asking why mothers fail to attend health clinics, it must be clear that one is not simultaneously asking why some children have not received the care and surveillance necessary to ensure their health. There are alternative sources of help which may or may not be adequate.

The question of significant and important under-usage of detriment to children would be extremely difficult to isolate and determine.

No study has directed attention to the fall-off in attendance evident in most studies of usage whereby after the first few months even users become under-users as the clinic seems to lose its relevance.

The consequences of non-attendance are far from clear, whilst alarmist notions abound leading one to believe children to be in grave danger. Rarely is underusage clearly defined, making comparability of studies very difficult. Defaulters are criticised for not attending clinic, not seeking medical advice, not caring for their children, producing ill health in their children and adding to mortality figures. Some or all of these can be found explicitly or by implication in the research reviewed. It is not clear what usage would be considered adequate.

McKinley's (1972) study classified users and under-users on the basis of their current ante natal care performance. Users had attended for their first ante natal visit before 17 weeks gestation and attended regularly for antenatal care. What constitutes regular attendance is not specified. Under-users had no antenatal preparation at all, attended first after 28 weeks gestation, were emergency admissions or had defaulted from set clinic appointments three times consecutively without offering excuses. Those included in the study were drawn from hospital records, being married, of social class V and had left school before the age of 16. It is not clear what care was on offer to these mothers in their locality, or if evening facilities were held for those working during the day. Those who were classified as users could be telephone owners who rang to offer excuses whilst still

underusing the services.

It will be necessary then in the present study to compile a profile of usage in a particular locality and attempt to establish the typical ideal and what then constitutes underusage. This study aims to build up a picture of what is actually meant by a non-user for a particular locality by establishing what was available to those in the sample, how much they knew of provision and what usage looks like across the sample. The profiles of utilisation behaviour can then clarify what is meant by under-usage, whether it is specific to a particular aspect of provision or applies to all aspects. An attempt will also be made to establish what the health care professionals working in this area consider to be adequate usage and how this relates to patterns of usage in the community.

2.3. AIMS OF THE STUDY

In this research we intended to listen to the comments which clients may have to make, acknowledging the importance of the meaning of encounters for them. There is a tendency in social psychological research to deny the social context and see human problems as internally caused.

Seeing problems as internally caused assumes personal consistency whereby prior states of the person (characteristics or attributes) could predict the situational outcome or how the client will behave in a given situation. Thus explanations are arrived at by going back to prior states or the characteristic given and the outcomes predicted. An analytical alternative can be found in Thomas' situational analysis whereby behaviour is described in situational-definitional terms as

responses to situations as defined by actors within them. (Ashworth 1979). The claim is made that in order to understand social conduct, we must look to the meanings of situations as they are experienced by the actors located within them. Such an analysis rests on the common sense notion that persons behave in accordance with their definition of the situation, ie on the basis of what they see is to be done, can be done and will be done by others. It embodies the notion that people act on the basis of their constructions of the world; they are active interpreters; and situations, which may be consistent objectively speaking, are always problematic when the subjective experience of the actor is considered.

The problematic, variable nature of situational definitions has led to a preference for more external 'objective' research. The way that constant situations may be variously defined by actors selectively constructing their own interpretations of them has minimised empirical investigation. Also the complete description of a situation remains impossible because of the infinite number of relevances in real world situations, actors bringing many interpretative schemes to bear. So whilst recognising the importance of subjective (qualitative) approaches to the understanding of behaviour, the properties of such situations have seemed unamenable to systematic investigation.

The most objective methods of research can also be the least informative; situations are assumed to be essentially similar for all respondents and they are scored on various dimensions thought to be of relevance. The richest and most informative methods are the most subjective and individual, requiring careful interpretation by the researcher. Where one wants to describe and understand relevances for

the under-user, there is a need for higher quality rich data requiring a primarily qualitative orientation towards choice of method. To this end, it was necessary to adopt a qualitative method which would facilitate the discovery of the meaning of use of medical facilities within the underusers own frame of reference, without prefiguring the areas of relevance to them. Subjective data was to be the means of discovering the meaning of use of medical facilities within the lifeworld of individuals without being regarded as 'subjective' in the derogatory sense of being closed to scientific scrutiny or uselessly idiosynchratic.

In this research, then, we attempted to use an open ended approach on a small sample of under-users seeking to map out more fully how they make sense of their experiences.

Ong (1983), in her study of new mothers in Oldham, concludes that if we want to provide services for women which respond to their needs and wants instead of contradicting them, we must start listening to and learning from their own accounts. (page 27ff).

This research then, aims to analyse the intelligibility and relevance of current care provision from the client's point of view. Their views are to be explored in a positive receptive light as a valuable and rich source of relevant and pertinent data, not primarily as a deviant group in any moralistic judgemental way. This may limit the generalisability of the findings, but appears to be an essential exploratory step in this field of research. There is little descriptive research into the health needs of vulnerable groups and a scarcity of direct surveys of clients' own perceptions of need. Whilst

human behaviour clearly can be studied at all levels of complexity, depending primarily on the aims of the research, the aims of this study are consistent with the adoption of a primarily qualitative approach.

There are four main aims of the study; the first being to arrive at a more discriminating and meaningful definition of usage appropriate to a particular locality and note which if any aspects of provision are most/least often used. The second aim is to monitor the extent and pattern of uptake, document preferred sources of help and attempt to identify client initiated uptake from professionally initiated contact. (See Chapter 4, page 154). The second aim is to relate the clarified view of uptake to sociodemographic features of the sample and some lifestyle features, to allow for comparison with previous research. (See Chapter 4, page 191). The third aim is to concentrate on the client perspective: a) To find out what the consumers thought of the provision they had been offered, with such questions as: what use are clinics and professionals to first time mothers, when and for what reasons? Are the services regarded as relevant, accessible and useful? What was their contact with the services like? and b) To discover what sorts of problems a mother has to deal with in her own terms, and to what extent these are acknowledged by services on offer: What do they see as their needs at this time? The fourth aim is to look in detail at the under-users' accounts, this being the most neglected area, with such questions as: how does health care as provided figure in their lives? and how do they see services in relation to their needs? (See Chapter 6, page 243).

CHAPTER 3: PILOT WORK AND RESULTANT METHODOLOGY

This chapter outlines the major parts of the research study and the methods employed at each stage. These include the selection of an appropriate health authority area in which the study could take place, and the procedure employed in identifying clients for inclusion in the study; the compilation of an instrument to discriminate between users and underusers of the services, and an interview protocol for use in client interviews.

In each section the major considerations which were taken into account in determining choice of methods are outlined; these are offered in some detail where substantial revisions in the light of pilot work were undertaken. This applies to the two instruments designed for use in the study; the underusage index, and the interview schedule. Finally, the procedures adopted for analysing interview data are outlined in full.

3.1 ETHICAL COMMENT

Before the commencement of the study, a number of administrative and ethical implications had to be considered. Approval for the investigation was sought and obtained from senior officers of the Area Health Authority and the Chairman of the Local Medical Committee. Confidentiality and preservation of the rights of the individual client were a prime consideration in obtaining approval. This can require a great deal of thought as Young (1979) suggests:

> "...personal details given in confidence to a researcher and thereafter beyond the patient's control, may be a necessary prerequisite to conducting research. One possible safeguard being that data should only be made available in such a way that a patient cannot be identified, which can pose serious limitations on the research."

Prior to permission being granted, the officers concerned had to be certain that these aspects of confidentiality were satisfactory in the context of the study. Mothers who were eligible for inclusion in the interview sample were assigned a number, which was the only means of identification used thereafter. Health Visitors selected those mothers who fulfilled the criteria for inclusion in the study, who had children born in the appropriate months for the study. Only then was the researcher allowed access to the clinic and other records. The Area Health Authority, settings chosen and clients who took part remain anonymous throughout the thesis to ensure confidentiality and privacy are maintained.

3.2. SELECTION OF SETTINGS FOR THE STUDY

The descriptive qualitative nature of this research precluded the use of the total Area Health Authority for the study. In any case neither the time nor the resources were available to do this. A controlled sampling procedure was required which would generate a reasonable number of care settings to be assessed, but which would not prematurely omit under-users or be unrepresentative of the area in any systematic way. It was also important to ensure that members of the sample should have the same provision available to them, so that client preferences in known settings could be studied.

3.2.1. Sources of sampling

The sample was taken from certain Health Visitors' case loads although it could have been derived from a number of starting points, each of which was considered and rejected:

a) general practitioner lists
b) hospital discharge birth records
c) clinic cards held at each premises, or
d) circumscribed districts of the Area Health Authority.

Each one posed difficulties which would prejudice either the completeness of sampling possible or the control over accuracy the researcher could maintain.

a) The main reason for rejecting GP lists as the source of sampling was the possibility that under-users may not be registered with a GP and so would be omitted at the outset.

b) It would have been desirable in some ways to start sampling and monitoring the study population at the hospital, following the new mothers through the first year of their baby's life. This strategy would have yielded clients all over the area, making assessments of provision for each one very difficult, also we could not be sure that sufficient numbers of a sample so generated would have access to the same provision. In any case such an ambitious scale was not possible given the research resources. An ongoing study which concurrently monitored mothers could interfere in unspecifiable ways with patterns of usage. A non-interfering retrospective analysis of usage was to be preferred.

c) Clinic cards are completed (initiated) when a client visits the infant welfare sessions, thus prejudicing the inclusion of non-users in the study.

d) Dividing the area as a whole into districts of equal size for which provision serving each population was known was not possible given the research resources (time, money, staff) available. There were no natural dividing lines and it became evident that some populations would have no clinic in their area, would be served by numerous changing health visitors and would prove unmanageable.

Each child born in the area (either hospital or home) is allocated to a health visitor so we could be sure that no mother satisfying criteria for inclusion in the study would be missed. (Any children born unsupervised by a health worker or not notified to the birth registrar remain outside of the study and an unknown group, and it is not possible to state with any accuracy whether this was likely to have occurred.) It is possible to document the provision available to each of the mothers on a health visitor's caseload and thereby establish the use made of it by clients.

The health visitor caseloads chosen were the higher ones, where under-usage is thought most likely to occur. A comparison of these Health Visitor caseloads with those of the rest of the area was undertaken to ensure they were not otherwise very unusual in any way which could make generalisations questionable.

3.2.2. Comparative caseload of health visitor

It was important that the health visitor caseload, i.e. number of children under 1 year, should be as nearly equal as possible, differing caseloads could otherwise be considered as one of the prime factors in the non-usage of services. It was decided to choose settings where the health visitors tended to have modal or higher caseloads so that any differences in uptake of the service would not primarily be determined by the higher numbers involved.

Comparable numbers in other aspects of the health visitor's caseload (eg children under five years, elderly persons etc) were considered in order that workloads across the settings would be as uniform as possible.

A period of two years minimum length of service in a particular care setting was chosen as an appropriate length of time for a health visitor to become fairly well established in an area. It was important that the health visitors involved in the particular setting were not idiosyncratic in terms of experience in the area. There is one reservation concerning the use of length of time in an area as a criterion in that more 'problematic' areas (eg those with high unemployment, sub-standard housing, high incidence of non-accidental injuries to children) tend to have a high turnover of staff. This means that such areas within the area may not be represented. However, for the purposes of this study, it was preferable not to use areas of high staff turnover as this again could be a determinant in uptake of services (Clark, 1973; Gilmore, 1974).

In order to select the sample, the total of each health visitor caseload for the year 1980 was examined and those health visitors with the modal/higher caseloads selected. A further selection was made necessary as research studies were already under way in two of the possible settings. Other possible settings were excluded due to long term sickness of staff necessitating emergency cover by another health visitor, or where the particular setting was staffed by a fieldwork teacher involved in the education of health visitor students and therefore having extra staff in the field.

3.3 SELECTION OF MATERNAL SUB-SAMPLES

A number of factors had to be considered when selecting the maternal sub-sample.

Socio-economic groups: A comparative study across all socio-economic groups could be undertaken or one could concentrate on socio-economic groups IV and V, where under-usage tends to be more acute. In looking at all groups, it may be possible to explain how and why some consumers make more appropriate use of the services than others. Comparison of users and non-users within a socio-economic group (ie those who share the same socio-demographic characteristics which may contribute to under-usage) is another important approach (McKinlay 1972b). A further approach is to allow characteristic features and a pattern of usage to emerge through investigation of a total sample, and then to concentrate on emergent groups at a later stage. This strategy was used in the present study in order that (a) a more

complete view of utilisation of the services in the area could be determined, (b) a detailed 'utilisation profile' for each set of mothers may be provided, and (c) special emphasis may be placed on 'within group' differences in utilisation.

First-time mothers: The maternal sub-sample includes primiparous mothers only, i.e. those who have had no previous pregnancies and therefore excludes women who may have had abortions or stillbirths and thus have had previous contacts with the maternal and child health services. Although under-usage of the child health services is considered to be more acute amongst multiparous women (CHS, 1976; DHSS, 1979; CPAG, 1978), it would be extremely difficult to get an accurate assessment of post-natal care for each pregnancy. These may have occurred in different locations, settings and with different personnel assisting, thus adding to the wide variability of unknown factors. It was considered that in choosing first-time mothers, a clearer idea of the contact and care received from the services would be obtained. The present study sought to examine the impressions received of, and attitudes developed towards, the available services, and to consider the future intentions of first-time mothers in regard to use of the services.

First-time mothers, then, were the preferred target sample for a number of reasons. Their contact with the services would be limited to this occasion and it would be possible to monitor exactly which services they had made use of and conversely avoided. They were

likely to be younger than others, thus forming at least one of the high risk groups causing concern to health professionals. They would be in the process of forming their impressions of services for future uptake/non-uptake and could be regarded as those most 'in need' of health service care as they had no previous experience of becoming mothers.

Age of child at time of interview: In order that a meaningful comparison may be made, a limit was placed on the age of each child at the time of the maternal interview. Each child was to be between 12 and 15 months at this time. In the past, studies have not used data collected after the fifth post-natal month (Graham, 1979); whilst the present study sought to examine the period 0-15 post-natal months, to determine takeup and utility of the services during the critical first year of life. There is a tendency for systematic takeup after the first few post-natal months to drop (Graham, 1979). Reasons for this may be assessed more effectively when investigating data for the first complete year of possible contact.

Children who die during the first year: Mothers whose children die during their first year would be a special group worthy of separate study (Emery, 1976; Oakley, 1976). They are not included in the sub-samples of the present study, partly because of the intensiveness of the care they may receive and also because of the humanitarian aspect of asking them to recall occurrences which may be particularly distressing to them. There is also evidence to suggest that this

group of mothers has been subjected to fairly intensive study already (Steele, 1966; Davis, 1976; Emery, 1979; Hull, 1977; McWeeny, 1977, Oakley, 1976).

One-parent families: It is possible to control for this variable by including only mothers and children from a two-parent background. One-parent families are likely to experience different problems to those experienced by two-parent families (Streather, 1979). However, it was considered useful to the present study to include single parents and to treat their contributions as those of a separate minority group.

Maternal sub-samples: The study, then, focuses on first-time mothers who, apart from the antenatal and postnatal care for this child, have had no other contacts with the maternal and child health services. They were interviewed by the researcher using a guided interview schedule, when their children were aged between 12 and 15 months. A selected range of socio-demographic and descriptive factors were collected to supplement interview data. The month in which the interview took place was determined by the date of birth of the sample children. Once a mother had been selected for inclusion in the study, she was contacted personally by the researcher either by telephone or by a home visit to arrange a date and time which was mutually convenient for an interview to take place.

It was appreciated by the researcher that some relationships had been

carefully nurtured by health visitors. Health visitors were therefore contacted before arrangement of any interviews to keep them informed as to the stage of the study and to ensure their availability for the clients to contact, if they had any reservations regarding the research or the researcher.

3.4. SOCIODEMOGRAPHIC DETAILS OF THE SAMPLE

In order to relate the present study to past research and ensure there was no systematic bias operating in the selection of the study sample, a number of sociodemographic features were collected.

It was hoped that given the area chosen for the study, there would be a good representation of those falling into the lower status categories of the Registrar General's classification (3 - 5), as most studies to date have interviewed samples biased in favour of the middle classes.

The major features documented were: the age of the mother at birth of the child; indicators of social class membership (schooling, occupation etc.); health education to date; mobility of the family; community contacts and geographical proximity to health services.

3.5 COMPILATION OF USAGE INDEX

In order to direct attention specifically to the under/non-user of the services in this population, it was necessary to arrive at a more meaningful and discriminating definition of usage. To monitor the extent and pattern in a given population, it would be useful to look at which if any aspects of provision are most/least often used, and to document alternative preferred sources of help and advice.

Underusage can mean any number of things with varying consequences and pertinence. Some problems have already been outlined in section 1, and here the main issues are summarised. (N.B. None of the features of usage monitored can be considered synonymous with child neglect. The question of the ways in which underusage can be of detriment to children lies outside the scope of this study. The index then remains a purely descriptive one.)

3.5.1. Types of underusage

The past research on underusage has commented on varying aspects which can be grouped as follows:

Ante natal care

a) No antenatal care before delivery (e.g. Pringle 1977), the mothers not having come forward in good time.

b) Non attendance at checkups, missed appointments, (e.g. C.P.A.G. 1978)

c) Non uptake of preparation classes, or late attendance at classes (e.g. CPAG 1978)

d) Late booking for confinement (e.g. Jay 1980)

e) Fathers in lower socioeconomic groups less likely to take part in preparation classes (e.g. C.P.A.G. 1978)

Post natal care

a) Those who have never attended clinic at all (e.g. McWeeny 1971)

b) Poor attendance at clinic (e.g. DHSS 1978), at any one time or by certain mothers in the lower socioeconomic groups

Late and/or inadequate uptake (Teffeny 1971), and those who start to come and then stop (e.g. Acton 1978) or finish early

The low/non attendance in clinics serving deprived areas (e.g. Spencer 1978b)

c) A higher percentage of lower socioeconomic group mothers not being seen by clinical medical officers (e.g. Spencer 1978b)

d) Lower rates of immunisation uptake in the lower socioeconomic groups (e.g. Blaxter 1981)

e) Defaulting from appointments with health care personnel (e.g. McWeeny 1978)

f) Fewer general practitioner consultations (e.g. McConachie 1977, Blaxter 1981)

Poor service response

a) Poor/no relationship with health visitor (e.g. McWeeny 1971)

b) Few home visits to the most deprived, and/or no increase in home visiting to compensate for non attendance (e.g. Blaxter 1981)

c) Hasty receptionists (e.g. McWeeney 1977)

d) Poor/no relationship with general practitioner (e.g. McWeeny 1977, Blaxter 1981)

e) Visited less often and turned away more often (e.g. McWeeny 1977)

Inadequate/ineffective health behaviour

a) Faulty perception of disease/illness states and relatively high alarm thresholds to seek help (e.g. McWeeny 1971)

b) Inability to activate services in times of crisis (e.g. McWeeny 1971)

c) More social problems e.g. alcholism etc. in non attenders (e.g. Blaxter 1981)

d) Lower rates of breast feeding (e.g. Davie 1972)

e) Negative attitudes to health care (e.g.Hulka 1971) and health care personnel (e.g. Graham 1979)

f) Mismanagement of time and/or resources (e.g. Aitken Swann 1972)

General comments

In general it is not possible to determine from the previous research what any particular mother did or did not do in relation to the range of services available throughout pregnancy and motherhood. Mothers may well exercise selective uptake, so that particular aspects of provisions are underused.

There is no generally accepted absolute level of usage which one could apply to any selected group in order to assess usage. It depends on the area covered, what services were available and which aspects are favoured by the health carers in each area.

It is not certain that underusers of one aspect of care will underuse all aspects, e.g. even those who never appeared at clinic at all could have had developmental assessments and immunisations carried out at the G.P. surgery, although one would tend to expect there to be a consistent trend as revealed in the continuing underusage of antenatal non attenders, post natally.

The links between attendance/contact with professional carers, and what could be regarded as 'healthy' behaviour remains uncertain, there being no guarantee that the one leads to the other (see Oates 1973).

In order to avoid making any premature omissions, it was decided to compile a checklist of all possible contacts a mother could have with the health services in this locality, and to have them rated by health carers working in the area to determine adequate usage from a professional point of view.

3.5.2. Compilation of professional usage scale

Following inter-disciplinary discussion, a 20-item check list of 'significant' features of maternal contact with the child health services was prepared (this can be found in Appendix 1). This check list was subsequently submitted to a multi-disciplinary panel for ordinal rating of its individual items. 18 out of 24 professionals approached, submitted completed ratings - a response rate of 75%. The validation panel consisted of:-

Consultant Paediatrician	2	Senior Health Visiting Staff	5
General Practitioners	2	Senior Midwifery Staff	1
Clinic Medical Officers	2	Health Visitors	6

Preparing and rating the check list accomplished two objectives. Firstly, it assembled a number of clearly-defined features of client behaviour for which there existed a consensus regarding their 'importance' for effective child health care. Secondly, it indicated the relatively high-ranking and low-ranking behaviours within that number, from the perspectives of a group of health care professionals closely connected with the child health services. By eliminating the low-ranking and imprecise items and by conflating related high-ranking items, the revised check-list in its final form included nine items in place of the original twenty.

It would seem invidious to attempt any weighting of such equally important items, one against another and in any case the ordinal character of the ranking order does not sustain such numerical comparison in a meaningful sense. It was, therefore, decided to score

each item on an 'all or nothing' basis, assigning equal weighting to all items included. Thus mean and deviation of clinic scores could be derived to assist selection of user and non-user samples.

The information can be collected from a number of sources, maternity service, co-operation cards, health visitor records, and clinic records, which can serve as checks on accuracy and thoroughness of data collection.

At present, there is no comprehensive collection of information of this nature available in one place for health care professionals, owing to the delivery of maternal and child health care by different practitioners. Problems have arisen in the retrieval of such information especially when a mother attends a clinic other than the one at which her usual health visitor is based. It is therefore important that information is retrieved from each source and checked as accurate, wherever possible.

Each member of the pilot sample was scored according to the 'all or nothing' basis discussed above, so that mothers scored either 1 or 0 according to whether they had fulfilled each criterion of usage on the check-list. A mother scoring 9 was to be considered as having made certain that her child received the most important aspects of health care and thus is considered an adequate user of the service.

3.5.2.1. Features of the selective checklist

The first item on the check-list concerns early antenatal care. This item is likely to be the most discriminative because a woman has to be aware of the procedure of contacting her general practitioner early in

her pregnancy. This is probably a much more voluntary step on the part of the pregnant woman, in that all other contacts cited in the check-list are usually initiated by a professional health worker. As such, it could provide an important indicator of future behaviour in the uptake of maternal and child health care services.

Item 2 concerns the uptake of antenatal parentcraft classes which also has a discriminative element in that women who work during their pregnancy may not have the opportunity to use this service. It is important to ascertain where and when such classes were available in order that possibility of attendance may be assessed.

Items 3 and 4 concern the visits of both midwife and health visitor after the birth of the baby. It is unlikely that a mother and baby are totally unavailable for either of these professionals to visit them at home. In any case, it is also likely that a measure of perseverance on the part of the midwife and health visitor and/or their colleagues would lead to a newly-delivered mother being traced.

Hearing tests (item 5) are generally carried out by health visitors in clinic sessions or in the home, if the mother is unable to attend the clinic. Most health visitors would ensure that this screening test has been performed. In the present study, health visitors in the separate settings are asked to state in which location the hearing test was performed in order to distinguish between attenders and non-attenders.

First medical examinations (item 6) are usually carried out in the local clinic or at a hospital outpatient clinic. Parents are usually

invited to attend clinic for examinations; but the service can be taken to the home where necessary.

Item 7 concerns subsequent medical examinations, for which these considerations also apply. However, this provision is not made in all clinics a feature which must be allowed for in selection of the sub-samples.

Attendance for developmental assessment (item 8) is usually by postal invitation which is followed by a personal reminder by the health visitor. It is likely that the health visitor will ensure that this is carried out; although it may well be performed in the client's home rather than at a clinic. The health visitor is, therefore, asked to specify the location of the assessment.

In an effort to ensure as complete an uptake as possible, a computerised system of call and recall for attendance for appropriate immunisation (item 9) was in use in the study area. Mothers receive 'official' notification of appointments for immunisation at or around the time the immunisation is due.

Most of the items on the check-list seemed to deal with the more physical aspects of child care; and, due to the nature of the items as discussed above, and service investment in their take-up, it was on the face of it rather unlikely that a severe under-utilisation of services would be in evidence as a result of employing these criteria.

In the pilot work, in addition to the check-list, an assessment was to be made of the number of contacts the mother may have had with the health visitor and other members of the health care services. This was important, in that some mothers may have seen the health visitor more frequently than can be recorded via a nine-item check-list, whilst other mothers might only have fulfilled those 9 items and no more, and therefore the check-list could not give a complete account of contact.

3.5.2.2. Pilot application of revised checklist

In order to test the adequacy of the revised checklist, it was piloted on 6 participants selected from a setting unrelated to the ones in which the study proper would take place. The pilot sample's scores are tabulated below:

TABLE 1 User/under user pilot checklist

Item of care	Informant Number					
	1	2	3	4	5	6
Booked for delivery before 20 week	+	+	+	+	+	-
Attended antenatal classes	-	+	+	+	-	-
Accessible for midwife's home visits	+	+	+	+	+	+
Accessible for health visitor's home visit	+	+	+	+	+	+
Baby hearing test completed	+	+	+	+	+	+
Attended for first medical examination of baby	+	+	+	+	+	+
Attended for second medical examintion of baby	+	+	+	+	-	-
Attended for Health Visitor's developmental check	+	+	+	+	-	-
2 or more immunisations requested	+	+	+	+	+	+
Total score:	8	9	9	9	7	5

Only informant 6 can be regarded as having significantly under-used the services both before and after the birth of her child. It is the policy of the Health Authority to ensure as far as possible that each item appearing in the check-list has been taken up by every mother in the locality. To encourage uptake, clients are reminded to attend clinic for specific events; they can be sent written reminders or visited at home in cases where invitations to attend clinic have been ineffectual. In this sample all medicals and other checks had been carried out at clinic, except in the case of informant 6 who having decided to avoid contact with the clinic, took no notice of written reminders and was not followed up at home. During the period of pilot data-collection, her child had not received a second medical examination and had not seen a health visitor for developmental assessment.

This table of items of care used, indicates the adequacy of surveillance from the professional point of view. It can also be regarded as covering the more 'physical' aspects of care, there being no provision for the more emotionally supportive aspects such as the resolution of problems with the aid of professional advice. A frequency count of the number of contacts a mother has had with service personnel, demonstrates that the scores on the check-list conceal a wide variability in patterns of uptake. The table below, which only considers three major aspects of service provision illustrates the differences between clients in the amount of contact they have had with the services during their first year of motherhood:

Table 2 Number of contacts with 3 types of service provision

Item of care	Informant Number					
	1	2	3	4	5	6
Number of attendances at clinic ante-natally	15	15	15	15	15	2
Number of home visits from health visitor post-natally	4	7	2	7	4	3
Number of attendances at clinic post-natally	40	16	20	28	12	3
Total Number of contacts	59	38	37	50	31	8

3.5.3 Rejection in favour of more complete index

The 9 item check-list was considered inadequate after piloting in a number of respects. It gives no idea of the extent of under-usage in the sample e.g. the number of visits to clinic shows much more clearly the wide differences which exist. The items also give a professional view of usage which is minimal and covers the most physical aspects of care. It would be possible for a mother to score 9 without ever appearing in clinic, and following return home from hospital, it would be difficult for any mother to miss items 3, 4 and 5. This gives a baseline of 3 points which one would expect all mothers to have scored.

This study is not primarily concerned with ante-natal care, although its importance and relevance is recognised as contributory to usage, attention was preferentially directed to features of post-natal care. This being so, many issues of interest to the present study are overlooked by the scale, e.g. the number of visits a mother can make, and chooses to make during the first 15 months of her child's life. It would be worth noting the popularity of continuing attendance after 15 months, to see which if any of the sample proper were still making

use of the clinic and to what extent. The pattern of attendance could also be important, e.g. some mothers may come early to clinic, and consistently and regularly attend up to and beyond the 15th month. Others may drop off very early, or come sporadically. There may be certain ages at which most mothers like to see a health carer, and others which are characterised by lack of attendance.

When attending clinic, the mother may have her child weighed (not necessarily by a health visitor), see her health visitor, and/or consult the community medical officer on duty. Each consititutes a quite different aspect of usage.

The health visitor has a statutory visit to pay to each client on discharge from hospital, and from this time onwards it is the discretion of the health visitor which determines the frequency of home visiting, based on such matters as her assessment of the client's needs, whether the client is being seen at clinic and requests made by clients. Some health visitors prefer to carry out all assessments in the clients home, so that in some cases at least 3 of her home visits will be for this purpose and standard for her caseload. For some mothers there are 2 baby clinic sessions offered each week whilst for others there is only 1 per fortnight which must be taken into account when comparing figures.

An attempt has been made to estimate uptake on the clients part, i.e. to separate as far as possible client initiated contact from that initiated by a professional. It was important to ensure that those classified as underusers would include those clients who had required

intensive or extensive follow up on the part of professionals, as they had not been 'users' in the sense in which we are interested in this study. In any case, as most aspects of child health care provision rely on voluntary uptake, those who had reluctantly been followed up at home, would be unlikely to score highly on the items requiring client initiated contact only e.g. attendance at clinic.

In every case all available records were to be checked and cross checked to omit repeated entries and ensure completeness of coverage. One source of repeated entries was where the health visitor recorded client contacts both on the clinic record and on her own record. As some mothers attended more than one clinic premises, all clinic records were to be cross-checked to ensure any attendances were recorded.

Data relating to general practitioner usage were not available to the researcher in this study, but past research which has closely monitored this gives no reason to suppose that those who made little use of the clinic, health visitor, and community medical officer, compensate by increased usage of their general practitioner services. In fact the reverse is usually the case (Court 1979). At interview all respondents were asked about visiting their general practitioner, but the actual number of visits made seemed to be poorly recalled and so was not included in the usage scale.

Particular attention was given to the amount and type of usage of the clinic itself, as most concern and comment in research to date has revolved around this major aspect of provision.

The main aim was to collect and present data which would give a clear picture of what usage was like for a particular group of mothers in one area of the country; to enable a description of how clinic and health care facilities are used in the first year of a childs life. To date, data allowing for this has not been available in the literature pertaining to uptake.

3.5.4. COMPILATION OF REVISED USER SCALE

A more appropriate user scale was devised, based on the pilot work outlined, which would provide a more descriminating index to divide the sample population and give a more complete picture of uptake for this group. The scale is made up of 11 items:

1. Health visitor assessments are scored according to their voluntary take-up by the mother concerned. Where it was noted in the mothers clinic/or health visitor notes that she had been followed up due to non attendance, then a 0 was entered in the data. Mothers could score 0,2,4,6 or 8, corresponding to number of assessments, 1,2,3 or 4 voluntarily taken up respectively.

2. Immunisation uptake was similarly scored according to whether the mother had attended voluntarily or not. They were scored if they had attended for immunisation regardless of whether this was carried out or not. (There are instances where staff would have deferred injections). 3 scores were possible, 0,2 or 4, corresponding to 0 no voluntary uptake, 1 voluntary visit, 2 more than one.

3. The hearing test was scored according to voluntary take up, either at home or clinic. Those who were followed up due to non attendance scored 0.

4. Clinic attendance was scored according to the percentage of possible attendances for the clinic in question. Some mothers could have attended 60 sessions during the 15 months of their childs life under scrutiny, others were only offered 30, a proportional score then allows fair comparison.

5. The gap score was the number of months (out of 15) during which the mother did not appear at clinic or contact the health visitor. This was in order to see if there were any ages at which a mother is less or more likely to seek professional contact. A high score (up to 15) indicates no missing months, a non-user would score 0.

6,7. The age of the child at the start of clinic attendance (item 6) and the age of the child at the end of clinic attendance (item 7) were monitored to see what kinds of patterns mothers adopt for the surveillance of their children. A mother who attended early and finished late, would then score a lot more than one who started early and finished early. These features were scored for each mother to balance high scores obtained from number of attendances item (4) which could have been made all at one time. Those who were not discharged from hospital in time to attend during the first or second months of their childs life could only lose 2 points and so their position on the user scale would not be artificially low.

8. The duration of attendance was monitored as distinct from the gap score (months missing) in order to allow those who had attended over a long period of time to score accordingly, to give some estimate as to the length of time they were using the clinic.

9. The first medical examination (whenever this was carried out) was scored 4, if it could be found in any record, otherwise 0 was entered in the data. As this was not offered at home, no entry indicates it was not done.

10,11 Non routine contacts with the health visitor (item 10) and clinical medical officer (item 11) were monitored as significant indicators of voluntary uptake of professional care. These were arrived at by taking the total number of contacts documented on all records and removing such items as 'weigh' only entries at clinic, asessment visits at home and the hearing test entry. Medical examinations and immunisation sessions were similarly omitted from the total number of contacts each mother had with the medical officer. These would include specific visits for advice noted on the record cards, visits for weighing or any other routine procedure which was accompanied by a consultation with the health visitor or doctor at clinic. This was usually noted on the record card and indicates active usage on the clients part. This kind of discrimination was considered important, as, a mother could have consistently attended clinic and simply have had her child weighed, never specifically being advised or helped by the health visitor or clinical medical officer. As merely a weighing facility, the clinic would then be approaching the role of a

chemist, rather than a child health service.

All details relating to this pilot work can be found in Appendix C.

3.6. INTERVIEWING RESPONDENTS

Prior to the design of the guided interview schedule, the researcher arranged a series of unstructured discussions using only a broad guide of topics for discussion, (Hoinville 1978). Respondents included mothers waiting in a clinic and health care professionals. The researcher used as few direct questions as possible so that respondents were able to talk as freely as they wished.

Three main sources of information were used in the formulation of the pilot interview: mothers attending clinics were interviewed while waiting their turn; health care professionals from both the educational and service sectors were consulted for ideas and advice; and past studies were examined for factors isolated as being related to usage and satisfaction on the mother's part. This multiple approach helped to give a broad base upon which to formulate questions for inclusion in the schedule. Ideas from each source were grouped together and formed into topic areas from which open-ended questions were devised. Both the pilot and revised forms of the interview schedules employed in the study are included in appendix 3.

Prior to any interview the respondent was telephoned or visited as necessary, to arrange a date and time convenient to both researcher and respondent. At the commencement of the arranged interview, the researcher introduced herself and explained again the reasons for such a visit supported by identification documents. The researcher then

asked permission to record the interview on audio-tapes, and stressed the confidentiality of such material, reassuring the respondent that no names will appear in any written report.

3.6.1. Revision of qualitative research methodology

The pilot interview data was analysed in detail, primarily by constructing 2 case studies, one of a 'user' and one of an 'under user' of the services. This helped to clarify the ways in which the areas of questioning on the interview schedule apprehended their concerns. Examples from this work are employed in what follows to illustrate revisions subsequently made to the interviewing approach adopted in the study proper.

Having completed the pilot phase of the research, the researcher began to assess the whole project anew and critically examine it's aims, methods and desired outcomes. The interview data was very rich indeed, providing a complex, in depth picture of an 'under' user and an 'over' user. In principle it seemed possible that the qualitative data could increase our understanding of underusage from the client's perspective.

Ideals of research

It became very clear how one's tacit understandings (not commonly articulated or formalised in research) inherently shape and form the content of the research.

The primary goal was to explore the situation from the client's perspective, which seemed to be a descriptive enterprise rather than e.g. trying to measure their degree of attachment to service ideals,

or correlating various background variables with prefigured categorial responses. Such approaches do not come from the experiences and activities of the individuals themselves, and it is this gap that the research sets out to fill. There was a need then to step out of this framework and examine the experiences of underusers as lived and understood by themselves.

Variation exists in psychologist's treatment of social behaviour and experience. The methods used to obtain data on which theories are based also differ radically. There is not even agreement as to what constitutes the legitimate subject matter for study (Chalmers, 1978).

The arguments are often diametrically opposed. For instance, some argue that because verbal reports are difficult to quantify and express in operational terms these are not valid as the subject matter of a science. Others hold that people's accounts of their own experience offer the most important means of understanding their behaviour.

It is therefore not without some serious hesitation that one undertakes research of this kind within the social sciences; such questions have been pondered interminably. For research to get underway, decisions have to be made, and these should be as well-informed as possible. As it was decided that the **research aims should gain primacy in determining methodology**, purist theoretical considerations were put to one side. It became clear that the whole enterprise of interviewing, and of qualitative research generally, required clearer elucidation.

At one end of the spectrum researchers align themselves with existentialism and phenomenology, which regards the issues of substance for psychology to be those of perceived meaning. The other extreme sets itself the task of formulating laws of behaviour rather than experience.

As the phenomenological approach has explicitly turned attention to qualitative matters, this was interrogated as a potentially viable one regardless of its poor standing with respect to traditional psychology. There were various features of the approach which at first glance seemed compatible with the aims of the study.

3.6.2. Features of the phenomenological approach

In outlines of the phenomenological approach to psychology, there seemed to be an intimate dialogue between approach, content and method, (Ashworth et al.1985; Giorgi 1970). Here it is explicitly acknowledged that the way a subject matter is approached determines the content.

In particular the researcher is treated as part of the setting of research, the context in which it takes place. The researcher's presence and actions are interrogated in order to determine their role in the production of data, which seems an important consideration.

The researcher is directed to focus on the **life world** of individuals as the site of psychological explanation. The phenomenological approach acknowledges the value of in depth personal analyses of individuals, which are primarily qualitative in intent, attempting to understand situations in terms of the experience of the person rather

than in terms of the person as observed from outside. It was important in this study to adopt a standpoint which would maximise the possibility of understanding the underuser's perspective. Thus this tenet of the phenomenological approach is not adopted here merely because of philosophical commitments, but rather because the research intended from the start to be an exploration of the client's perspective. The persons lived experience then, is the starting point for analysis (rather than observed membership of a category); this is exactly the focus of interest for this research, and the most neglected area of enquiry.

Interpretation was the basic concern of the research, i.e. placing centrally the researcher's act of making sense, and not diminishing the significance of the subject's experience. The practical constraints of working with people were actively explored, rather than being spirited away as researchers are tempted to do.

3.6.2.1. The interview procedure

The justification for an approach rests on evidence and argument, and in what follows, both are presented. The account is primarily psychological, not philosophical.

First of all interviewing itself was brought under critical scrutiny, to see to what extent it was capable of providing the data sought. The critique is presented in detail as it was instructive in the choice of method adopted in the present study.

The procedure for analysing interview data is then presented, detailing what steps were taken at each stage in order to produce the

results. This was done in order to explicate the method used, and also to isolate problems which required clarification.

Having laid out the approach and procedures used in the analysis, the researcher felt it was necessary to explicate the phenomenological approach, as it is not yet a popular one, or particularly well understood. There then follows a clarification of the terms in which the research was done, as the move to a phenomenological analysis requires a shift in understanding not readily worked out in methodological texts. This was to aid judgement as to the validity and reliability of the method.

This then is an account of the problems found when attempting to employ qualitative interviewing as the main means of data collection in a research context. The problems are laid out to show how and in what ways a traditional approach to interviewing could not provide the desired data. Comment arises from a particular project but can be regarded as highlighting the real problems any honest researcher must deal with when interviews are the important source of data. There is a consideration of some generally recognised principles of good interviewing drawn from the natural science paradigm in relation to what actually happens in practice. Concrete examples from interview material are used to demonstrate how such principles, derived from construing interviewing as an objective eliciting device, are not tenable and introduce gross distortions in the interview itself - the very thing they are meant to be overcoming in the pursuit of unbiased data. It is further shown that when an alternative, phenomenologically-based approach to interviewing is adopted, the concerns of the researcher are quite different and the defects

previously outlined can be regarded as strengths of interviewing as a means of attaining relevant data.

To recap on the research interest, where lower social class members have been interviewed, they do not do 'well' at all, in that what they say is subject to the researchers own judgement which sets out to look for causative factors (whether they be perceptual, motivational or whatever in nature) which can be contrasted with "more desirable" middle class attributes. Even though subjective (qualitative) research on the whole has been disregarded in favour of what are considered to be more objective modes of enquiry, the subjective is nevertheless inferred. The researcher typically interprets the objective facts (partial though they may be) according to whatever notion of motivation he adheres to. More recent research (Graham, 1979) and comment (Burkeman, 1980; Chalmers, 1980; CHC, 1980) has questioned the validity of what has been termed 'blame the victim' research. They have indicated that failure to use services may be due to the inappropriateness of the provision itself in meeting the needs of clients and have taken seriously the clients' point of view (Oakley, 1980; Graham, 1978) - though here again the underuser has not been sought out for interview. Nevertheless, a considerable amount of dissatisfaction was found even amongst users, whose problems were not well understood by the providers of services, apparently.

My study was undertaken to investigate the reasons offered by mothers themselves for their selective uptake, concentrating on those who would be regarded as underusers, the aim being to find out what their contacts with the services were like 'in their own terms'. To this end, it was decided to employ interviews, which it was hoped would

allow for an exploration of the underuser's point of view.

Some considerations about interviewing

There are all sorts of considerations which need to be taken into account when utilising interviewing in research; decisions and choices have to be made as to how to proceed and what importance to attach to what kinds of data. The natural science paradigm draws attention to certain aspects of interviewing which can be contrasted with the matters which would concern a phenomenologically-based approach.

From the natural science paradigm many considerations have been brought to bear on the validity of interviewing as a means of accessing unbiased and reliable data. Such matters as the varying ability of people to recall events accurately; the effects of time delays between an event and its retelling; problems to do with influencing the interviewees responses (with e.g. leading questions), and many other matters have been explicitly dealt with by most writers. It is clear that interviewing is acknowledged to be a highly subjective exercise but it is construed as one which can be controlled for such distorting factors. The idea behind the rigours of interviewing seems to be that as in a laboratory experiment, if one holds all other factors constant then differences in response will be a product of different attitudes within respondents.

When liberated from the constraints of natural science, interviewing can be construed in quite different terms. It would not be likened to a laboratory experiment, rather it would be seen as a social encounter

of a particular kind. Here the intention is to focus on the importance of the interview situation itself as a social encounter and the implications of this for the conception of interviewing as an objective eliciting device, and for the interpretation of the resulting data. This has been neglected in most methodology texts, and most often totally ignored as an important consideration. Usually excluded from the analysis is any consideration of the ways in which the researcher carrying out the interview participates in constructing the data. If the interview schedule is regarded as a stimulus given to elicit a response, then this requires that an event has a standard effect on all who are subject to it, which can never the the case with human beings because what is of crucial importance is the meaning the event has for the person which defies standardisation. What a respondent says in an interview is usually taken to be indicative of some underlying predisposition within the person and not as a result of the shared meanings and expectations operating in the interview itself. The interviewer is thought to be taking part in an impersonal, technical and manipulative relationship over each aspect of which she can excercise control with predictable/specifiable consequences. At the outset she must assume she knows how people tend to react to certain stimuli and just bear in mind these biases and allow for them in order to get at the truth. At least such ingredients as empathy, intuition and imagination are indicated by such a stance if not acknowledged to be operating in the interview itself. What follows is an attempt to look at the ways in which meanings, expectations and shared rules of conduct are negotiated between persons participating in an interview in contrast to the positivistic picture of isolated individuals merely responding to each other in a controlled social context.

Interviewing in practice

When trying to converse with the respondents taking part in my research, and obtain useful, important information of real relevance to them, it proved impossible to follow the rules of rigour which can be found in many methodological texts. A number of other texts have drawn attention to the problems which are dealt with in this overview; (e.g. Denzin 1970, Newsom et al 1976, Hyman et al 1976, Halfpenny 1979), in attempts to make interviewing a more reliable measuring device. Those which deal with health-related research interests were mainly consulted (e.g. Treece and Treece, 1977, Selwyn, 1978, Jenkins 1975, Bausell 1979, Moser et al 1971, Selltiz et al 1964, Miller 1970, Richardson 1965, Lewin 1979, Helmstradter 1970, Sudman et al 1982, Dominowski 1980, Runkel 1972, Wragg 1978). Overall, the advice given on how to carry out valid and reliable interviews assumes too much control over what goes on on the part of the interviewer. It ignores the social context in which interviews take place and the part played by the interviewer in the construction of data. Now we can turn to some generally recognised principles of good interviewing in relation to what actually happens in a research situation, showing not only that they are not tenable, but that they introduce gross distortions in the interview itself, the very thing they are meant to be overcoming in the pursuit of unbiased data.

The advice given can be regarded as relating to four main problematical areas of interviewing:

A) When it is considered appropriate to use interviews.

B) The question of relevance and irrelevance, and what can be regarded as true and unbiased data.

C) The interpersonal relationship in the interview situation itself, which amounts to the problem of keeping optimum conditions constant.

D) The analysis/processing of data to produce relevant unbiased results.

A) The appropriate use of interviewing

The richer data which one can get from interviewing a person, as opposed to their filling in a questionnaire, is thought to be necessary where one wants to 'put flesh on the statistical bones'; in other words they are to be used as an adjunct to 'more objective, quantitative' methods. Often they are only recommended for pilot work (e.g. in the construction of an attitude inventory), or to amplify and check up on questionnaires. Semi-structured interviews are recommended for use when one wishes the respondents to express themselves at some length, bearing in mind that they must be carefully worded and have enough shape to prevent aimless rambling. In general the researcher is warned off using unstructured interviews, as these require considerable skill, due to the built in hazards of redundant information, questioner bias and questionable relevance of content.

All of this seems to relegate interview data to a position of secondary importance at the outset, usually almost merely justified by a need to make a research report a little more interesting. Not everyone would agree that they are of such limited usefulness. Where one wants to discover a person's view of a situation the interview itself can provide the areas of relevance, to be subject to statistical treatment if this is considered necessary. If one has already decided on the areas of relevance and only requires instances of them then there seems little point in interviewing. In this respect, there seems to be little difference between

interviews and questionnaires, neither being particularly suited to tapping the views of respondents themselves. When interviewing is considered from the natural science viewpoint as an objective eliciting device, it becomes stripped of all usefulness as a means of accessing important and genuine information from respondents. It is then judged according to the criteria by which other scientific techniques are assessed in the natural sciences. As a result the data must be regarded as less than satisfactory, of only secondary importance, soft (i.e. subjective) and consequently unreliable.

The reorientation involved in adopting a phenomenological perspective restores interviews to a position of central importance in research, not a mere adjunct to other methods; they are considered a main means of access to the respondent's life world. The aim is to obtain rich and detailed descriptions of the respondent's own concerns, opinions and actions in her own words, rather than eliciting bits of behavioural responses to precategorised stimuli. One is more interested in how matters appear to the respondent than in how to fit answers into prefigured categories - the first step being uncensored concrete descriptions which come prior to any efforts to control, manipulate or quanfity what is said. Such descriptions are not treated like physical variables; the focus is not on control but on understanding the meanings intended.

The respondent is given the freedom to choose her own areas of importance and to put emphases where she feels they should be, so that anything which she feels is worthy of mention is registered as data. It is important then that she be allowed to structure her descriptions in her own way and not be tied to a rigid schedule or form.

Subjective bias does not arise in the way it does on a positivist understanding of interviewing as the subjectivity of the researcher is the very means of access to the meanings and themes which make up the qualitative description. All of the description is seriously considered precisely as the respondent described it, before the particular concerns of the research focus are applied and allowed to organise the material. The subjectivity or concerns of the researcher are made explicit in this regard rather than assumed to be controlled factors. The dialogue between the researcher and respondent possible in an interview allows for the exploration of the respondents concerns.

B) The question of relevance in the pursuit of unbiased data

The question of relevance, although usually considered only in relation to digressions from the main focus of research on the part of respondents, can make itself felt right at the start of the interview on first approaching a potential respondent. In some cases, I found myself unable to make the desired enterprise either intelligible and/or interestingly worthwhile and was refused co-operation. Others were anxious to please, offering to help in any way they could but were not sure they had the credentials to participate usefully. This is an important consideration, as some of those approached obviously had no idea how to act in such a situation and were well aware of this. Approaching respondents and inviting their participation in a project presupposes an appreciation of the researchers aims and, in some ways, a general appreciation of social concerns - which may be true of the middle class well educated respondent who is familiar with such things but is patently not true of the lower class respondent who has no idea of the part she is being asked to play and therefore

cannot comply.

The interview situation then requires the respondent to see herself as an object worthy of study, who holds opinions and views on (in this case) motherhood, which she is only too willing to divulge. It was evident that some respondents had never been asked for their participation in this sort of activity before and found the whole idea very strange indeed. This was not always the case: for some the experience of motherhood and views on health care facilities were seen as issues to be discussed in this manner, but for others they could not see what I wanted at all. This does not mean they would have nothing to say for example about being a mother, but just that they had never considered treating it in this way, as a topic to be formally discussed. From the replies given on approaching potential respondents it is possible to see the lack of correspondence between my concerns and theirs. In particular one of the aims of the study, to help improve provision for the consumer was not one that they shared. They were quite content to have nothing to do with it, or just did not see it as a changeable thing, it was seen as a given, to be ignored or endured. In declining my invitation to take part, the following was not uncommon:

> 'I don't think I can help you there, love; it's got n'owt to do with me... I don't go...'

Idealised interviewing

In the advice pertaining to approaching potential respondents, one is encouraged to expect to find an interested, motivated and receptive person who has a general understanding of what the interviewer has in mind. They are expected to understand the general importance of

academic work of this sort and to be friendly and cooperative. We are given to believe that most people cannot resist such an opportunity to talk about themselves.

Some of those in my sample who agreed to be interviewed were distinctly uncooperative throughout, either by poking fun at the whole excercise as not something to be taken seriously, or chose to take on a disinterested enactment of the part whilst making sure nothing of any real consequence was said. The former situation usually resulted in chaos where the interviewer was questioned in return, justifying herself at every stage, as the respondent did nothing to hide her total scorn for the whole encounter, while the latter took the form of a rigid question and answer (monosyllabic) routine throughout. Both can be seen to be flagrantly flouting the rules of the encounter for their own reasons. In some cases then the smooth running encounter one is led to expect did not happen at all.

Carrying out interviews then is not a mechanical procedure to be applied across a sample of respondents, rather it should be possible to allow the reality itself encountered to determine the process. Where the best intentions of the researcher were not perceived and there was a lack of correspondence between the research concerns and theirs, the researcher is called upon to be convincing, and able to reassure clients that their interests will be respected. The ways in which such interviews proceed reveals something of the client's concerns. The researcher was treated as an intruder and subject to the distancing used to keep authorities of all kinds at bay. Rather than writing them off as 'difficult' clients, it was necessary for the researcher to treat their concerns seriously and question her own

perspective for its relevance to their situation. The need to be adaptable, then, is not a fault but a necessity to access matters of real importance to the clients. Rather than approaching respondents with what are thought to be technical and manipulative interviewing skills, there is a need for an open, genuine and sympathetic approach which treats the interview as a personal encounter.

Unbiased, objective questioning

The researcher is advised to first of all stimulate the respondent with questions which are relevant and meaningful to her situation, which does not seem too difficult until one closely examines the ways in which questions are responded to. To illustrate, it is useful to look at the assumptions built into questions asked, which quite unwittingly can contain alien and often amusing notions for the respondent. One question in my schedule concerned the part played by the respondent's husband/partner in antenatal preparation, as antenatal classes now seek to encourage fathers-to-be to get involved. For some, the very idea of a man taking part in antenatal preparation was highly amusing, if not alarming. It was not considered to be an appropriate activity for a man at all. At the very least this made clear to the respondent that she was talking to someone with very different ideas to her own. This could be regarded as merely illustrative of public resistance to new trends in provision, but such considerations apply to much less obviously contentious areas of discussion.

When asked what advice they were given by their doctor on confirmation of their pregnancy, I was made to realise that this was not an accurate way of talking about their experiences with doctors, as one

respondent put it;

> 'Advice ?...Waht do you mean, advice, he don't give yer advice.... they don't talk with yer, he just telt (told) me to go up to clinic and take these pills' (iron tablets).

It became clear that 'advice' was far too equal a word to use to describe their dealings with doctors; they were given authoritative directions to follow. To merely answer my questions would have been to totally misrepresent their experiences.

Even the apparently harmless common sense notion of planning to have a child was not seen as such by all respondents. A number of them construed planning to have a child as referring to their desire to have one or their willingness to care for a child. It was obviously seen to be a moralistic issue, to do with whether they approached the advent of motherhood in the correct way. Such answers as;

> 'Oh yes love, I wanted her, she was a wanted baby'

and

> 'Well I definately haven't had any regrets about having her.'

show the mothers to be answering to the implied charge of irresponsible feckless breeding, which was not meant by the questioner. It became clear that the whole notion of planning to have a child was to do with organising one's family around a career, which was hardly relevant for some respondents.

The problem illustrated here, is one of looking at the researcher's own analytic concepts which were completely divorced from the terms in which respondents themselves understood and described their experiences. The answer to such dilemmas is not simply a question of finding a less value laden word to substitute, as even though there

may be one, it will have it's own nuances of meaning which differ markedly from person to person. The important issue is not one of unbiased objective questioning but of ensuring precision in meaning.

Such descrepancies should not be overlooked or hidden by the interviewing method, but seen as an important feature of human discourse. An interviewing method which claims fidelity to the phenomena would acknowledge that there are a multitude of meanings in any 'text' and allow for the exploration of meanings intended, to examine how a respondent has understood a question and show a willingness to acknowledge new material brought to light. Efforts at clarification should not be haphazard but built into the method and lead to self correction and thus precision in meaning. To avoid premature analytic/explanatory constructs in the questions and analysis, key terms would be developed and employed after contact with the data and not before. Where the interpretation of meaning is regarded as the important task, it seems necessary that the researchers' own involvement with the subject matter be searched and articulated through self searching and openness to others.

Facilitating a relaxed conversation

Most outlines of the interviewing method suggest that the researcher start off the interview with non-threatening impersonal questions, for example the filling in of background details in order to put the respondent at her ease and allow her time to relax into the interview proper - when more pertinent, potentially emotive topics can be broached.

What at first sight seems trivial to the researcher can in fact be

highly symbolic for the respondent. One example of this was the first part of my schedule which required the respondent to go through a tally of amenities she had available to her, which was meant to be a purely fact gathering excercise. From the full transcriptions of the taped interviews, it can be noted that none of the respondents who lacked any of the amenities simply ticked them off as present or absent. Some were anxious to stress that they could manage very well without, for example, a washing machine; while others stressed the hardships and difficulties involved in managing without one. Both were at pains to show a concern for hygiene and cleanliness, 'as any good mother should'. It was also apparent that it could be quite distressing to confront a person with what could be seen as a discreditable agenda of inadequacies they must admit to, it being obvious that I, or the agency I worked for, considered such amenities to be at least desireable if not necessary to good mothering, (or I would not have asked about them).

From the analysis of the full transcripts of interviews, a prime consideration of the respondents' is revealed - to be seen and to portray themselves as good mothers. To merely categorise presence/absence, to amass quantitative data, would ignore this major concern. Their concern was with dignity rather than accuracy of reporting, showing the overiding importance of treating the respondent as a person and not something to be measured in any abstract way. The interview is more accurately to be seen as an interpersonal encounter, and not a technical matter with procedural rules which can be adhered to and administered in a clinical way. In this regard it would seemto be more important to listen to what comes without selectively testing hypotheses, so as to take a non-categorising approach to what is taking place at the moment.

Invalid self reporting

In advice regarding what to expect in interviews, one finds a mixture of tolerant amusement and patronising contempt for the respondent, with suggestions as to how to correct for tendencies in human nature which may distort one's data. For example we are warned that the unscrupulous respondent may use the interview as a platform on which to air their prejudices, it being implied that only the most naive researcher would take what was said seriously.

Such prescriptions can hardly be regarded as an objective excercise in any sense as the researcher must judge when this is happening to the extent that is is a false account, and discard it. Here again there are some guidelines, the researcher being advised to discredit certain tendencies which incidentally, one would expect the least privileged to display. These are where a person overstates the case (it is thought) to extract more benefits, or where the person makes excuses (false ones) to make up for apparent inadequacies.

The bitterly angry accounts given by some of the respondents in my sample of the treatment they suffered at the hands of the services would most certainly have to be regarded as prejudiced. Instances in which they felt deliberately ignored, publicly ridiculed or accused of child neglect do not avail themselves to reasonable, unbiased recounting. The events were experienced and recounted, as stark threats to their self respect; in the interview it was vital to self esteem that the respondent 'redress the balance'. It is important that the professional be seen to be at fault and themselves to be innocent of any blame. This is clearly in evidence in the following account:

A particularly impoverished respondent was advised by her health visitor to help herself to some second hand clothing which was available at the clinic. She reluctantly complied and sorted out some suitable items, a task which entailed considerable cost to her self-respect as she was seen to be scrounging by the other mothers there. The humiliation was made worse by a member of the clinic staff demanding payment for the items, which she had been led to believe were free.

> "Well I didn't know you had to pay for 'em, and she were right snotty about it, ... so I had to put them all back 'cos I didn't have the money to pay."

When informed that the health visitor had offered the clothes freely the staff member backed down and allowed her to go, demonstrating to the respondent that she had acted wrongly, probably 'fiddling' the money for herself. In good faith the respondent had agreed to demean herself by accepting second hand clothing, only to find when she got to the clinic that she was to suffer uncalled for public degradation.

When relating an incident or event, distortion is inevitable as the person is anxious to portray herself as a respectable citizen who should not have been treated otherwise. In this respect, it is not unusual to find mistakes on the part of professionals gloriously described as proof of their ineptitude. Disqualifying a professional who has wronged a client from any claim to credibility often entails relating numerous examples of their incompetence.

Thus the doctor who reprimanded one client for wasting his time, is subsequently held responsible not only for the possible loss of the child but for many other events deleterious to her well being;

> 'It said on bottom of bottle (home pregnancy test), to go see your own doctor, so I went, and he says... It's gastric stomach you've got. I'd been badly... and thought I was losing the baby, ... but that doctor still insisted it were wind I'd got.... up to me really showing and then they changed their minds. If I'd have took any notice of him I'd have done something heavy and lost it !'

and later;

> 'that doctor of mine, he shouldn't have the job he's got, he don't even examine the bairns properly... he didn't see that she (the baby) has got a bad chest... and he gives wrong medicine out, ... it would have killed a child to give what he said...'

It can be seen that not only do the aggrieved find it necessary to bolster their self respect by giving a one-sided account of how they were wronged, but in general a person will tend to make their lives seem more socially praiseworthy than they were, better planned or more intentional. Such considerations are not taken into account in the rigorous prescriptions for interviewing as laid down by positivist writers, they are not to be seen as important expressions of the person's life situation, but corrected for as blatant distortions of the truth.

Overstatement, understatement, lying and contradictions are common in interview data, and would usually be written off as unreliable reporting. However, where the researchers task is one of understanding the respondents perspective, such glib judgements would not be permissible. If the respondent believes what she claims, then there are real consequences in that she may well act on the basis of such beliefs, whereby it would be important to accept them as her truth. They could be more carefully investigated by trying to find the meaning of the distortion for her by empathic interpretation, backchecking and making sense of the interview as a whole. In this

way the analysis could be particularly sensitive to the respondent's own interpretation of her situation, and tolerant of ambiguity, contradiction and the unexpected, which may quite accurately reflect how she feels.

In any case, in qualitative research, this is where our interest lies, - in getting as close to the persons understanding of her 'life world as possible rather than amassing facts as they appear to the researcher with her assumed access to objective reality.

Minimising redundant data

The interviewer is advised to control the content of the conversation by not allowing respondents to wander off the point, to keep bringing them back to the areas of relevance. This is usually referred to as the problem of minimising redundant data of no use to the researcher, and focuses on the tension between what the respondent wishes to talk about and the inverviewer's concerns as a researcher. In some ways the interviewing technique can be regarded as specifically trying to control those who do not stick to the rules of interviewing, those who do not treat it as a fact gathering excercise. They define the situation in their own terms and have no idea of what the researcher has in mind, which makes them unsuitable as respondents. As the conversation is primarily structured by the questions asked, the appearance of diversions could be regarded as indicative of the success of the encounter in terms of how relaxed and informal a very artificial situation has become, the respondent having been allowed to define her own areas of relevance. In this sense some areas of importance may emerge almost in spite of the interview. In some ways, then diversions can be regarded as rich descriptions of the

respondents concerns, in that they always reveal something of the world of the describer and cannot be dismissed so easily as irrelevant. One example from my research concerns the account given by a respondent about the recent loss of her car.

The car had been a bargain, the only one she had ever had, which held out the possibility of getting around more easily. Unfortunately her husband had not been able to get hold of the ownership documents - leading them to believe that it must have been stolen. Rather than risk conviction, they got rid of the car quickly, only to discover that the new owner had no problem in obtaining the relevant documents.

This was one in a long line of disappointments in life she had suffered. Her plans often came to nothing, every attempt to better her lot being flouted by forces outside her control. She feels hard done by, underserving of the bad luck which comes her way. She expresses similar sentiments towards the services, in terms of the possibility of hope being held out (e.g. in terms of extra money to buy necessities), soon dashed by administrative punitive red tape (rendering her not entitled to claim). She does not have a specific attitude reserved solely for the services, they are only one more trial of the many in her powerless existence.

Constraints in the interview

The researcher is not meant to influence the respondent in any way which would bias her response. However, respondents are well aware of the encounter as an interview and realise there must be rules governing what is to take place, even if they are not always clear about what these will be. It is commonplace to find respondents

actively negotiating guidelines in the interview itself. They overtly offer statements for validation by the researcher both in terms of relevance for the interview, as in:

'I don't know if this is what you're after but...'

or

'Should I tell you about (an incident), will that do ?'

and also in terms of the social acceptability of what has been said as in:

'Is this the sort of thing that most people say ?'

Respondents do not treat the researcher as the objective reporter which some would pretend, and so they do not give clearcut answers which are untainted by the interviewer and amenable to categorial analysis.

The interpersonal relationship in the interview

Advice mostly takes the following form: the interviewer is advised to create a friendly and pleasant atmosphere to gain the respondent's confidence by smiling and showing enthusiasm, in response to which the respondent will usually react positively. Most people are thought to be happy, curious and quite pleased to be interviewed. If the interviewer is totally responsive and receptive to whatever the respondent may say, by maintaining an appearance of spontaneity and naturalness, it will lead to an interview highly charged with information. This is meant to create a climate in which an ordinary person's ability to talk is freed from ordinary constraints. The researcher must remain friendly and warm towards her subjects, but not so friendly that the subject responds personally, rather than stating her opinions on the topic. The researcher wants the person to express herself as a subject and not as a personal friend.

Interview data is replete with examples of the respondent reacting to the researcher on a personal level, rather than acting as a subject proper, which seems to require her to strictly tie her answers to questions posed in an objective impersonal way. This is clearly shown in the more obvious example offered here when the respondent was talking about her immediate feelings on becoming a mother:

> 'You'll think me terrible for saying this but, I never did like N, (baby's name) when I'd first got her, she were always crying and cranky. I think she were windy most of the time and I just didn't like her at all. I know it sounds stupid but it took me a long time to love her.'

The respondent is clearly well aware of the socially unacceptable nature of what she is about to say, and comments on how she thinks such an admission will be construed in personal terms by the researcher at the time.

Whilst it is unlikely that the respondent will respond as to a personal friend, the hope that she will be freed from the ordinary constraints which govern normal interaction between people is also unfounded. In some ways the interviewer will always be seen as a judge, as in any social encounter. In every case it is clear that the respondents felt they were being held to account for themselves. Even if one manages to get away from the more institutionalised idea of a judge, as a professional possessing social power over the respondent, one can never escape from the inevitable judgements people make about each other as a matter of course. In the interview then as in any social encounter, the respondent will try to ensure that she is seen to be a worthwhile person in possession of socially desirable values, no matter how clinical the interviewer tries to be.

In the following example, the respondent wishes to display herself as being a knowledgeable person to the researcher. When asked whether she felt well on disharge from hospital, she mentions her painful scar resulting from caesarean section:

> '...it's about a foot long...but it's right good surgery, not like a frankenstein scar, you know, ...it's got the stitches that dissolve themselves. I don't suppose you will know this but apparently there's five layers from the womb to the outside skin in a woman...'

The apparently spurious addition of such 'facts' has little to do with the question being asked, but serves a more important function for the respondent, that of ensuring she is seen to be well informed about such matters.

Value free questioning

The researcher is advised to make every effort to ensure her statements are value free, and to have an impartial and unbiased approach towards the respondent which is thought to come through conscious effort. Some writers acknowledge the impossibility of making value free statements and recognise that it is not simply a matter of not loading questions in a particular way. The aim however remains to cut out bias by correcting for potentially value laden distortions.

Leading questions as such cannot really be avoided in interviewing, as even the act of raising certain issues to be discussed must be acknowledged to be encouraging the respondent to talk about some things rather than others. Sometimes grossly innaccurate assumptions about the respondent are deliberately included in questioning on the

understanding that the innocent will vehemently deny the imputed quality, but one can never be sure this will always happen and if the respondent is offended, the remainder of the interview could suffer.

In phenomenologically-informed interviewing, value free questioning does not arise as such, it is more important to try to elucidate the respondent's viewpoint as understood by the researcher; as a point of method, the researcher is required to be aware of her own presence and of interpersonal processes, making for more accurate interpretations. It may be more useful to rigorously investigate assumptions built in, and influences on answers given, than to imagine such matters to be controllable and predictable.

Preserving the anonymity of the interviewer

We are told that the interviewer must not be involved in a relationship with the respondent, as perceived non involvement will encourage her to impart a confidence. It would seem to depend rather on in what way the interviewer is seen to be involved and the consequences are never as predictable as this suggests. The ideal is for the interviewer to remain anonymous so as not to bias what might be said in any particular direction. This seems impossible to achieve as at best the mysterious anonymous researcher can only hope to receive non-committal, evasive replies which anyone would give to a total stranger. The very fact that she is carrying out a project in this area at all provides enough trappings for the respondent to decide who she is talking to, even if she only assumes the person to be interested or knowledgeable about such things. More importantly the respondent will ask, and needs to know, enough about the researcher to decide what to say and how to act in the encounter, as

can be seen in the following example where the respondent was asked to assess how useful she had found her health visitor to be:

> Respondent: 'Do you know Mrs. X very well then ?'
> Interviewer: 'No, not really, I don't have much to do with them, they just put me in touch with people...'
> Respondent: 'Oh, she's right fussy have you noticed ?... I just don't like fussy people... and she always comes round when I'm in the middle of doing something'.

It is not just a simple matter of perceived non involvement that is important. The respondent needs to know of possible allegiances before deciding what to say, as otherwise she could be guilty of social indiscretion and find herself denigrating a close colleague.

When confronted with questions from the respondent, we are advised to use non-directive techniques, which essentially means to be evasive in response to a direct question. Again it is not a simple matter of avoiding saying anything in case the response is affected: whether the interviewer chooses to answer directly or not will 'distort' the conversation. To be seen as unhelpful or uninterested is as much of a distortion to the respondent's perception of the interviewer as anything specific which might be said. The idea of a balanced, non-involved encounter with another person is based on a false conception of what human interaction is like.

Non judgemental responsiveness

The interviewer is warned to avoid biasing responses by the giving of approval or disapproval during the encounter. Rather, one is often encouraged to give non-judgemental responses like 'I see' to whatever the respondent may say. It can be most inappropriate to respond in this way to whatever is said. For example, in response to a very sad,

distressing story, such a non-committal response does not avoid bias in any way, as it can totally devalue what has been said - and would most probably be received as disapproval. Often, when relating a well told story, the respondent anticipates an appropriate response. She would expect surprise or amusement to be shown, for example, to indicate that the punch line had been appreciated. To react otherwise would amount to a gross distortion of the encounter, only serving to make both parties acutely embarrassed.

There is a need for the interaction itself to be analysed thoughfully and any judgements arrived at made explicit. From a phenomenological perspective, it is maintained that significant knowledge of human life is obtainable by a genuine human relationship not a technical one.

Standardising input

In order to standardise stimulation across the sample, one is advised to stick to the interview schedule, which will ensure flow and variety of pace. It is felt to be important that the wording and order of questioning is adhered to in order to minimise any bias which may creep in. The respondent who is talking freely, however, will not adhere to the order of the schedule. She will cover topics before they are introduced, and continually reintroduce those of importance to herself. On occasions she will express an opinion which would make it most embarrassing and destructive to the encounter for the next question appearing in the schedule to be broached.

In relation to the wording of questions, it was also found necessary to rephrase some questions to ensure the respondent had understood. What are regarded as factual questions are seen as anything but

factual to the respondent because, for example, some of the questions did not naturally arise for her, they required her to reflect on her experience and reprocess it into other terms in order to provide a response. When asked to enumerate problems encountered during the first few months of motherhood, for example, it was clear that their experience was not seen in these terms:

> Respondent: 'Well I mean things did happen, yeh, but I mean I didn't have no problems with her (baby), she were alright most of the time...'
> Interviewer: 'I really meant anything that had worried you in particular, when you were first coming home...'
> Respondent: 'You mean with her not feeding proper, and stuff like that ?... We got all that sorted out in the end... so nothing really, no... no problems...'

She prefers not to regard such minor difficulties as <u>problems</u> she faced. Such a treatment would make what occurred seem worse than it was; the connotations are all wrong, implying failure or lack of ability. In any case mothering was not seen in terms of problem solving, it was not something to be thought about in this way, you just get on with it.

<u>Question construction</u>

The type of questioning to be used has received much discussion, but it is generally acknowledged to be best to use non-restrictive, open ended questions in order to elicit the most valid response as this gives the respondent room for manoeuvre, and little guidance as to how to respond.

In some cases, rather than allowing the respondents more flexibility, open ended questions merely befuddled and silenced them. Such questions give no indication as to what the researcher is looking for, and require the respondent to have confidence in her views and to be

able to define areas of relevance. A number of respondents did not feel comfortable when faced with open ended questions. For example, when asked what they thought of the clinic, they asked for more clarification, as in 'What do you mean, in what ways ?', or avoided specifying by saying they had never really thought about it. When specifically asked about certain aspects of the clinic, they had no difficulty in providing an answer.

In other instances where respondents showed reluctance to express a point of view, this was due to the constraints operating in the interview itself. They expressed their need for time to think about what to say, and were not happy to blurt out whatever came to mind. They wanted time to consider what their opinion might be, now they were being asked for one, and also what such an opinion might say about them.

Following a set text and rigid questions construction would be of little value where the concern is to let the world of the respondent reveal itself in an inbiased way. Ensuring the person has understood questions as intended, calls for flexibility to elaborate; the researcher should feel at liberty to rephrase questions, discover distortions and on occasions to formulate the underlying message and send it back to the respondent for verification.

Analysing interview data

When one comes to attempting an analysis of the data, most of the guidelines give priority to the minimising of processing time. To this end the interviewer need not wait until all data has been amassed, some analysis can take place during the interview itself.

One strategy suggested is the judicious use of a pencil during the encounter, whereby the researcher marks down the point in the interview where it is felt something of importance is being said.

The experienced interviewer is considered capable of judging on the spot what is to be regarded as important, as the full transcription is considered to be totally unwieldy and full of redundant data. Such immediate discriminations can only be based on the preoccupations of the researcher and imply that one already knows at the outset what sort of things one is looking for.

The criteria suggested for marking points are such things as where the respondent talks with great feeling, where a particularly clear or vivid example is given or where something particularly unusual or striking is said. Such an approach would result in the exclusion of the less articulate respondents contributions. What is not said in an interview can sometimes be as revealing as what is stated. The less articulate respondents' interviews defy analysis by any of the more traditional methods which scrutinise the data with the above considerations in mind.

One of the respondents in the present study, never completed a sentence to the end, most often she gave up on whatever it was she had started to say. She would begin an answer in a lively fashion which gradually tailed off to mumbling as she struggled to find the right words. Overall she was evidently disgruntled by her contacts with the services but could never have made a passionate convincing case for herself. She expressed doubts as to whether she was ever taken seriously by the health professionals and had grown used to being

turned away. In sum the interview could be taken as an example of the persons ability to speak for herself in general and expressive of her hopelessness neither of which would be amenable to the categorial analysis of manifest content, but could be seen as important to a consideration of her underusage of the services.

Categorial analysis

Most often interview data is subject to categorial analysis, whereby the content is grouped according to the researcher's own system, with topic headings derived from pilot work. This interpretative process is not as straightforward and uncontentious as it appears. It requires the researcher to make judgements at each stage, which are rarely made explicit.

It is conceivable that the respondent may have been describing events to illustrate quite different points, of importance to her, from those which the researcher reads into the data; some interpretations can amount to a gross distortion of the data. One example from my own research illustrates the problem of trying to group responses under general categories. Some of the mothers in the sample felt they had been left to care for their child alone with no help forthcoming from the child's father. They had to carry all of the responsibility for the welfare of their child alone and felt that this was the reason for their unhappiness and depression. This seemed from the researcher's point of view a reasonable and important identification of a problem faced by mothers. There were, however, other respondents in the sample who also experienced a minimal lack of involvement on the fathers' part, but would not identify this as contributing to their depressed state. They expressed amazement and gratitude towards their

husbands for the minimal contribution they were prepared to make:

> 'Oh he's (the father) really good with him (the baby), he loves him, he doesn't have much to do with him... but you can tell.... one time he helped clear up the mess the bairn made without saying a word to me about it... and now he's started to say some things to him...'

In this particular case it is clear that she does not expect much help from her husband at all and to identify this as one of her problems would not be a faithful analysis of the data.

Lack of clearcut criteria for interpretation generally, and the distortion of grouping as similar experiences with distinct meanings for the respondent, are only two of the many problems which face the researcher who attempts to analyse interview data by traditional methods.

A more appropriate analysis of interview data has been offered by (Giorgi, 1970, 1975) which seeks to develop interpretative procedures which can be used with rigour to do justice to the richness of qualitative data rather than seek its transformation into quantitative results. The reorientation involved draws attention to quite different areas of concern than those which assume a natural science paradigm. The respondents' contributions are not regarded as responses to stimuli but as descriptions of aspects of their worlds, the task of the researcher being to let the world of the describer reveal itself through description. It is necessary to adopt interpretative procedures, as lived meanings are not always known explicitly but must be discovered and articulated. Criteria of validity and rigour change in relation to the concerns of a qualitative approach. Only a few indications of the contrast with

positivist approaches are made here.

Interpretation is fulfilled by a rigorously specified means of engaging the naive descriptions and discerning their psychological sense, a process which entails bracketing, intuiting and describing. As a first step, all of the data obtained is seriously considered and presented precisely as the subject described it before any other concerns are allowed to organise the material. Any preliminary analysis would be considered premature in this respect. The researcher is then required to deliberately put aside all preconceptions and try to see what meanings the respondent is conveying. Each part of the data is investigated as to its meaning in the respondents terms and only later for its relevance to the research interest, any judgements are made explicit. Thus the possibility of genuine discovery is maintained by the systematic search for meaning. The procedure is descriptive and interpretative as the researcher is not interested in some 'objective accuracy' of the respondents views, rather an attitude of maximum openess and a bracketing of all prejudice are the desired features. Importance is not assigned on the basis of frequency of occurrance across the sample or clarity of expression. An attempt is made to articulate the essential meanings, not always self evident.

Any structuring of the data depends on an articulated guiding interest which could be gone through by another person. It is acknowledged that there is much of interest in the data which is not immediately relevant to the research focus. Validity is not based on how close one has got to experimental control but on fidelity to the data which can be achieved in a number of ways. During the interview answers can

be rephrased and fed back to the respondent for verification, the aim being to achieve an accurate understanding of her perspective. When oriented to the research interest, others can carry out the analysis and compare interpretations to bring to light any bias.

Some concluding comments

It is not so surprising to find that expressed intention on the part of the respondent bears little relation to subsequent or (as in my research) past behaviour; the interview itself is recognised as an interpersonal encounter so there is a strong likelihood of socially acceptable things being said. One clear example from my research would be the respondents' apparently contradictory stance towards clinic attendance. When asked why they thought some people never went, they were quick to locate the fault in the under user:

> 'Well, I think they just can't be bothered, they're too idle and would rather be playing bingo... they can't care much about their bairns can they ?'

Later in the interview when asked about their own attendance, they were forced to admit:

> 'Me, oh I never went myself.'

Clearly the respondent does not regard herself as a lazy, uncaring mother, the criticism given of non users is rather a reflection of the respondents concern to be seen to hold 'correct' views/socially desireable values, which she probably expects the researcher to hold. The interviewee is concerned with staging a socially praiseworthy persona, whereby it is perfectly understandable for one to both acknowledge the importance of an issue, and yet choose to ignore it in behaviour.

When the interview is acknowledged to be an interpersonal encounter it is clear that as with any such encounter, the normal constraints governing interaction will be operating. It is important to realise that the researcher will be getting 'edited highlights' from respondents, which display what the person wants displayed, and also a reluctance to talk about events which cannot be depicted as socially praiseworthy. It serves no good purpose to ignore or pretend such things are not going on when a person is interviewed in a research situation. Interviewing does not become an objective data eliciting excercise merely because it is convenient/necessary for the researcher to construe it as such.

Such an analysis of the interviewing technique could have been offered by a hardline behaviourist, who wishes to strip interviewing of any credibility as an acceptable style of research, to show that it can never be a truly scientific, objective method. The conclusion given is for psychologists to stop wasting their time trying to study such impossibly subjective areas as self reporting. However in acknowledging the problems of interviewing as an objective eliciting device it was intended only to point out how it is being treated in psychology as something which it is not and could never be, regardless of how many safeguards or balances were built in. It becomes clear that the criteria and methods of the natural sciences cannot be applied unproblematically to the concerns of the social sciences which require their own appropriate modes of investigation.

The interview then from a phenomenological perspective, is a very different enterprise from that to be found in traditional psychology. It is neither a free conversation nor a structured questionnaire. The

interview schedule is used, not to ask particular questions, but to focus on certain areas rather than others.

This involves a radical move away from 'objective' scientific approaches and places the lived experience as articulated by respondents as of prime importance, (Kvale, 1986)

3.6.2.2. Separate analysis of under user accounts

Following the pilot interviews and subsequent reflections and revisions re interviewing, the researcher decided to reformulate the research in order to more closely satisfy the aims of the study. The interview schedule would be used in order to introduce topics for discussion, and rather than the schedule being rigidly followed, the interviewee would be encouraged to elaborate and introduce any areas of concern to her; the schedule was then to be no more than a guide for the researcher, to remind her of certain areas of interest, a semi structured format. It was hoped that in this way matters of concern to the interviewees would be allowed to emerge.

The qualitative aspects of the research project as a whole were twofold; to find out what the consumers thought of the provision they had been offered; how they construed their problems at this time, and to direct special attention to the underusers, to gain a detailed appreciation of their concerns.

In order to produce detailed case studies of underusers, it was decided to adopt a phenomenological orientation to the analysis of their interviews, to try to gain some indepth understanding of their relations with the services.

There were also more general questions which could be addressed by a less detailed survey type approach, to gain a more general picture of how the sample as a whole found their experiences with service provision. It was decided to content analyse the rest of the interviews to address the more general issues.

At the time of interview, the researcher did not know which members of the sample were to be regarded as under users and which were not, so that any distortions attributable to such information could not be operable. Each interview then was to be carried out 'blind' and subsequently subject to phenomenological analysis or content analysis, depending on the categorisation of the interviewee concerned.

Each interview was taped from beginning to end and typed out in the form of the conversation which took place; preserving the researcher's contribution at each point.

Content analysis of interview data

The research questions of interest to the Area Health Authority, were to do with the type and frequency of opinions across the target sample studied, whereby the applicability of favoured explanations of underusage could be tested to some extent. The wider audience for whom the project was conducted, then required that a survey of opinions was undertaken, investigating the relationships between sociodemographic and usage characteristics, and categorial responses to certain areas of service provision.

In each interview, information was sought on approximately identical topics, and the analysis was primarily structured according to the matters of interest which directed the research; not those which would necessarily naturally arise for respondents. The coding structure adopted was not designed in advance of data collection, but was constructed in contact with it.

A number of texts were consulted which offered advice on category formation, the avoidance of response overlap and the requirement for mutually exclusive distinctions (Wragg 1978, Youngman 1978, Lazarsfeld 1972); but essentially the categories were formed for the purposes of the research in hand, there being no ready recipes for every research situation.

Initially, concrete categories which encompassed the range of opinion expressed in response to each question were tabulated. These were very detailed and diverse. These were then organised under section headings dealing with each aspect of interest, where upon the preliminary categories were recoded into more general clusters, or simplified dichotomies. Thus, tentative definitions of categories were developed, tried out and revised, and tried again, until the whole scheme was capable of including all responses, in meaningful groups.

The response categories were then tabulated according to sociodemographic characteristics, and usage positions, and chi square analysis performed to test the degree to which the distributions of responses differed from a chance pattern.

Some recoding of the data into fewer categories was found necessary in order to avoid contravening the assumptions of cell size for chi square analysis. The coding and procedures were checked by a separate coder, to ensure reliability was maintained across interviews. All analysis of interview data was conducted 'blind', so that coding would not be influenced by knowledge of the interviewees uptake of provision.

3.6.3. Phenomenological analysis of under user interviews

The procedure to be followed in producing case studies of the under user interviews is laid out in some detail as it is not readily available in most methodological texts.

Procedure

The procedure adopted for analysis of the underusers' interview data was based on the systematic outline provided by Giorgi (1975), which requires both a taking to pieces and restating of the contents. At each point, a separate note was made of assumptions and preconceptions which occured to the researcher as the transcripts were read through. Each of the transcripts was analysed in turn; and each point of procedure applies to each one.

First of all the transcript was read, a number of times until the researcher was sure she understood each part, and a preliminary awareness of the interviewees concerns began to come clear. The researcher then undertook a careful scrutiny as to what was going on in the interview itself. In this respect the taped conversations were invaluable, and could be listened to again and again, so that

attention was drawn to such matters as forced phrases, preferred topics, strong opinions, recurrent phrases and images.

In particular the researchers questions, as asked in the interview itself were probed to see if they had obviously biased the interviewees comments, e.g. forced agreement, or obvious going along with the researcher. Any instances of this were noted and ommitted from the analysis.

The aim at each stage is to understand and respect what the interviewee has to say. The method requires empathy, which can be defined as an ability and willingness to imagine oneself in anothers shoes. This means that during analysis the researcher does not merely react to what a person has to say, judging it to be right or wrong, correct or incorrect, but considers it no matter how offensive or obtuse to be potentially important and revelatory of the respondents understandings.

Each statement is made sense of and accorded the same degree of importance as the interviewee intends. The researcher is required to bring to awareness decisions she is making i.e. passages which are to be overlooked as irrelevant to the research concerns have to explicitly accounted for. They are later questioned as to their relevance to the research interest, and importance to an understanding of the interviewee. At each point therefore arbitary (biased) decisions are guarded against both a painstaking and illuminating task.

The overall tone of the interviewee is accorded importance, as her stance on each issue, and any reservations on her part, are interrogated for their relevance to the research.

The researcher is constantly re-attuned to the interviewees interests by the requirement to articulate judgements which are being made. Judgements are suspended, in order to gain a deeper understanding in the clients own terms.

e.g. It can and does appear to be feckless and irresponsible for a poor mother to insist on buying new, blue clothes for her baby boy, given limited resources and additional calls on her meagre income for necessities. To have spent all her money on such apparently inessential, almost frills, seems ridiculous. However, in this analysis the researcher must be aware of standards and criteria which are being applied and whether these are truly unbiased. The aim is to understand the text, not to judge it. So what this mother was showing was nothing to do with fecklessness, and the researcher is required to recognise the standpoint from which such judgements have arisen, and articulate what was the central meaning for this mother as described in her concern for blue clothes.

The particular stance of the researcher requires elucidation at this point. Phenomenologists refer to it as bracketing. In this, all presuppositions are put to one side, to allow the interviewees concerns to emerge as concretely as possible.This does not mean that the researcher naively believes everything she is told e.g. "Health visitors don't care", they may or they may not, but the focus of interest is not accepting or not accepting the truth of such

assertions, but what this means to the interviewee, how and in what ways she has come to this conclusion.

A complete transcript and each step of the procedure has been put in Appendix 4 to allow the reader to follow the procedure in practice, and to see how themes were identified, as important to one interviewee. N.B. (in any reproduction of this work this section is to be ommitted as the respondent could recognise herself in the complete transcription, it is included only as a means of assessing the method employed).

Meaning units are identified as a means of breaking up the whole transcript into manageable parts which usually amounted to sets of exchanges between the researcher and interviewee about a particular topic. In spoken text of this kind, this was fairly straightforward, natural breaks occurred as the interviewee decided what she wanted to talk about, changed her mind or moved on to the next point. The researchers primary interest was the interviewee's relation with the services and their experiences of being a mother, these two guiding interests were kept in mind when examining the text in stage 3 of the procedure. Various situations they described of contact with the services were of particular significance. Anything they had to say about how it was being a mother, or contacts with the services were taken seriously and considered relevant.

The restatement in terms of themes was an attempt to capture the meaning of each related experience. Details of who said what, to who may not be as important as the way the interviewee felt about it, then or afterwards. The themes were stated however in normal everyday

language (not from psychological theory or other system of constructs) and kept as close to the interviewees as possible. To borrow terms from other areas of psychological theory involves the danger of importing a lot more than a term, it's meanings and uses within an approach, it could distract and distort the meanings as discovered in the text.

The identification of the themes and their arrangement are the researchers contribution to the results, and they could always have been otherwise (e.g. if the research interest had been different.) - This however does not make them arbitrary. They came from a close and rigorous inspection of the interviewee's own views, and due to the method adopted, are considered to represent a more complete, less biased and selective account. Each meaning unit being considered in turn as potentially of importance to an understanding of the interviewee.

Move to more general themes

Some themes which emerged could be put together under a more general one which encapsulates them both, while showing it to be an important one for the understanding of the interviewees experience. Whereby sections of the text are reordered, regrouped around similar themes to form a coherent whole. This involves abstracting the central more general theme which captures the essential features of meaning, and relationships between the themes. In this process, the level of abstraction is determined by the goals of the research, so that for some purposes very high level abstractions can be arrived at. The purposes of the present study seemed best served by remaining as close to the concrete description as possible. These are the main themes

identified for each interviewee. Themes from each case study are compared with the others to establish any concordance and difference. Transcripts were compared to see if the emergent themes from each applied to any or all of the others. In some cases the theme could be found, but was not as explicit as in the ones where it clearly emerged. In others the contrasting themes could be regarded as bipolar views on a similar area of importance, so that a more general theme was identified.

The results are presented in a way that shows the important dimensions of underusage in general terms, which are then illustrated with concrete examples.

Many writers are anxious about descriptive research, as it is thought it remains on a purely anecdotal level (see Oakley 1980) unless some attempt is made to unravel the interconnectedness of data. This is a real concern, but may not have to be answered with recourse to causal analysis; the interconnections can be brought to light in terms of **meaning** and this is what the phenomenological analysis aims to achieve.

The themes then which constitute the results of this section of the research, were found in the data. Each meaning unit as identified was interrogated as to its central meaning, and a short phrase sought which would capture this. The meaning is then articulated as to its relevance to an understanding of underusage.

CHAPTER 4: MAIN STUDY: IDENTIFICATION OF UNDERUSERS OF SERVICES

INTRODUCTION

In this chapter the results of the sampling procedure and usage scale adopted for use in the study are presented. A brief description of the area in which the target sample lived is offered, followed by a more detailed profile of their sociodemographic characteristics. The severe problems encountered in attempting to research such a difficult group are outlined resulting in a careful documentation of the representativeness of those agreeing to take part in the interview stage. The use of the usage scale is presented in some detail, as it served to produce an overall profile of how services were used by the sample as a whole, a detailed outline of what constituted underusage for this locality and the grouping of sample members into high, medium and low usage groups, to be used in the analysis of qualitative data generated by interviews. The clarified picture of underusage is then compared with previous research into the problem and some conclusions drawn.

4.1. SELECTION OF SETTINGS

Profiles of the health visitor caseloads were constructed covering 9 key features which allowed for their comparison, to ensure idiosync ratic ones were not selected. On each of the indicators, the health visitor caseload chosen for inclusion, fell within the modal or higher caseload bracket. It was further checked that they were not atypical of the area as a whole. All tabulated summaries of this data are to be found in Appendix 5.

From a consideration of the data, 12 health visitor's caseloads were considered eligible for inclusion in the study. Three of these could not take part, they were ill or engaged in ongoing reasearch.

The caseloads covered 4 areas, which provided a mix of urban, rural, private and council owned housing.

Area A is a mix of town and country, a small mining town with countryside and agriculture still surviving. The majority of houses are local authority or NCB owned, some new, and a substantial proportion of private housing. The other main areas of work apart from mining and agriculture are in small businesses.

Area B is a mainly urban area becoming more and more run down. The housing is mainly terraced, local authority owned of the oldest type. There are a few privately owned dwellings. The main employment is of an industrial type from the steel and allied industries and some factory work to be found on the fairly recent Trading Estate.

Area C is an expanding area becoming more desirable. The oldest part is a small village which has spread to the open country. There are a large number stone built cottages and some new modern buildings which attract first time home buyers of the middle manager type, giving an influx of younger families. Entire estates here are mixed private and local authority housing. The motorway nearby favours commuters.

Area D is a fair mix of open country, mining town and agricultural land with a small trading estate undergoing development. There is a large NCB estate, very extensive area of local authority housing and at least one third private bungalows. The population mainly work in mining, steel and allied industry, agriculture or commute to other larger cities.

4.2. SELECTION OF MATERNAL SUB SAMPLE

As outlined in the pilot section, mothers were to be interviewed when their child was between 12 and 16 months of age, to allow for a full year to have passed since the birth and discharge from hospital. This meant interviewing mothers at specific times during the research period.

When the criteria for inclusion in the study were placed on the total number of births recorded for the time period of the study, there were 149 mothers who made up the study sample and who were approached by the researcher. The tabulated summary below shows each area and health visitor caseload which contributed members of the sample.

Table 3 Contribution to the study sample from each HV area

Area	HV	No of mothers	Omitted	Total	Area Sample size
A	1	17	0	17	36
	2	19	0	19	
B	3	24	-4	20	66
	4	23	-1	22	
	5	25	-1	24	
C	6	10	0	10	28
	7	18	0	18	
D	8	9	0	9	19
	9	10	0	10	
		155	6	149	149

The six who were omitted violated one or more of the criteria for inclusion; they already had another child which was not documented in their birth record, or were now outside the area and not in receipt of the services under scrutiny.

The 149 mothers then were a complete sample. Further sampling was not necessary, as 149 seemed a manageable number for this study's resources. The advantages to be gained by contacting every person satisfying the criteria outweighed other considerations as it was important to gain as complete a coverage as possible.

4.3 SOCIODEMOGRAPHIC PROFILE OF THE SAMPLE

There were many problems in amassing the sociodemograpic data for this sample, mainly because there is no single or consistent record of such

factors to be consulted. Data was collected from the clients themselves when visited, the health visitor record card, or clinic card. When none of these sources yielded data, a blank is entered on the tables. e.g. for factor (1) age of mother, out of a total sample N = 149, the number for which age known = 88, which means that 59% of the data was available.

The percentage response varies with each factor, depending on it's accessibility to the researcher.

Table 4 Availability of sociodemographic data

	Factor	N		%
(1)	age of mother at birth of child	88	=	59%
(2)	school	86	=	57%
(3)	age left school	86	=	57%
(4)	qualifications	86	=	57%
(5)	health education	86	=	57%
(6)	previous occupation	86	=	57%
(7)	present occupation	86	=	57%
(8)	Partner's occupation	125	=	83%
(9)	time in present occupation	85	=	56%
(10)	residences since childhood	85	=	56%
(11)	contacts	86	=	57%
(12)	property type	115	=	77%
(13)	bedrooms	128	=	85%
(14)	number of people	110	=	73%
(15)	property condition	84	=	56%
(16)	domestic facilities	86	=	57%
(17)	journey to clinic	85	=	57%
(18)	journey to GP	79	=	53%
(19)	marital status	93	=	62%
(20)	years known partner	80	=	53%
(21)	years with partner	81	=	54%
(22)	together before child	81	=	54%
(23)	planned pregnancy	60	=	40%

As the researcher interviewed 87 out of 149 potential respondents (58% of the sample), data are incomplete.

Missing data then resulted from incomplete record cards and/or reluctance to provide the information on the client's part. Wherever possible both clinic/HV record and client's responses were checked for concurrence and any mismatch clarified before entering the data to the tables. For each factor the client was the preferred source of data as neither health visitor records, nor clinic records were always complete or up to date as to current circumstances of each mother.

Despite extensive follow up of all potential respondents, there were many problems encountered by the researcher in securing the cooperation of all members of the sample. A detailed breakdown of the fate of the intended sample is offered in section 4.4.5, but at this point it remains necessary to note that members of this group of potential respondents were very difficult to research, especially in view of their estrangement from the services, it being necessary to adopt a **criterion of many visits**, (this was 7 unsuccessful visits and 3 calls/notes/or letters left at the address), before it was decided to regard them as unobtainable. The researcher was pleased with the response rate obtained, as were the advisors to the study who fully anticipated a much poorer response overall.

Factors 1, 6, 7, 8, 12, 13, 14, 16 and 19 were sometimes also available on the HV record card or clinic card, but not always, and only factors 12 and 13 could be collected by the researcher herself independently of the client or HV records. Tabulated summaries of all sociodemographic data are presented in **Appendix 6**, wherein account is taken of the incompleteness of data collection.

Profile of sample population

Of the 155 mothers referred by the health visitors for inclusion in the study, (i.e. those satisfying the criteria outlined before,) 6 were omitted at the outset, 2 of them had left the area, and four had another child already.

The mothers were aged between 17 and 36, at the birth of their child, 78% being between 20 years and 30 years and relatively few (i.e. 6%) at or below 19 years, and 13% at or above 31 years. (Table 1). 85% of the sample were married or living with the father of their child, 3% were divorced/separated and 10% were single parents, (Table 18).

Before becoming pregnant, most had been employed in factory work or some service occupation e.g. waitress, shop assistant. These made up 68% of the sample, for the remainder 23% were working in a professional (e.g. teacher) or semi-professional (e.g.nursery nurse) capacity, and a few (i.e.6%) had not been employed at all. The remaining one member was a farmer, (Table 6)

At the time of interview (i.e. 12 - 15 months after the birth of their child), only 9% were working outside the home. They were: one farmer, one shop assistant, 2 teachers, 2 nursery nurses and 2 laboratory technicians. The remaining 91% were now housewives and did not intend to take up extra employment for the forseable future, (Table 7).

When judged by their partners occupation, only 9% could be considered middle class by most standards and these would include 1 optician, 2

metallurgists and 9 teachers. 16% were non-manual workers (police, security officers, accounts clerk), 40% skilled labourers, 24% non-skilled labourers and the remaining 9% were currently unemployed. The remaining one member was a student, (Table 8).

Most of the mothers had left school at 16 (82%), leaving a small number 15% who stayed on for further education (Table 3). 88% had left school with minimal (1 or less than 1 'O' level) or no qualifications. Only 10% had studied for 'O' and 'A' levels and 2% were professionally trained, (Table 4). At school none of the members were given any instruction in baby care, 32% had studied human biology, 37% had studied domestic science and 22% sex education. 4% could not recall any of these health education topics, (Table 5).

It was most common for members of the sample to have spent 5 or less years in their present accommodation (84%), the remaining 15% had been there for between 6 and 8 years, and only 2 members had lived in the same house for over 9 years, 43% of them had only been in their present house for 2 years or less. (Table 9).

80% of the members had moved house 4 or less times since leaving their parental home. 20% had moved 5 or more times and only 4% could be considered to be exceptionally mobile having moved 8 or more times, (Table 10).

The sample was almost equally divided between private house owners 56% and those renting accommodation 43%, made up of council houses and flats, or tied (NCB) property, (Table 12). Only 9 members were housing more persons than their accommodation could hold comfortably

(i.e. more persons than bedrooms), (Table 13). 6 of these had 3 bedrooms and were accommodating between 5 to 10 people. The remaining 3 had 2 bedrooms and were accommodating either 4 or 5 people.

The majority were content with the condition of their accommodation 82%, the remaining 15% having a major complaint or finding conditions unliveable. The complaints included, overcrowding; lack of hot water, indoor toilet, or adequate heating; chronic damp, peeling walls, or crumbling ceilings, and/or an inability to furnish or carpet rooms adequately, (Table E14).

5 members of the sample had none of the domestic facilities monitored in the study, i.e. no hot water, fixed bath, indoor toilet, cooker in working order, washing machine, telephone or access to a car. 6 had no fixed bath, 7 no indoor toilet, 8, no cooker in working order and 13, no washing machine. 75% had all of the items, 40% of these also having access to a car, (Table 15).

9% of the members did not have any regular contacts in their neighbourhood (e.g. friends, neighbours or family nearby), and no one had more than 3. 15% had one regular contact, 31% had two and 44% had 3 persons they visited or were visited by fairly regularly, (Table 11).

91% of the mothers walked to clinic, 7% took the bus and 1% used a car. The journey took between 2 and 60 minutes. 65% of the sample took 10 minutes or less, 32% took between 15 and 30 minutes, and only 1 member had to travel for 60 minutes, (Table 16).

When visiting their general practitioner, 40% of the sample walked, 35% took the bus and 4% used a car. It took 10 minutes or less journey time for 59% of the sample, 29% took between 15 and 20 minutes, and the remaining 10% took between 25 to 90 minutes to reach their G.P. (Table 17).

Although 34 (40%) members of the sample included having a car in their inventory of domestic facilities, only 2 of them made use of it to go to clinic, and 4 to go to their G.P. for the remainder the car was mainly used by their partner.

The sample was made up predominantly of lower social class members, those having professional occupations being under represented. This study population then differs from those of others researching underusage which cover predominantly middle class respondents. This is probably due to the sampling strategy adopted in the study which was to include all mothers having their first child of a certain age, and to go and visit them, rather than take a captive sample to be found present at clinic/or hospital.

The data was compared with that relating to the usage of the health service to see if the relationships established in previous research and comment hold for this group, (see section 4.4.9).

4.4. REVISED USAGE SCALE

The usage scale developed for use in this study was analysed in some depth to try to elucidate the nature of underusage in this locality and to divide the respondents into groups of users and non users. The bulk of the raw data and statistical operations are to be found in

Appendix 7. Each item on the scale was considered in turn in order to establish how accurate an assessment of uptake it was. (Appendix 7). Some general features of uptake for this locality from this analysis can be outlined.

There was a difference between voluntary uptake of health visitor assessments and actual uptake of assessments, showing that while 78.5% of the sample had 3 or 4 assessments carried out during the first 18 months, in only 29% of cases could this be considered client initiated.

By contrast, 89% of the sample could be regarded as having voluntarily taken up immunisations. (attended clinic for more than one session for immunisation purposes) and 83% voluntarily had their hearing test done. Few made maximum use of the clinic attendances possible for them i.e. only 8% attended for 50% or more of possible visits. The majority of 92.6% attended clinic for less than 50% of possible visits.

From the gap score calculated, it became apparent that the clinic was not attended on a very regular basis (e.g. monthly) by most members of the sample. 73% having gaps of over 4 months during which time they did not go to clinic or see their health visitor. It was most usual for interviewees to begin attending clinic before their child was 4 months old (i.e. 86.4% did this), and very unusual to start after this age. It was also more usual for them to carry on attending until their child was over 12 months old (69% did this), although the percentage had fallen from those initially attending. Most interviewees attendance spanned over 12 months of their childs life

(78.8%). It was unusual not to make an appearance at clinic at all, or to attend over a short period of time.

Overall then, the most common pattern was for interviewees to attend clinic infrequently over the first 12 months of their childs life, there being long periods of (between 5 and 9 months) gaps in contact with the clinic and health visitor. Moreover interviewees were more likely to attend up to their child becoming 9 months old, after which time more do not attend than attend except for the 12 month stage when there is a peak probably coinciding with the 12 month medical assessment which takes place. Interviewees rarely made more than 1 visit per age/month, those who made more frequent attendances tended to do so in the first few age/months of their childs life. Most had had a medical examination carried out, only 18% had no record of this. 86% of the sample had at least one non-routine contact with their health visitor, where they had sought her advice, or rang her for a visit, however, it was unusual for this to have occurred on more than 4 occasions. All interviewees were visited at home by the health visitor, but there were wide differences in the number of visits, it being unusual to be visited more than 5 times. They were moreover very unlikely to ring the health visitor and request advice or a visit, whilst non-routine contacts with the CMO at clinic were very rare.

4.4.1. Trends in uptake for this locality

For the sample as a whole not all aspects of service provision were equally unpopular, the marked reluctance on the part of most mothers to seek out the health visitor assessments can be noted in contrast to their relatively unproblematic uptake of immunisations.

Considerable follow up by health visitors was in evidence to ensure that most persons had these assessments carried out, indicating an overall reluctance on the part of most consumers. Having had one assessment done was furthermore no guarantee that others would be voluntarily taken up later on. Overall 71% of the sample required encouragement. Immunisation uptake was relatively favourable when compared with other features. Only 5 persons had none done (who could have been eligible) and a further 14 (i.e.9%) presented problems. For the hearing test, the problem of uptake was less marked than for assessments there being approximately 16% for whom encouragement was required.

Few persons made maximum use of the clinic attendances possible for them. Only 8% went to 50% or more available sessions, whilst the remaining 92% were content to attend less than 50% of available sessions. Nearly half the sample i.e. 42% attended for less than 19% of possible sessions.

The clinic and health visitor were not seen regularly or consistently by most of the sample. They had gaps of 5 - 9 months in contacts, making it unusual to attend monthly. The clinic and health visitor then were not a focal point of usage for the majority of this sample. Most mothers come to clinic very early in their childs life, i.e. 86.4% attended for the first time before their child was 3 months old. They attend infrequently, but most carry on until their child has reached 12 months of age (i.e. 69% had made attendances up to that age).

At 9 months of age, attendance drops dramatically, except for the 12 month visit which most adhere to. Overall if they go at all, mothers are more likely to attend one time in each age/month of their child's life, they are less likely to go more than once in any one month. When they do attend more than once in any one month, this is usually before their child reaches 5 months of age.

Most contacts with health carers, (i.e. HV, CMO.) are for specific tasks, assessments, immunisations, medicals, i.e. professionally inspired goals. Whilst most interviewees had one other non routine contact with their health visitor, more than 4 was very unusual. Most interviewees were unlikely to have many home visits from their health visitor, and were also unlikely to ring her up for advice. Non routine contacts with the CMO were very uncommon, whilst the majority of persons did have their medical examinations carried out.

This summary then provides a general picture of usage for this locality, which constitutes the context within which underusers for this locality can be identified. All mothers in the sample were placed in deciles along the usage scale in order to generate groups of users and underusers for comparison. In order to see how usage of services differs from the major trends for each group, to more fully comprehend what constitutes underusage some detailed comparisons were undertaken.

4.4.2. Comparison of decile groups in relation to major trends

A comparison of those appearing in the lowest decile with the summary of the majority trends in the study, shows how and to what extent they differ from the usual pattern identified, i.e. in what ways underusers differ from others.

4.4.2.1. The lowest decile members

The lowest decile mothers were part of the majority who required encouragement to have health visitor assessments carried out, and like the rest of the sample were more likely to have their immunisations done than take up other aspects of care. They formed part of the 16% who required encouragement in order to have the hearing test carried out, and part of the 46% who used the clinic 19% or less of the times available to them. Low usage of the clinic was not very unusual in this sample. They did however have higher gap scores than the remainder of the sample having missed contact with carers for more than 5 - 9 months out of the 15 monitored in the study.

Half of those in the lowest decile were like the average scorer who came early to clinic, whilst the other half unlike the rest came either late or not at all. Those who came early in this group also differed from the main sample in also leaving early too. It was common for the rest to carry on attending till their child was 12 months old or more. After one or two initial visits they did not go again.

Like the remainder of the sample half of those in the lowest decile had the medical examination done. Also like the rest half had non routine contacts with their health visitor, but these were significantly fewer than those for other decile groups. None of them had any non routine contacts with the CMO at clinic, but this was a rare occurence for the group as a whole.

As a group then, members of the lowest decile had fewer contacts with

their health visitor either in or out of clinic. Half of them show similar profiles to the majority of the sample, whilst the other half was relatively different in profiles of usage.

4.4.2.2. The middle decile members

The usage profiles of those falling midway along the decile groupings, when compared with the major trends can be seen to be the most commonly found pattern.

More required encouragement for assessments by the health visitor than did not, as with the majority of the sample. Partial uptake and those requiring encouragement exceed those voluntarily having them done.

Like the majority of the sample, immunisations were voluntarily taken up on the whole, i.e. only 1 person required follow up or persuasion. There was only 1 person requiring follow up for the hearing test, in line with the majority of the sample who required little follow up.

Members of the 5th decile contributed to the 42% of the sample who attended clinic for less than 19% of possible sessions, and also the vast majority who were content to attend for less than half the sessions available. None of them scored above 40% of possible visits, giving a fairly low uptake in this group.

The members of the 5th decile show a more varied gap scoring than those in the 1st or 10th deciles, having members in each of the 3 groups described as having low, medium and high gap scores. A small number attended monthly, and 9 had fewer than 6 months of no contact with either the clinic or health visitor. The remaining 7 had

relatively longer gaps between contacts. The group was almost evenly divided between those consistent with the majority (having gaps of 5 - 9 months) and those being more like the higher scoring deciles. Like the majority, they attended clinic early in their childs life and continued to attend up to 12 months of age and beyond.

There were some few members in this group who had not had the medical carried out, the majority had. They were more likely to have a small number of non-routine contacts with the health visitor, making them distinct from both the lower and higher scoring deciles, and like the rest of the sample relatively unlikely to have non routine contacts with the CMO.

On most features of usage then, members of decile 5 behaved similarly to the majority in the study.

4.4.2.3. The highest decile members

This decile group contributes the highest scoring users of the services, and were found on close examination of their usage profiles to be quite idiosync ratic.

These were in some ways quite different in their usage profile from the majority of the sample. Unlike the majority of the sample they did not require much follow up to ensure health visitor assessments were done. None of them required follow up for their hearing test and unlike the rest of the sample they attended clinic much more frequently i.e. all of them had attended for 39% or more of possible visits, whereas the group as a whole (92%) attended for less than 50% of possible visits.

Again unlike the rest of the sample, they had very low gap scores, none had gaps of more than 4 missing months, whilst gaps of 5 - 9 months were more usual. Clinic then was a focal point for this decile group.

Like the majority, they came to clinic early and carried on attending until their child was at least 12 months old and beyond. Their attendance however was unusual being consistent and regular over the period of the study. Like the majority, they had their childs medical carried out, but unlike the rest they had numerous non routine contacts with their health visitor, she was not just contacted for specific tasks, but was rung up by this group for advice.

Like the rest of the group they had few non routine contacts with the CMO at clinic.

Those in the uppermost decile were then quite unusual in terms of the majority in this study, and in some ways their uptake could be considered to be that most indicative of active client initiated contacts.

4.4.3. Discussion of the index

a) This is a first attempt to discriminate users from non users on a more comprehensive scale than has been done before. A number of further revisions would be necessary before it could comprise a reliable, definitive scale for use in other studies or further research. It would have to be piloted on a large number of mothers in

the population in general to have any comparative usability and compared with other scales, monitoring other factors to see how it relates in terms of validity, comparability and sensitivity. The main aim was to collect and present data of a measureable sort which would provide a clear picture of what usage was like for this particular group of mothers in this particular area. The scale does show how the clinic and health care facilities were used in the given sample over the first 16 months of each childs life. To date, data allowing for this has not been available in the literature covering uptake of postnatal services.

b) Despite reservations regarding the infancy of the scale and the specific improvements which would increase its validity and reliability, the researcher was confident that those selected out as under/non users, and high/over users would fall into these categories whichever criteria was used. Those in the lower deciles clearly did not make use of the services and so correspond to the problem groups which have given cause for concern in the literature. The high scorers made extensive and consistent use of all that was on offer to them.

c) The units of measurement cover very different kinds of behaviour. e.g. ring up health visitor, score 1, have assessment done, score 1, the only unity being that each score of 1 indicates a contact with the health service. There is therefore, no indication as to how important each item is in its contibution to underusage. Each score was, however, unambiguous and ascertainable.

d) The scores themselves are relatively meaningless, they were merely

a means of dividing the sample along measureable dimensions of usage. They give no real indication in themselves of a persons uptake e.g.

A score of 6 can mean: either one HV assessment - score 2 and all immunisations - score 4 or some immunisations - score 2 and hearing test done - score 4

A score of 22 in comparison to that of 6, could seem at first glance to reflect a significantly higher rate of usage, until it is realised that a person could gain this score from one attendance at clinic. e.g.: an early start at clinic at child age 3 months - score 13 and an early end at clinic at child age 4 months - score 4, with duration of attendance of 1 month - score 1 and medical examination at clinic - score 4.

e) The groups scored sufficiently differently between deciles to warrant being considered different in terms of usage.

f) Some weighting of scores (features of usage) might be desireable to make the scores themselvs more readily comparable with each other. As it is they serve to order the population into low, medium and high usage groups. Certain items which contribute a wide range of possible scores e.g. (items 6, 7 and 8 where is was possible to score 0 - 45 inclusive) served to spread the sample, but they do not convey any particular degree of importance to that item in terms of usage.

g) The scale as a whole relies heavily on **recorded** contacts with health carers, and consistency in record keeping across professionals and clinic settings cannot be assumed. Although health visitors and

record keepers had rules and preferences governing their recording, there was no standardisation of entries. No attempt was made for example by the researcher to influence or specify how records should be kept.

h) One major gap in the index was general practitioner consultations, home visits, etc., so that no consistent record of who used their GP service when and for what reasons could be kept. Any continued hospital care was however included.

i) The attempt to construct this scale has shown the difficulties which arise in assessing usage in any meaningful way. It does give a much more detailed breakdown than ever before of what usage consists of and how it can be monitored. It is then a first attempt to realistically portray what happened in one locality.

j) The distinction between voluntary and encouraged uptake in particular was a real problem for this study, but an important enough one to demand an attempt. The discrepancies which emerged are interesting ones, showing there to be a real difference between what can be considered client initiated contact and that brought about by professional efforts. The distinction then is an important one, easily and often overlooked by research.

4.4.4. Regrouping deciles to facilitate comparison

The deciles were grouped together to facilitate statistical analysis in the following way.

Table 5 Regrouped Deciles: Low, Medium and High Scorers

Deciles	N	T	% of sample	Mean score
1	15			21.7
2	14			50.7
3	15	44	29.5	61.2
4	18			67.6
5	20			72.6
6	11			75.2
7	13	62	41.6	79
8	15			83.8
9	14			88.7
10	14	43	28.8	99.9
totals	149			69.6

Low scorers 1, 2, 3
Medium scorers 4, 5, 6, 7
High scorers 8, 9, 10

From the discussion of patterns of usage, those appearing in the lowest decile showed more variability in scoring patterns than the more homogenous scoring for those higher up the scale. It seems then that lower scorers can be regarded as showing at least 2 fairly distinctive kinds of (non uptake), half of them showed profiles of usage which resembled that for the majority of the sample, whilst the other half was relatively different. (All details of this are to be found in Appendix 8). For comparative purposes in a statistical breakdown though, they were grouped with deciles 2 and 3 to form the lower using section of the sample.

The tables in Appendix 8, show how the 3 groups can be contrasted in terms of uptake, showing them to be sufficiently distinct from one another to be treated as separate groups in the analysis. As noted in the paragraph above some within group differences e.g. in the lower deciles are worthy of further analysis.

The patterns of scoring (in terms of percentages) in each decile grouping when compared with the patterns of scoring for the sample as a whole, show there to be 3 usage groups which could be considered as distinct from one another. These are referred to as lower scorers; middle scorers and higher scorers, and have been used in the analysis for comparative purposes.

The higher and lower scoring groups were found to have nothing in common, their patterns of scoring were quite different and, further, more in opposing directions. They were both different again from the middle scoring group on most features of the index. The clear distinctions were blurred by the following 2 considerations:

a) on a few features, both high and low scoring groups contained a significant number of members who scored similarly to the majority of the medium scorers.

b) on certain features of usage both high and low scorers can be found to be in with the majority of the sample. Even so their scoring patterns are quite distinct.

4.4.5. Participation of respondents in the study

The researcher was able to calculate usage scores and some sociodemographic data for all 149 people eligible for inclusion in the study. Interview data however, was not available for all 149, as a number did not take part, although all were approached by the researcher and invited to be interviewed.

Exhaustive attempts were made by the researcher to secure the cooperation of all potential respondents, a workload which took up the major proportion of the project time.

A significant number 37 (24%) were never in when the researcher called at the premises, at various times of the day, and evening and at weekends. Notes, letters and telephone calls did not meet with any response. A criterion of 7 unsuccessful visits and 3 follow up letters/notes/calls was adopted whereby the researcher gave up after this strategy had failed. It was felt on some occasions that the potential interviewees were at home but did not answer the door, others just could not be located at all. 6 (4%) of designated sample were lost to the study because they had left the only address known for them. In 2 cases the address on their records was found to be disused housing which was being pulled down. The remainder were empty properties with no sign of current habitation. Forwarding addresses could not be found for any of them. The 2 who were omitted had moved out of the area before interview and so could not take part. The researcher could have availed herself of help from the health visitors in the areas, but felt this would prejudice the separate identity of the research, it was not to be presented as part of service provision. It would also have been easier to take a sample from clinic or other service premises, but would necessarily have overlooked gross underusers. These had to be searched for and persuaded to take part, making the project very difficult to carry out. Only the persistence of the researcher secured the participation rate obtained.

4.4.5.2. Representative participation

After usage data had been analysed and the sample arranged in deciles, it was important to determine if some deciles had contributed a disproportionate number of either participants or non participants. It could have been possible for example for there to have been no representatives of the lower deciles agreeing to be interviewed.

Table 44 (in Appendix 9) gives an overview of participation (and non participation) in the study across deciles. In 3 of the deciles non participation exceeded participation, noticeably these are 2 of the lower and one of the middle deciles.

The patterns of participation are not regular then or in one particular direction, i.e. the lowest scorers did not unanimously refuse to take part (in decile 2 more participated than did not and in decile 6 more refused than took part.) However, participation in the study was higher for the high scoring groups, i.e. especially deciles 9 and 10, where over 70% agreed to take part. This was as anticipated, showing that those appearing in the lower deciles were indeed those least likely to participate in service uptake and research interviewing.

Summary of participants in the study

More persons took part in the study than did not. 58% took part, 42% did not. The rate of participation, though not high, is regarded as an achievement with a sample which is specifically chosen because of its lack of contact with "officialdom".

Tabulated summaries of these data are to be found in Appendix 9, (tables 43-48).

4.4.5.1. Fate of the sample

In all there were 6 possible fates for the sample, which seemed different enough to warrant comment. The aim of the researcher was to obtain taped interviews from all respondents, in the final analysis. 63 persons (42%) agreed to have a taped interview (Appendix 9, table 43).

Some 24 mothers (16%) agreed to be interviewed but did not want to be taped, they found the whole idea, disturbing or embarrassing. In these instances the researcher wrote as much detail as possible in the interview itself.

Only 17 (11%) refused to take part at all: they did not like the idea, had no time for such an enterprise or were too busy to take part at that time. Of the 17 counted as refusals, 7 repeatedly missed arrangements made for the interview, on at least 3 occasions. Undue pressure was not put on any potential respondent who clearly did not want to take part. Once the researcher was satisfied that they had understood the intentions of the project and they had refused, the matter was left. As already outlined before, 37 (24%) were never in when the researcher called, 6 (4%) were lost to the study as their addresses were out of date and 2 were omitted because they had left the area.

The participation rate was particularly low for those classified in the lower 3 deciles, 43% took part in this group. 64% of the medium scorers participated, whilst 65% of the high scorers were included in participants.

The main problem encountered was being unable to locate the target persons, 24% of the sample were never in when the researcher called, despite repeated attempts of varying sorts to include them in the interviewing. The percentage, 'never in' increases to 40% for the lowest scoring decile group, showing them to be one of the hardest groups to secure for interview. The lower decile groups were however represented in the interview phase of the study, whilst the highest scoring decile groups 9 and 10 were very well represented, there being over 70% participation here.

When an overview of the fate of the 149 original members of the sample was under taken, it became clear that refusals to take part were just as likely to come from the highest scoring deciles as they were from the lower and medium scoring ones. Those excercising their preference not to be taped were also likely to come from any decile. All decile groups contributed participants to the study, making the data collected reasonably representative of the whole sample. The lower scoring groups were however, slightly under represented and this was taken into account in the interpretation of data. Participants were on the whole representative and typical of their decile membership in scoring.

4.4.5.3. Sociodemographic comparison of participants in the study

It was necessary to try to assess how representative of the sample as a whole participants were in terms of sociodemographic features. These were only available from interview data for some dimensions, making exact comparisons impossible. However, there were 2 sociodemographic factors where data was available for those participating and those not participating in interviews. These were partners occupation which could be collected for 125 persons (83% of the sample), and type of property occupied which was collected for 115 persons (77% of the sample).

Table 6 Partner/father's occupation

Data were available for 83% of the total sample (N = 149); which was compared with data from participants agreeing to be interviewed N = 87 (58% of the sample).

	WHOLE SAMPLE		PARTICIPANTS	
Occupation	Frequency	%	Frequency	%
Unemployed	12	8	10	11
Student	1	.6	0	-
Unskilled	30	20	17	19
Skilled	50	33	38	43
Non Manual	20	13	13	14
Professional	12	8	9	10
Unknown	24	16	0	-

Participants in the study were not noticeably confined to any one occupational group, each group was reasonably well represented.

Table 7 Type of property

Type of Property	Whole Sample Frequency	%	Participants Frequency	%
Private flat	2	1.3	0	-
Private house	65	43	49	57
Council flat	9	6	7	8.2
Council house	36	24	28	32
NCB house	3	2	3	3.5
unknown	34	22	0	-

Participants were not confined to any particular type of accommodation group, the breakdown being essentially similar to that available for the sample as a whole.

The researcher was reasonably confident that those who participated in the study by being interviewed were not untypical of the sample as a whole in any particular or consistent way. They were representative of all groups in the catchment area, at least in terms of the factors on which comparison could be made.

4.4.6. Relationships between sociodemographic and usage data

Various comparisons were undertaken to determine if the deciles contained members who were distinctive in terms of sociodemographic factors from one another. A Summary of the relationships tested for significance can be found in Appendix 10 (Tables 52-71).

Overall, the tested relationships between position on the usage index and various sociodemographic features did not yield significant results. The trends which were noted from the tables of percentages presented (in Appendix 10) were as follows:

1. In contrast to preceding research findings, both high and low scoring interviewees tended to be younger than the remainder of the sample, although lower users were under represented in the older age group.

2. Lower users were more likely to have partners in lower social class occupations, a trend in keeping with that found in other research. However, high scorers were also likely to come from the

lower socioeconomic groups, showing there to be no consistent trend between social class membership and usage of services.

3. Lower decile members were more likely to come from those occupying either council or NCB owned accommodation, in contrast to medium scorers who were over represented in private sector housing.

4. Lower decile scorers and higher decile scorers were both likely to belong to lower socioeconomic groups as reflected in interviewees previous occupation, a finding complementary to point 2 above. One means of discriminating between members of the lower socioeconomic groups suggested by the percentage distribution in the tables was that low scorers were unemployed before becoming mothers, whilst high scorers were employed in mainly unskilled work prior to motherhood.

6. In terms of educational matters, low and high scorers were less likely to have attended grammar school than middle scorers. Middle scorers tended to stay on at school after the age of 16, unlike low and high scorers who left before that age. Medium scorers tended to have qualifications in contrast to low scorers, making the data on educational matters fairly consistent. There were no visible differences in subjects of relevance to health education in the sample.

7. An attempt was made to monitor the stability of living arrangements in the sample in order to relate this study to previous research which sees haphazard, feckless and erratic living patterns as contributing to underusage. The features chosen to measure this are subject to a number of difficulties. They were chosen by the

researcher informed by the literature relating to underusage, but have not been tested for validity or reliability in terms of what they propose to assess. Fine discriminations in the categories were not preserved due to the small numbers in the study, comparison demanding gross groupings to be presented.

8. In terms of the length of time the interviewees had lived in their present accommodation, both high and low scorers would be considered 'less stable' having spent less than 2 years there. They were not more likely to have moved house many times though, making assertions about stability of living arrangements tenuous.

On the face of it, the number of house moves would seem more likely to reflect stability of residence, than the length of time spent in current accommodation, but as both high and low scoring interviewees tended to be younger than medium scorers, maybe this accounts for their lower rate of moves, i.e. older people (medium scorers) are more likely to have moved house more times than younger people. The ages for each group were not vastly different, and if age were the main determinant of house moves one would expect the higher scorers to show more house moves than lower scorers. From table 70 (Appendix 10), it can be seen that this was not the case, both low and high scorers having made less house moves. In any case with such small numbers it is difficult to be sure if trends are to be treated seriously or not.

9. At time of interview, low scoring groups contained more members who were either single parents or separated than the other groups, although the majority (as for other user groups) were married. High scorers in particular contained a large percentage of married

interviewees. If this is regarded as a more stable arrangement then, the lower scorers again can be regarded as containing marginally more members with less stable living arrangements.

10. Regardless of conventional indicators of stability, the research tried to assess how well established relationships were, whether married or not, to see if the same trend held. In terms of how long the interviewee had known the father of her child, only high scorers were noticeably different from the rest of the sample, in having known their partner for less time than others, whilst medium scorers were more likely to have known their partner for over 6 years. When the number of years the parents have been living together is taken into account (thus omitting single and separated interviewees) lower users were more likely to have either been living with their partner for less than 2 years, or over 6 years, than medium or high scorers. In terms of this parameter the lower user group displayed both unusually 'stable' and unusually 'unstable' living arrangements in terms of the group as a whole, whilst single parent interviewees were more likely to underuse the services - a consistent and persistent finding in previous research as outlined in chapter 1 of the thesis.

11. Assertions as to neighbourhood contacts being conducive or not conducive to usage of services were not borne out by this study. There were no noticeable trends which could be put in the service of either interpretation.

12. Overcrowding was minimal and of equal incidence across decile groupings.

13. Lower scorers were much more likely to have housing problems, due to the property being in a poor state of repair than any other group. Both medium and high scorers being content or very happy with their property.

14. The length of time it took interviewees to get to clinic and general practitioner surgery was slightly less for the high user group, but not noticeably longer for low user groups in relation to the whole sample.Both lower and medium scoring groups took over 10 minutes to get to their general practitioner surgery, diluting any proposed relationship between usage and geographical proximity.

The under-representation of lower decile members as participants in the study, contributed to the difficulty of interpreting the trends, although the percentages presented took into account the lower response rate evident in these deciles and so comparisons are fair. Due to the lack of statistically significant findings, the comparisons must be regarded as essentially descriptive.

The discussion has been confined to trends evident in the tabulated percentages occurring in each category, none of which reached significance levels. In those comparisons for which more data was available, the trends almost reach significance levels, but it is not possible to be sure if the trends discussed would be significant had larger figures been available. Some features were noticeably exploratory in nature (e.g. stability of living arrangements) and would require solid grounding before being considered salient dimensions on which comparisons can be made. They were included in order to directly facilitate testing of results reported in previous research.

A gross comparison of the lower, medium and upper scoring groups revealed lower and higher scorers to be more similar to each other than medium scorers in terms of sociodemographic features. None of the trends reached statistical significance, but they were consistent across the sociodemographic features documented. There follows then a tenuous characterisation of each usage group in terms of their similarities and differences in sociodemographic terms.

In contrast to the middle scorers, the higher and lower scoring groups were similar on a number of features. They tended to be younger, to come from the lower socioeconomic groups, were less likely to attend grammar school or have any qualifications. They contrast with one another in other respects as the lower scorers were distinct from the higher scorers in their tendencies to live in tied accommodation, to be separated or single parents and unemployed prior to becoming mothers. They also tended to be less content with the state of their accommodation and to have fewer domestic facilities.

The Medium scoring group was distinctive from the others in the following respects; they tended to be older than high or low scorers, were more likely to have partners in higher social class occupational groups, and be living in private accommodation. They had professional occupations prior to motherhood, attended grammar school and had some qualifications.

They were more likely to have known their childs father for longer than other groups, and have been living together for between 4 and 6 years; to be content with the state of their property, and have access to more domestic facilities (i.e. washing machine, telephone and car).

These characterisations are gross generalisations derived from the trends observed. They merely point out the ways in which each group contained distinctive members who behaved sufficiently differently from the majority to warrant comment. The groups each contained persons whose sociodemographic profile was like that of the majority in the study and the trends pulled out did not reach significance so that the characterisations are in a sense an exaggerated and simplistic picture of the sample. They were drawn up for descriptive and comparative purposes not to be taken as robust dimensions on which the sample can be divided.

It is tempting however, to speculate on the significance of the similarities between the highest and lowest scoring groups. In terms of 'at risk' criteria, they would both be considered vulnerable and in need of particular attention from the services, whilst the middle scorers could be regarded as containing those least 'at risk' in terms of health matters. It seems that those enduring the least favourable life circumstances are both more likely and less likely to make use of provision, than others who are more comfortably placed. (Any explanation of underusage which makes reference to life circumstances, would have to embrace both under and over users of the services, the one which avoids involving provision in their lives and the other which most actively encourages professional help.) It seems then that both avoiding and encouraging professional involvement are strategies employed by those who are most vulnerable by virtue of their life circumstances. One possible thread of unity would be to see both as reactions to the anxiety thought to accompany poor life circumstances. The higher scoring group enlist the help of

professionals in their concerns, whilst the lower scorers avoid any such contact. This theme is returned to in the analysis of the qualitative data where it is given some support by the finding that the lower scorers tended to have little faith in the ability of professionals to help them.

4.4.7. Selection of case studies for in depth qualitative analysis

As those members of the lower deciles were the most difficult to locate and the concern about underusage was the main focus of this study, particular attention was given to the interviews obtained for these groups. Ideally the researcher would have preferred to present detailed case studies for all those who took part from the lower deciles. In practice this was not possible.

From table 71 (in Appendix 10) it can seen that of the 29 persons falling into the lowest 2 deciles of usage (i.e. scoring 57 or less on the usage index), 10 taped interviews were obtained. One taped interview was unusable as it had not recorded the interview clearly enough to be transcribed, another 3 were not suitable for analysis as the health visitor was present throughout the interviews, and they were noticeably different in tone and content from the others. This left 6 taped interviews which produced suitable data for analysis, which are presented in the qualitative section on underusers.

4.4.8. Summary of underusage index results

Given the many and varied problems in the definitions of usage/non usage, the researcher decided to start afresh (i.e. not adopt definitions of usage supplied in other studies) by documenting all types of contact a mother could have with the health services in this

locality over the first 16 months of her childs life.

What would be considered adequate usage from a professional point of view was investigated, being defined as that which would ensure a child received adequate surveillance for the first 16 months. After piloting the professionally inspired checklist it was rejected in favour of a more comprehensive one which satisfied the aims of the study more appropriately.

Results are then presented which show the patterns of usage across the sample, what most people do take up and which aspects they do not make maximum use of.

It was found that considerable follow up by health visitors was in evidence in ensuring all 4 assessments were carried out. By contrast most interviewees had turned up voluntarily to have their immunisations and hearing test carried out.

Few made maximum use of the clinic sessions available to them, and clinic was not attended on a particularly regular basis by most of the sample. Most attended clinic initially before their child was 4 months old, and attended up to the 12th month, whilst overall the numbers attending fell steadily over the 16 months monitored. It was unusual not to make an appearance at clinic at all, or to come for only a short period of time. The peak in attendance evident at age 12 months, showing that interviewees tend to attend for specific purposes or procedures, in this case the 12 month medical offered at this stage. Relatively frequent attendance (i.e. an interviewee attending clinic more than once per month of her childs life) was rare

and only occurred in the first 4 months, whilst most interviewees do have at least one medical carried out. Non-routine contacts with health visitors were not numerous in most cases, and the sample as a whole were unlikely to ring her up or request a visit.

To facilitate comparisons and delineate underusers the sample was divided into deciles, and typical profiles of uptake for each decile group outlined to show what membership of each decile meant in terms of usage.

Overall it seemed that members of deciles 1 and 5 behaved (in terms of usage) in ways consistent with the majority of the sample, whilst the membership of decile 10 were quite unusual and could be considered as those displaying the most active, client initiated uptake.

Reservations regarding the use of the index were outlined. The scores themselves were meaningless and merely a means of dividing the sample into positions along a scale of usage. The positions along the scale (i.e. deciles) were sufficiently distinct to warrant treatment as separate groups, whilst the scales reliance on recorded contacts was noted. General practitioner consultations were not available and would have provided a more complete picture of uptake.

In order to facilitate statistical analysis, the deciles were grouped together to form lower, middle and upper scorers. Problems with regard to treating all members in each of the 3 groups as similar were outlined. In particular those in the lower scorers showed 2 distinct patterns of uptake whereby half of them could be considered as similar to the majority of the sample, whilst the other half were quite

different and constitutive of the gross underusers. A thorough comparison of the 3 decile groupings on each aspect of uptake showed them to be sufficiently distinct from one another to justify treatment as separate groups in subsequent analyses. They were distinct from one another in their pattern of scoring, whilst the higher and lower scoring groups were not to be regarded as exceptional in all ways from the majority of the sample.

A number of the target sample did not personally take part in the study. Those who did agree to be interviewed were investigated to assess how representative they were of the sample as a whole.

Across deciles the pattern of participation was not particularly consistent or in a particular direction. Lower scorers did not unanimously refuse participation, but were more difficult than others to include in the study. Participation from the higher scoring group was noticeably more forthcoming.

Participants were further found to be representative and typical of their decile group. The slight under representation of lower scores was taken into account in other parts of the study dependent on participants for data.

Relationships between decile position and sociodemographic features were tested for statistical significance. Due to the small numbers being dealt with, highly significant results were not obtained. Only trends evident in the data could be discussed, and are to be regarded as descriptive rather than definitive.

4.4.9. Comparison with previous research

In keeping with earlier research on underusage outlined in Chapter 1, the lower users tended to come from the lower socioeconomic groups, and had more members who were single parents or separated at the time of interview. Higher scorers took less time to get to both their clinic and general practitioner, than medium or lower scorers, but the relationship was not consistent, as lower and medium scorers took similar amounts of time to get to these facilities. Lower users were more likely to report severe problems with their accommodation.

In contrast to earlier research, both higher and lower scorers tended to be younger than the sample as a whole, and were both over represented in the lower socioeconomic groups. One possible destinction between them may have been in terms of employment prior to motherhood. The higher scorers were more likely to have been employed, and the lower scorers to have been unemployed prior to motherhood. They were both different from the middle scorers, in educational terms, who had stayed on at school and gained some qualifications. Both higher and lower scorers were found to have less stable living arrangements on some indicators and more stable than middle scorers on others. The operationally defined indicators of living stability were tenuous and inconsistent. There were no noticeable trends in neighbourhood contacts enjoyed by the sample in relation to usage. Some of the issues raised in the research summary can be addressed by these.

With regard to definitions of usage/non usage, very few members of this sample did not attend clinic at all; rather the main problem was poor/low attendance by a majority of the sample, and the lower

socioeconomic groups in particular, bearing in mind that the higher attenders (also predominantly from the lower socioeconomic groups), made the most effective use of all the services. Thus the DHSS' 1978 identification of poor attendance by lower socioeconomic groups as the main problem is partially confirmed and requires alteration to take account of high scorers. McWeeny 1971 drew attention to non attenders, who make up a very small part of the problem, i.e. N = 5 in this study in contrast to 46% who attended for 19% or less of the available sessions.

Very few come to clinic and cease attending early (N = 16) (as identified by Acton 1978), whilst late takeup was applicable to only 4% (N = 7). Rather the problem is that as identified by Jeffery 1971 and DHSS 1978 of inadequate take up, prominent in this sample.

Spencer 1978 found a higher percentage of lower socioeconomic group mothers were not seen by clinical medical officers at clinic, which would be confirmed by the uptake monitored in this study, i.e. over 95% of the lower scorers had no non routine contacts with the CMO, i.e. their contact was limited to receiving immunisations or medicals. It was very uncommon for any interviewee to have non-routine contacts.

However, a very small number had no contact at all with the CMO, N = 4 because the majority at the very least had their immunisations carried out.

The lower rates of immunisation uptake by members of lower socioeconomic groups (Blaxter 1981) was confirmed by this sample but

not markedly so. More of them required encouragement than other groups, but the majority voluntarily attended for them. The issue of poor service response cannot directly be assessed by the data in this study however, it was possible to see if non attendance at clinic was compensated for by more home visiting.

The number of home visits includes, requested visits, assessment follow up and hearing tests being done at home i.e. all visits during the 16 months of the study. One would expect there to be a link between clinic attendance and the number of visits to clients homes if non attendance leads to more follow up.

It can be seen that the lowest scorers were more likely to be visited at home more times than the average, showing that health visitors did compensate for non attendance, in contrast to Blaxter's 1981 assertions to the contrary. However, it can be noted that 47% of the under users were not visited more often than average showing that compensation is not uniform or complete.

When we take into account the number of non routine contacts with the health visitor (i.e. an assessment of active uptake of this service), it can be seen that the lower scorers in particular have no non routine contacts, i.e. contact with the health visitor was limited to tasks or specific tests to be done. They were not likely to ring her up or have many non routine contacts with her. The compensatory home visiting then was confined mostly to routine testing for the gross underusers.

4.5. CONCLUSION

The usage index achieved a number of the aims of the study. It enabled the researcher to identify non users/under users of the services in this population, and to be able to pick out those requiring more detailed analysis in the qualitative section. It was a highly discriminating index, revealing both between and within group differences worthy of comment. The detailed picture of what usage was like for the sample as a whole, showed how mothers selectively make use of the services, and how and in what ways underusers differ from the majority. Attention was drawn to the importance of the distinction between client initiated and professionally initiated contact. The discrepancies found between voluntary uptake and actual uptake were considerable and worthy of attention, allowing for an assessment of active voluntary uptake by the sample, on which the higher scorers could be considered unusual.

CHAPTER 5: MAIN STUDY: CONTENT ANALYSIS OF INTERVIEW DATA

INTRODUCTION

There were a number of different kinds of questions which this research project set out to answer, and whilst it was found appropriate to adopt a phenomenological orientation for the in-depth exploration of under users' accounts, there were other questions of a more general nature which could be addressed by a content analytic approach. Here, the emphasis was on finding out how the mothers as a whole related to service provision and becoming mothers for the first time, what were the most frequently mentioned problems, and what kinds of problems they faced.

The questions included in the interview schedule (in **Appendix 11**) related to the 2 main areas of interest in this research. Firstly, **becoming a mother** for the first time, what the experience was like, and the sorts of problems and kinds of help that are needed, and secondly, **relating to the services** for mothers; how each aspect of provision was experienced; the problems and good aspects of provision, and how uptake was perceived.

5.1. CATEGORISATION OF INTERVIEW DATA

In this section the responses of the sample as a whole to the various questions asked in the interview schedule are presented. The answers given were grouped into categories of responses which could be contrasted with one another. All responses to each question were included in the analysis, grouped into categories which could contain each range of views.

Questions in the interview schedule were phrased in particular ways which affected the scoring patterns produced, e.g. general questions like 'Did you have any worries or problems during this past year?' often elicited vague overall replies like 'not really', whereas on further specific questioning where the researcher ran through a list of possible problems (identified in the pilot work) and the interviewee was invited to comment on each one, the presence or absence of each type was more accurately determined.

This form of questioning was generally preferred in this study, a general open question directing the interviewees attention to a particular topic, which allowed her to specify areas of relevance, which was then followed by more specific probes covering specific issues of interest to the study.

The problem of forming categories of broader or narrower scope is one faced by any categorising of material, categories can be so general as to be an ineffective means of detecting any differences, whilst very specific ones may relate to the responses of only a very few persons.

Broad categories were formed in this study which could contain all shades of responses (usually on a positive/negative continuum) and those who were 'unsure' or 'didn't know'. These were then illustrated with particular examples which show the specific ways in which the responses belonged to the category. In most cases, the categories emerged immediately as obviously different responses were being offered.

Illustrative quotes are presented where these help to convey or illuminate the nature of each category of responses, and were chosen on the basis of their being particularly vivid representations of the category or comprehensive containing most/all the elements relevant to the category.

Each section of the interview schedule indicated an area of interest, and a range of questions to be asked in order to explore the area. In the analysis the categories represent conflated answers to the range of questions along the major lines of difference which emerged from each area as a whole i.e. the answers to each question were not presented separately. From the pilot work on interviewing it proved more fruitful to proceed in this way, rather than simply ask one question and categorise the responses to it.

5.2. STATISTICAL ANALYSIS OF CATEGORIAL RESPONSES

The analysis was carried out with two main purposes in mind. First of all to find out what the sample as a whole had to say about various issues relating to: (a) motherhood (what the main problems were, and what they would do in future pregnancies) and (b) usage of the services in general. This allows for a more comprehensive appreciation of what a group of first time mothers see as their needs at this time and how and to what extent these were met by service provision. Secondly each set of responses was analysed with respect to uptake of the services, to see if there were any views/comments on which users, and non users could be considered distinct from one another. Similarities and differences in categorial responses were

analysed to see where these lay both within and between the 3 categories of uptake identified by the usage index, (outlined in chapter 4).

A tabulated summary of the interview data is offered in Appendix 11, where each question area of interest is presented with a tabulated breakdown of the responses given, arranged according to decile membership.

The responses in each table were tested for significant relationships with usage (using chi squared techniques as the tables are presenting the number of times a particular response was offered) to detect whether low middle or higher scorers were significantly more likely to offer any of the categorial responses.

On most of the questions asked, the decile groups were not found to be significantly different from each other in terms of the categorial responses tested. Similar numbers of each decile responded in similar ways to the questions asked, or at least the responses offered by each decile were not distinct enough to render a statistically significant chi-squared value. Where a non significant result is noted then, the conclusion is that the feature in question cannot be regarded as having a direct bearing on uptake patterns found in the sample. In these cases only the pattern of response for the sample as a whole is regarded as the important information yielded by analysis. Where there are no differences in categorial responses **between deciles,** the frequencies of responses were then presented in terms of percentages, to show what the pattern of response was like **within each decile** group.

The chi-squared technique was again used in order to obtain a measure of the significance of discrepancies in the percentage distribution of responses within each decile in relation to the distribution for the sample as a whole. (A test of 'goodness of fit' between each decile distribution of percentages and that of the sample as a whole).

This was done in order to measure to what extent the observed percentages appearing in each decile category were different from those which obtained for the sample as a whole (the expected frequency of response), any discrepancies being reflected in large values of chi-squared. Where discrepancies were found this indicated that the decile group was significantly different from the sample as a whole in its pattern of responses.

When this occurred, then, the decile groups were not to be regarded as significantly different from each other in categorial responses, but significantly different from the patterns of scoring for the sample as a whole in certain ways which are then laid out, and discussed. Distinctive features of each decile groups' response patterns show the ways in which members of each group can be regarded as different from the rest of the sample, and so are useful guides to interpretation. They offer suggestions of trends in response preferences which have a bearing on, but are not directly related to usage.

In Appendix 11, each table heading indicates the area of questioning being covered, the range of responses offered in a categorised form and the percentage of respondents offering each type. The chi-squared

result is placed beneath each table to indicate where any significant trends were in evidence.

What follows then is a summary of the main findings in the interview data subject to content analysis, which relates the ways in which the sample as a whole related to a) becoming a mother, and b) their relations with service provision. Where quotes from interviews are given, the respondents identification number follows.

5.3. RESPONDENTS VIEWS ON BECOMING A MOTHER

Child rearing

There were no differences between the deciles in those claiming to have learnt from their family about childrearing practices or not. Assertions about the family being the preferred source of advice and help for underusers in particular, then, were not supported by this data. (Data: Table 73, Appendix 11)

Preparation for baby's arrival

Over half (54%) the responses indicated respondents had no problems in preparing for the arrival for their baby. For those with problems, these fell into 4 main categories. Housing problems were the most numerous; e.g. repairs to the flat not being completed in time, or it being impossible to heat the premises adequately. Money problems (16%) were due to unexpected crises:

> "we were alright at first, but then my husband got laid off, so we didn't have much money to get all the stuff together" (110)

or a constant problem:

> "we never seem to have enough to go round, so getting all the stuff together was a strain" (95)

There were a few mothers who felt they had been given poor advice on purchases, which cost them dearly (9%):

> "we got far too much stuff in the end; stuff we'd never use" (81)

or was difficult to obtain. (Data: Table 77, Appendix 11)

Major worries during first weeks

The respondents were asked to enumerate their major worries on first coming home with their child, in an attempt to find out what mothers needs are at this time. Only a small number of respondents could not remember being particularly worried about anything. (7%) For the majority problems were mostly to do with feeling competent to care for their child; worrying about doing everything correctly, a difficult task for those who constantly had to worry about providing food, warmth and clothing on a meagre income (28%). These problems were heightened with the advent of a child requiring special equipment, and arrangements (22%):

> "getting nappies really clean with no hot water...hoping the damp wouldn't get on to her (baby's) chest, and just keeping one room warm all the time...it was all them" (94)

The need to cope with an additional workload, requiring untiring efforts 24 hours a day worried some mothers (16%):

> "I felt tired and not fit to cope, and the baby was sick a lot which was a worry, and I didn't know if I could manage alone" (157)

whilst feeling ill themselves or worrying about the possibility of their child getting ill (8%) was a worrying feature of their first few weeks of motherhood for others;

> "I used to feel very alone and worry a lot, would she (baby) be alright? when would I start to feel strong again..." (38)

Those who were suffering from depression expected it to go on forever (3%):

> "I couldn't see no end to it at all, just crying and not sleeping and spending all days right at the bottom" (94)

Ten percent of respondents remembered their ability as a mother being directly challenged by a professional causing them alarm and considerable anxiety;

> "clinic accused me of overfeeding her (baby), but they rely on statistics and just say 'you've got a fat baby' which scared me to death at the time; and next time, health visitor seemed to have forgotten what she said, I don't think they care enough about what they say, they just say anything to you..." (76)

> "she had a real cheek that one (HV), she says 'Oh I think you could do to soak them nappies, to get 'em really clean' as if they weren't clean or sommat, and I'd spent all time with my hands in dish, they were clean, it's just they weren't brand new..." (158)

(Data: Table 78, Appendix 11)

Problems for the first year

For the first year as a whole, there were 4 main problems identified by the respondents as standing out. Feeding was the major cause of concern, "getting it right" (158) was a constant difficulty (40%), changing from breast to bottle feeding and most common of all the baby being sick:

> "she were just sick all the time, and no-one seemed to know how to stop it" (103)

Possible illness of the baby was a major source of concern, to do with whether the baby was growing healthily (having a bent toe, turned up toe, turn in the eye) or the consequences of accidents (falling, banged head on floor, fell down stairs, knocked teeth out) sometimes exasperated by the incompetent care offered by professionals (24.8%):

> "She (baby) knocked herself out and I rang doctor, and receptionist said just to let her sleep till doctor could get out, and when midwife came she said that was worst thing I could have done!..." (93)

Other illnesses were bronchitis, colds, 'flu, bleeding cord not healing quickly. Having a baby who just would not settle was very wearing for some, constant crying and struggling being put down to wind, the cold or just unknown causes (11%). Some mothers remembered immunisations being problematic, (11%) sore lumps developing at the injection site, sickness and diarrhoea after the injection, and worry about side effects or possible damage to their child. (Data: Tables 79, 80 and 84, Appendix 11)

Help and advice

Some of the respondents felt they had problems in obtaining help and advice during the first year (25%) or found advice was conflicting or innappropriate and led to self reliance (25%):

> "at clinic they haven't got a brain between them, idiots, and what's more they haven't even had kids, so how would they know! so I just did what I thought" (93)

> "What was wrong was all the conflicting advice, that was worse than none at all, so I tried to go it alone" (157)

They were not sure where help and advice could be obtained:

> "everyone said 'Oh that's a good idea but it's up to you, don't come to me for advice' or they only told me what I already knew, not what to do or who to turn to" (38)

or were ill prepared for the realities of motherhood: (17%)

> "no-one told me what to really expect, it was the shock really of having to give up work to be a mother" (93).

Those who felt they had plenty of help and advice had relied predominently on their own mother or family members who had children

(23%). The remainder who did not consider help and advice to be inadequate preferred to just get on with it (9%), relying on their own experience and intuition. (Data: Table 81, Appendix A11)

Financial problems

Respondents in well paid households did not find having a baby to be a particular problem financially (6%). The majority of those who did have financial problems relied on their family for support; (36%)

> "my husband was on strike and we had to manage on family allowance, the big things got bought by family and I got gifts from work which turned out to be essential. We still find it hard going, it's never ending expenses... now its shoes..." (76)

and

> "essentials always come first, there's now't left for anything else so we just do without... we relied on friends for all large items... I suppose we were quite lucky there..." (108)

The sudden loss of one of the two incomes, and additional expense of the child contributed to the problem; (15%)

> "suddenly there was no income from me and managing on one wage was very hard, ... the unemployment are reviewing my case... they messed me around so I'm hoping to get a very large cheque..." (156)

Second hand goods have been widely used as a strategy for survival;

> "most sufff I'm afraid is second hand. It's been a nightmare with shoes at '7.50 a pair, we just can't afford them." (93)

> "If I'm really being honest with you I've just got a lot of things second hand 'cos I knew he (baby) would grow out of 'em quick... Oh and lots of home knitting" (38)

(Data: Table 82, Appendix A11)

Illness of mother

Those who claimed they had no time to be ill formed the majority response to questions about the interviewees state of health; (51%)

> "When we all had flu it was terrible, I just had to drag myself around doing things, there was no time when I could be ill and go to bed" (76)

> "I had all sorts of infections and pains, but no time to think about it, just carry on regardless" (93)

> "I think I had nervous exhaustion really, along with thrush, ceptitis (sic), colds and being run down, there are times when I've just wept, getting uptight... but it's all just a state of mind really... you get on with it." (52)

It is clear that they were ill at times through the first year but could not afford to recognise this and be sick, or have a rest. Those who found they were suffering from depression had a particularly bleak year; (15%)

> "I got depressed six months after he was born, I was just lying in bed and couldn't move an eyelid. The doctor came twice and gave me tablets to help me sleep. I was tired out you see, run down and in the end my mum came to stay to help out... you just don't feel anything, not even for your baby, you have no interest at all... we couldn't go out either 'cos we had no pram so I just had to sit in all the time while he (husband) was out with his friends...he was awful then... he blamed me saying I knew what I was taking on which I didn't...you see I just tried too hard...and I got no break" (93)

Those suffering from long term illness were 1 epileptic, 1 asthmatic and 1 bronchitic which presented particular problems e.g: (3%)

> "I've only had 2 fits since the birth, but all my worry was about the pills I'm supposed to take and them getting into my breast milk, so I didn't take them when I thought I shouldn't... the doctor didn't seem sure what was happening..." (81)

11% of the respondents complained of disfigurement resulting from the pregnancy and birth which left them feeling unattractive and unhappy;

> "there's marks left all over the place, it's horrible... I would never go swimming now..." (157)
>
> "I used to be right slim and smart before all this... now it's lumps everywhere and none of my clothes fit" (46)

(Data: Table 83, Appendix 11)

Illness of baby

Respiratory type problems were those most commonly reported (36%) when respondents were asked what kinds of illnesses their baby had had, which covered flu, cold, chills, sniffly, temperature and coughing. Teething was the next most common 'illness' talked about (39%) which caused a lot of night time crying and loss of sleep for respondents who found their child difficult to soothe. Colic was particularly disturbing to the respondents for the same reason, that there seemed little they could do to help their child with the pain (16%). Other infections and bad crying through the night were relatively uncommon (9%) and (6%) respectively. (Data: Table 84, Appendix 11)

Quality of life

When asked to enumerate what they had missed most since becoming a mother, the most common response was freedom, time to oneself (39%)

> "I'd like the freedom of doing something, just when I feel like it" (158).

Having one's own money was also missed; (21%)

> "I hate having to depend on my husband for money" (69)

linked with missing work outside the home, as was the restricted social life; (16%)

> Sometimes it's a long time before I see anybody, so I do get a bit lonely,... the only people I know are from work and... I don't know the neighbours, so I've got nobody really" (38)

Only a small percentage did not miss anything of note (5%) and considered their life as a mother unreservedly better than before. (Data: Table 99, Appendix 11)

5.4. RESPONDENTS' VIEWS OF SERVICE PROVISION

Knowledge of provision

None of the respondents claimed to know a lot about provision, but as they were all first time mothers maybe this is not so surprising. As a whole their responses indicated either they knew nothing at all 69%, or some parts and not others 31%. There were no differences in response patterns between deciles, showing the sample as a whole to feel equally uninformed. The majority of respondents claimed to know nothing about provision, prior to becoming a mother. A typical response being:

> "My own G.P. was involved like, but I didn't really know enough about it all, where to go and what to expect..." (95)

(Data: Table 74, Appendix 11).

Hospital stay

Only one third of the sample reported having no problems with their hospital stay, for the remainder the experience was marred by one or more notable costs. The main complaints were with regard to the treatment meted out to mothers by the staff. They remembered feeling humiliated, neglected, and degraded being forced to do things against their will and subject to unnecessary pain from callous staff.

One interviewee conveys particularly well how difficult it was to secure help:

> "nobody was outright nasty, it wasn't something you could put your finger on, so I couldn't actually complain about anything or anybody in particular, just there was no-one around... you don't like to ask for anything when you think they're busy... you always felt as if you were being a nuisance... so none of us actually rang the bell...you just felt cut off" (38)

or even be sure of what was wrong. Others were more certain:

> "I was terrified, it was awful, always on edge with them and I hate being told what to do, ordered around like a fool" (41)

The sheer range and prominence of problems experienced whilst in hospital are worthy of noting in their own right, but could be regarded as setting up expectations with regard to future contact with health care personnel. There were no differences between decile groups showing this to be unrelated to gross underusage, but it may have been contributory to low levels of usage and poor service expectations. (Data: Table 75, Appendix A11).

The next service professional the sample met was the midwife, where there was a large majority of positive appreciative responses like (92%):

> just knowing she was there helped, I never felt alone... one night the baby wouldn't stop crying and in the end I rang her up, ... and she told me what to do then and there... she were lovely" (38)

Those who had a poor relationship with their midwife were afraid of her;

> "they always have a look through the windows, so I was a bit frightened really" (52)

felt they were being checked up on:

> "just in and out in 2 minutes, just to look round the house and see if it's clean, so you're on your own really" (41)

or subject to incompetence;

> "You can't trust 'em, she said stitches would dissolve, but then she had to cut them" (69)

There was no significant relationship between decile grouping and positive or negative relationship with midwives. (Data: Table 76, Appendix 11).

Attendance at clinic

The majority of respondents were apprehensive about attending clinic (71%). Apprehensions about going to clinic were to do with not being sure of what would happen there, and being subject to judgements as to one's adequacy as a mother. Dealing with a new baby in a public setting was an ordeal;

> "I was just terrified that I'd drop her in public" (52).

> "I was in a right state... tried to be careful and that, it was all a bit embarrassing, I was all hot and flustered and she (baby) was crying a lot..." (69)

> "I knew I was going to have to deal with her (baby) in front of everyone... feeding her and her crying and I was scared of making a fool of myself' (94)

> "'cos it's a new baby you've got, you're sure they're watching you, you're sure they're checking on how you do it" (110)

and not knowing the system was awkward:

> "I thought it was just weighing... but then I had to go and see everyone... luckily my husband came with me first time 'cos I was a bit nervous" (76).

Those with positive expectations knew what went on there (29%).

(Data: Tables 85 and 86, Appendix 11).

Functions of the clinic

The clinic was recognised primarily as the place for weighing babies (40%), and to a much lesser extent any other function. It was rarely regarded as a place for socialising (12%), even by those who enjoyed their visits;

> "It's very nice, small and friendly and you can see a doctor there every other week, there's no problem there, so you don't have a problem for long... it's best for the small things, which are always big to you, but silly to ring someone up about" (38).
>
> "the health visitors were always right pleased to see us and said summat nice about baby and remembered anything I'd said were worrying me, it were right nice." (158)

22% regarded clinic as a source of advice and 17% as where various tests could be had. (Data: Table 87, Appendix 11).

Preferred system of attendance

The majority preferred the pop in system (69%) currently in operation at all clinics in this locality mainly because this left them free to determine when they would go;

> "You can't be expected to keep appointments" (43)
>
> "then you don't have to go every week or every so and so" (69)
>
> "so that you're not tied down a time or a day when you've got to go no matter what" (83)

More sessions of the pop in variety could help;

> "you have to wait hours, that's the only problem, why can't they have two days a week when they're on ?" (93)

Those who would like an appointment system (6%) offered two reasons for this. Waiting times would be reduced and they could get a more personalised service;

> "that way I could see my own health visitor for assessments, and not just anyone who doesn't know us" (41)

(Data: Table 88, Appendix 11).

Unproductive clinic visits

Respondents were asked if they'd ever preferred not to go to clinic for any reason or found it a waste of time when they did go. A majority (as found in pilot work) concorded with these sentiments (45%), but continued attending as a safeguard for their childs welfare (12%). Those who claimed they preferred not to go had most often had an unfortunate, undermining experience when they had been:

> "I didn't want to go back when they said she (baby) was overweight, and another said another thing" (41)

> "we (the health visitor and I) disagree on most things, and they don't know my babbie... it's not like servicing a car and they force you to see her..." (93).

or found the whole experience distinctly unpleasant;

> "it's far too over crowded and I just want to walk out, I don't want to sit in there" (52)

> "it's a pretty rough area, and you get horrible people with dirty babies all crowded together, I was frightened to death he (baby) was going to pick something up" (48)

Regardless of unpleasantness and unfortunate experiences, some (12%) felt they should still go;

> "I look on it as an extra bit of reassurance... to know they're OK" (95)

> "even though I think he (baby) got colds from there... you have to go don't you" (52)

Those who had never preferred not to go only attended for what was regarded as essential in their eyes; (22%)

> "I only went for what was needed, so it was never just a waste of time, like injections and..." (157)
>
> "I just don't go every 5 minutes, just when I want to go for an injection or the tests they do" (81)

Those who went for weighing saw this as a waste of their time in retrospect: (45%)

> "You can have a baby weighed anywhere can't you ?..." (78)
>
> "when I didn't need to ask the HV anything it was a waste of time just queuing for weighing" (158)

Those who liked going felt; (15%)

> "it was nice to know there's someone there" (103)
>
> "they always have time for you, and I felt welcome there" (37)

(Data: Table 89, Appendix 11).

Reasons for underusage

Respondents were asked to offer reasons they thought some mothers did not make use of the clinic. There were 3 main kinds of reasons offered a) reasons which showed under users to be at fault (20%), b) those which blamed the services (36%) and c) reasons which showed underusage to be a sensible option (40%).

a) Those who offered reasons for non attendance which saw the mother as at fault, thought they must be idle, uncaring and/or stupid (20%)

> "silly know it alls" (91)
>
> "just not diligent enough over the baby's welfare" (52)

b) Where the services were blamed for non attendance, this was thought due to poor expertise:

> "they said there was something wrong with her childs legs, which upset my friend... when they went to specialist they found nothing wrong, it were a bad diagosis, just messing her about... and she never went again" (103)

or unpleasant environment:

> "it's noisy and it's crowded and you come out feeling a mess" (103)
> "just like a cattle market..." (41)

being the most common description. Or disrespectful treatment:

> "I know they ask a lot of personal questions there, but maybe they have to"(52)
>
> "they just don't seem to care enough" (93)

> c) Those who thought non attendance could be for sensible reasons saw that there may be no good reason to attend or that the mother may have other demands on her time in some cases.
> "you just never come away feeling better for it, you've still got to sort it all out yourself and that's what you've gone for" (76)
>
> "they might have other children, and it could be out of their way" (94)
>
> "they might have more children or no problems" (158)

This question allowed for a glimpse of what popular images of the clinic and underusers were like. They closely follow the main reasons offered in the research literature; but were on the whole more sympathetic towards the underuser. Lower scorers seemed to be more aware than most of the possibility of underusage being seen as the result of an uncaring attitude on the part of the mother, or of the clinic itself being unpleasant to visit, whilst middle scorers were more inclined to see underusage as a sensible option. High scorers suggested an interfering/disrespectful health visitor could be the main reason for underusage. (Data: Tables 90A and B, Appendix 11).

Importance of clinic services

Respondents were asked how important they considered the tests and checking which was on offer at clinic, and a majority considered them to be important (75%):

> "We haven't had 'em done, but I think the health visitor should make sure no-one is missed out" (41)
>
> "I knew she (baby) was alright but I like to see it all written down somewhere" (52)
>
> "I don't even mind waiting for that because they're so thorough and they put your mind at ease" (103)

A higher than expected frequency of responses questioning the validity of or meaning of the checks came from the lower scorers, but other groups were not totally convinced either:

> "You'd be able to tell yourself if they (babies) were slow or 'owt" (69)
>
> "The health visitor said his eye was going in, and the doctor found it was OK" (76)
>
> "One time they looked at my friends babies' testicles, but not at mine, and I wondered if I should mention it but you don't like to" (81)
>
> "I don't take 'em too seriously... they're not very reassuring, they secretly read a brown envelope about my baby's heart because of my husbands attack... they thought I was stupid, rather than tell me they were checking for a heart murmur... it made me even more worried" (137)

Those who thought the checks were irrelevant to real problems were having major problems in other areas of life; (8.9%)

> "You can't expect a child to be over developed when there's not enough to eat in house, and we're all freezing at night..." (16)
>
> "I want to know how much coal's going to be for winter... anyone can see if he (baby) is picking things up..." (102)

Middle and high scorers offered less than expected frequency (statistical) of direct criticism or questioning of the tests, whilst the higher scorers were more likely to advocate the value and importance of them than the other groups.

From the profiles of percentage responses within each decile group, it seems that lower scorers tended to be more critical and questioning about the value of tests etc. carried out at clinic, much more so than the higher scorers who were unlikely to be critical. This could be regarded as a tendency for the higher scorers to be more conventional in their attitudes than the lower scorers, or maybe reflects simply a willingness on the lower scorers part to admit to holding unconventional views. (Data: Table 91, Appendix 11).

Health visitor home visiting

An attempt was made to assess the adequacy of health visitor home visiting from the samples point of view. She was not regarded as a frequent visitor on the whole (89%), but this was not always an undesireable state of affairs. 38% of responses indicated they were happy with infrequent visits;

> "I'm not bothered though, I don't want them to come much" (37)
>
> "I think she's only been twice, but they go to those that can't manage I think" (38)
>
> "It's like social workers, they spend their time with problem families, so we didn't get that many visits" (94)

42% would like to have been visited more often than they were;

> "Only 6 times isn't very often is it?" (142)
>
> "I don't think 3 times in a childs life... it isn't much is it?" (113)
>
> "It would be nice to know they'd pop in when they're passing just to see how you were" (106)

As with those who were content with infrequent visits, 9% thought the health visitor only came when something was wrong with the family:

> "I've got a friend who she visits a lot, perhaps they think there's something wrong with her" (5)
>
> "they come to sort out problems if you've got any" (12)
>
> "like a woman I know, she (HV) visits there 'cos the baby's been interfering with their sex lives... but I didn't know you'd see her for that" (16)

The lower scorers were more likely to regard infrequent visits as adequate, whilst middle scorers were more likely to regard frequent visiting as a sign that something was wrong with the family. Higher scorers would like to have been visited more frequently on the whole. Those who perceived their health visitor to be a frequent visitor were pleased with this because she came when they were most in need of help, and could be relied on (8.9%)

> "she told me where to buy cheap things... to come to her with any problems... she's nice" (21)
>
> "she's not interfering... helped me to get rid of my milk properly, and even lent me a tube for when I was going to a wedding... " (124)
>
> "I think it always helps to share your problems,... and she took time to explain..." (1)

(Data: Table 92, Appendix 11).

Health visitor approachability

The most frequently offered response to questions about how approachable the health visitor was, revealed that she was on the

whole regarded as very easy to get along with, or easy enough when necessary (55%). The higher scorers were particularly likely to express these sentiments, but most members of the other groups also found her approachable;

> "I like her, I think she's open minded and doesn't talk down to you like some people do" (103)

> "She's told me all about her kids, so I believe her and we always have plenty to talk about" (130)

The health visitor was considered very helpful by those who found her approachable, (20%)

> "she was a great help because I could sit down and chat to her, I mean I asked her quite a lot of things and any advice she gave me I did... I'd have been lost without them" (48)

Middle scorers were more likely to report approvingly that the health visitor had encouraged contact by leaving her telephone number. Lower scorers were more likely to claim that the health visitor was supposed to be approachable but in fact was not;

> "I've seen her so infrequently, I wouldn't want to ask anything" (93)

> "you could go and see her I suppose, but I've no cause to" (37)

> "when I told her what my job had been before, from then on she sort of assumed if I wanted help I'd get in touch, I'm not saying it's what she ought to have done" (2)

More responses than expected claiming to trust in a credible health visitor, (i.e. one who is herself an experienced mother) came from lower scorers (whilst others also pointed this out as a bonus) (20%). Those who found her to be unapproachable objected to being ordered around, or ignored: (21%)

> "she just snaps, never explains, it's better when she's not there" (5)

> "One day she took all his (baby's) clothes off in the garden... he were freezing and she told me off for putting him in cotton balls" (16)

> "she would not be helpful, just order you to do it her way... never listen to your point of view" (129)

Lower scorers were less likely than the sample as a whole to see their health visitor as approachable when necessary, whilst higher scorers showed exactly the opposite trend. They were also more likely to see their health visitor as helpful <u>because</u> she too was an experienced mother. In particular lower scorers tended to point out the apparent approachability of the health visitor, which was not true in practice, both of the other decile groups were less likely to report this. (Data: Table 93, Appendix A11).

Health visitor role

The respondents' understanding of the health visitor role was assessed, and it was found that her policing functions with particular regard to detecting child abuse and insanitary houses were emphasised (51%). Lower scorers responses tended to indicate more uncertainty as to her role, whilst higher scorers were more likely to acknowledge the 'policing' role, or claim to know all about it from their work experience;

> "they have to check you're looking after them okay and not hurting them" (142)

> "they check up on babies... see whether they're clean and well cared for" (106)

Those who were unsure were puzzled; (18%)

> "I've no idea, I mean it seems such a waste of time" (93)

As a problem solver, it was mainly to do with childrens needs; (7%)

> "she probably would help with say personal problems, or refer you to somebody who could help, but it's mainly child welfare though" (158)

which was felt to be appropriate;

> "she's been very concerned for the baby, I suppose that is her area of concern... but she doesn't understand our problem at all. (38)

(Data: Table 94, Appendix 11).

Baby literature

Respondents were almost equally divided between appreciation of baby literature as informative and rejecting it as useless. The higher and lower scorers in particular tended to regard them as useless, either because they were too generalised or too rigid in their advice (28%):

> "You would only worry if you tried to follow books, all about the average baby who doesn't exist" (73)

> "my friend told me to take no notice of books, 'cos they only cater for the perfect baby, so I didn't read them" (93)

> "they're just not practical enough, they make it all sound too easy, especially breast feeding, it is not easy and not very satisfying" (157)

The middle scorers in particular tended to regard them as informative; (30%)

> "I relied on them a lot, got quite a few booklets free from newspaper adverts" (158)

> "I read the leaflets at ante natal a lot, and remembered bits, odd little things, but it's the little things that matter, ...I don't use 'em as a bible, but I often go back to them." (38)

(Data: Table 95, Appendix 11).

Reluctance to seek advice

Those who claimed they were on the whole reluctant to seek advice and help from the services were further investigted to see if this related to the quality of their relationships with health care professionals. There was found to be a significant relationship between general reluctance to seek advice and having a poor relationship with their general practitioner. This was especially so for the lower scorers. For the sample as a whole, their reluctance to seek advice was due to fear of being put down and being unsure of the legitimacy of their needs (37%):

> "I'd much rather see someone I know first, like my mother and then I'd go to the authorities, but only then" (37)
>
> "you don't know what they're doing half the time and they can't wait to get rid of you" (81)
>
> "they're not very nice to you, but when I really do need help, I get my mother in law to do it for me, she works for social services you see and knows how to handle them right" (108)
>
> "when I was sort of warned not to pester the health visitor at clinic so much, now I really think hard whether I really do have a convincing reason to go or not" (38)

Those who reported having an untroubled relationship with their GP were highly satisfied (i.e. 64% of respondents).

> "he always comes when I ask, no problem" (68)
>
> "he's more interested in me... says if I don't want to breast feed then don't" (2)
>
> "he's fine, and I get along with him okay, he knows us you see" (26)

Those who had problems relating to their GP (36%) complained of brusque treatment, being treated as a pest and not listened to respectfully, and most often being unable to get past the receptionist;

"he just laughs at you..." (16)

"The advice he gives you is okay, but I don't like going much, I avoid it if I can, I store 'em all up to tell all at once" (19)

"he just won't come out, and the receptionist decides if a visit is necessary..." (5)

"the receptionist is dead nosey, she asks all sorts of intimate questions, and you just can't get past her" (76)

"he's just not the sort of person you can talk things over with" (87)

"he's young and has no idea... treat you funny... anyway a man doesn't understand and things... and you see a different one each time you go" (69)

"they can't be bothered with you... just kept telling me to stuff things down (baby) like cabbage and orange juice. I treated him (for constipation) myself in the end" (108)

(Data: Table 96, Appendix 11).

Relationship with midwives

There was not a statistically significant relationship between reluctance to seek professional help and the quality of relationship with midwives. (Data: Table 76, Appendix 11).

Advice seeking and health visitor relationship

There was not a significant relationship between reluctance to seek advice and their relationship with the health visitor. The majority reported no real problems with their health visitor; (72%) feeling they had a good relationship with her. The health visitor may be more available to mothers for consultation rarely requiring getting past a receptionist. The kind of good relationship most appreciated is illustrated in this comment;

> "she was very useful, more her attitude that helped me, she never said 'ought' but always first made little suggestions... never looking down at me. That gets my back straight up, if someone tries to tell you what to do (1).

(Data: Table 93, Appendix 11).

Recommended clinic attendance

Respondents were asked to comment on whether they would advise others to go to clinic or not and the majority (69%) affirmed that they would.

> "Oh yes, especially at first...it's good to go for your own peace of mind" (37)
>
> "Oh yes, it helps to know you're not all on your own" (52)
>
> "Yes... if only to meet other mothers there, it's worth going" (157)

Advising others to attend was favoured regardless of what the respondents themselves had done, lower scorers being particularly keen to recommend it. Both high and middle scorers were more likely to point out conflicting advice as the main reason to avoid going. (Data: Table 97, Appendix 11).

Suggested changes in provision

Respondents were asked to indicate any changes they would like to see take place in provision; in particular anything that would have been more helpful to them. The main change suggested was for there to be more care and concern shown towards mothers by staff encountered at each stage (especially in hospital). (51%)

> "just to take more interest really" (81)
>
> "just don't treat you so lightly, it's really worrying having a baby to care for" (93)

> "I wish they would all be a bit more interested really, otherwise you feel you are putting on to them... I mean they ask you to come don't they?" (156)

Changes they would like to see in hospital care were reduced waiting times, the possibility of seeing the same person on more than one occasion, more dignified respectful treatment, and more freely offered information.

The need for a social outlet specifically for lonely mothers was expressed by 15% of the respondents, in order to share problems, have somewhere to go and meet other people. Changes suggested for the health visiting service (15%) were; a call for more realistic and less confusing advice, more privacy accorded to mothers especially at clinic (e.g. not asking publicly what the baby can do encouraging competition), less 'snooping' (5%), and more freely offered information to allay worry.

Suggested changes in medical care (15%) would be, more sensitive and careful listening to mothers, and more continuity of care in seeing the same doctor, so that they would be familiar and advice would be less conflicting. (Data: Table 98, Appendix 11).

Future intentions

Respondents were asked what if anything they would do differently next time round, should they ever have another child. The majority of responses indicated that they would not be nearly so worried as they had this time; (53%)

> "I will do as I think like bottle feed straight away, no messing about and panicking, it doesn't do you or baby any good" (69)
>
> "I'll do what I think is best, not worry or take so much notice of other people" (73)
>
> "I would not nearly be so frightened, as I've so much more confidence" (38)

A sizeable proportion of responses (35%) indicated that the services would be used differently, more to their advantage;

> "I'll get into a better hospital next time using the doctor..." (41)

and under their control;

> "I will draw the line myself on everything e.g. breast feeding" (87)
>
> "I will not be so soft and put up with unpleasantness" (144)
>
> "I still don't know if I could stand up for my rights, but I'd be prepared to take the consequences" (38)
>
> "It would be different, we're not daft now, we know what's going to happen, there'll be no messing about" (3)
>
> "I would know what to expect, where to go, and stand up for myself more (101)

Ten percent would still like to get the hang of breast feeding successfully whilst a few did not know what in particular they would change (4%). (Data: Table 100, Appendix 11).

5.5. SUMMARY OF THE MAIN FINDINGS

The three groups of scorers (lower, middle and higher) did not differ markedly from one another in their responses to the majority of questions covered in the interview schedule, showing a general concordance between them about various issues related to becoming a mother for the first time and what they thought of service provision in particular. The responses outlined then can be regarded as relevant to all first time mothers, at least in this locality.

A large majority of the sample felt badly informed about service provision in general, what it was there for, what to expect and how it could be made use of. Poor hospital experiences were very common, and may contribute to poor expectations of care in the future. The midwifery service was almost unanimously regarded as valuable and appreciated.

Problems mothers had in preparing for their childs arrival lay mostly outside the province of the services, housing, money and being unmarried being those most commonly cited. However, some mothers felt they had suffered from poor advice or being unable to locate any.

On coming home with their new baby from hospital, only a few mothers remember having no problems. For most their major concern was to do with personal confidence and competence in being able to look after their child well. They worried about doing everything correctly, especially when they had a poor income. Providing adequately for a first baby presented special problems in managing meagre resources, the initial outlay on equipment being a source of worry, and the added difficulties of not having adequate facilities e.g. hot water or a washing machine. The sudden change of style, pace and importance of work was difficult to cope with leaving some mothers wondering about their ability to cope especially with the 24 hour a day demands made on them. For those suffering from depression, coping proved too costly. Given the overall major worry about competence in rearing a child well, those whose ability as a mother had been questioned by the

services were extremely anxious and angry at the insensitivity with which they had been treated. Chronic tiredness, feeding their baby adequately and loss of sleep remained the most common problems encountered. Mothers were unsure of where to go for help and advice with their problems or were in receipt of such conflicting and innappropriate advice that they resorted to self reliance. Some felt distinctly ill prepared for the realities of becoming a mother, whilst those who felt they had been given plenty of advice and help tended to rely on their family and friends with experience of child rearing.

Financial problems were ameliorated by family whilst the sudden loss of one income or both (through redundancy) was exacerbated by the additional expense incurred in providing for a child. For some financial problems were a constant burden.

Most of the mothers suffered from minor illness during the year, but felt that they could not 'be ill' in any way, meaning they could not take time off baby care to look after themselves. Their needs were put on one side in favour of their childs welfare; which taken together with the incidence of chronic tiredness and lack of sleep which were thought to be their main problems, adds up to a considerable strain.

Respiratory type illnesses (coughs, flu, colds etc.) were the most frequently reported illnesses their babies had suffered through the year with teething as the next most common.

The clinic was regarded as serving very limited functions by the sample, weighing being the focal and most important one cited. As a place for advice, developmental tests, postnatal checkups it was to a much lesser extent recognised as applicable. Only 22% of responses suggested it was where one could obtain advice from the health visitor. Even though most of the sample had attended a clinic, at least on a few occasions, and had had their medicals and assessments carried out there, these were not regarded as its primary purpose.

The pop in system as preserving of their choice and autonomy was preferred by the majority of the sample. The majority considered going to clinic merely for weighing as a waste of time in retrospect, even though they would continue to attend as a safeguard. It was then disappointing but necessary to most mothers to attend clinic which probably accounts for the minimal usage most made of the sessions available to them. All of those who described it as a waste of time attending had preferred not to go on some occasions and cited various reasons for this. The main ones being, it was a waste of time and/or they had had an undermining experience when they were there, or just found the place to be distinctly unpleasant, crowded, stuffy and noisy. The majority were prepared to put up with these aspects though, and carry on attending, however infrequently. Those who did not think attendance was ever a waste of time, had made very minimal usage, by only attending for certain tests and immunisations to be carried out, they did not just have their child weighed. Very few felt they had enjoyed attending overall, making it a fairly negatively valued service, which was more or less endured overall.

5.6. SPECULATIVE DIFFERENCES BETWEEN USAGE GROUPS

As the numbers being analysed in this study were small, and the interest directed towards understanding usage patterns, the responses were further scrutinised for any differences in the patterns of responses offered by each decile group, in relation to that for the sample as a whole. Any ways in which their pattern of responses (in terms of percentages) differed from that for the sample as a whole held out the possibility of revealing trends in response which were indicative of differences relating to uptake. Any trends in responses which were quite distinct for a group could provide clues to account for their patterns of uptake.

The questions in the interview schedule which when analysed according to profiles of responses for each decile group revealed some such trends are summarised in Appendix 11.

The differences discovered are to be regarded as mere indications of ways in which patterns of uptake are to be explained as in each case the features of responses singled out for discussion did not clearly divide the three groups.

When asked to enumerate the problems they had faced during their first year of motherhood, there were some differences in patterns of responses for the three decile groups. Whilst the majority reported feeding and illness of their baby to be major problems, lower scorers were less likely to concur with these, prefering to cite having a

'cranky baby' who was difficult to manage as their concern. (Data: Table 80, Appendix 11). The only relation to uptake suggested by these differences and consistent with other data would be that higher scorers from their professed wider appreciation of the health visitor roles and relevances (Data: table 98b, Appendix A4) were more likely to consult their health visitor about this problem, whilst having a difficult baby is not a clearly defined problem which those **'unsure' of the health visitor role** would readily think of seeing her about. Such an interpretation depends on their being a link between one's perceived problems and seeking appropriate help. Regardless of problems encountered, lower scorers were more likely to report being apprehensive about going to clinic in the first place (Data: Table 86, Appendix 11).

There was also a tendency for a higher than expected percentage of lower scorers to report having had no major problems or worries during the year, about their child. The percentage is small though and should not be over emphasised as underusers were under represented in participants, whereby only 5 of them contribute 25% of the decile reponses. (Data: Table 80, Appendix 11).

Being **apprehensive about attending clinic** for the first time was found in each decile, and did not offer an immediate distinction between decile groups; however, the lower scorers were more likely than the sample as a whole to report feeling apprehensive about going. The other tables on which lower scorers produced response profiles which were noticeably different from the rest of the sample are consistent with the interpretation, that they did not have a convincing and/or reassuring picture of the services roles and relevances; they were

more likely to suggest that they were unsure of the health visitors role (Data: Table 94B, Appendix 11) more likely to regard her as unapproachable (Data: Table 93B, Appendix 11) and also more likely to question the validity and/or relevance of the checks carried out at clinic (Data: Table 91B, Appendix 11). They were also more likely to express their appreciation for 'experienced mothers' as health visitors (Data: Table 93B, Appendix 11). Taken together these tendencies in responses indicate that the roles and relevances of the clinic, whilst poorly understood by many (Data: Table 74, Appendix 11) were particularly likely to pose problems for the lower scorers, or that lower scorers were more likely than others to voice their lack of conviction about provision.

Higher scorers were relatively unlikely to question the importance and/or validity of the checks and procedures carried out at clinic, and more likely than the sample as a whole to unhesitatingly affirm their importance (Data: Table 91B, Appendix 11). There was then an acceptance on their part of the services terms of reference and willingness to go along with them. Middle scorers were more likely to suggest that the tests etc. may not be particularly relevant to a mothers concerns. Their intention to use the services differently with any future child (Data: Table 100, Appendix 11) is consistent with their questioning of their relevance and use, as they had determined to be much more selective in future.

Lower scorers and middle scorers then were more likely to question the services, especially clinic, whilst lower scorers were particularly likely to specifically draw attention to the discrepancy between professionally desireable aims i.e. that health visitors are supposed

to be approachable, and how this is experienced by the consumer i.e. in fact they are not (Data: Table 93B, Appendix 11). They were slightly more likely to suggest that they would not recommend clinic attendance (Data: Table 97, Appendix 11) than the sample as a whole.

Lower scorers were content with receiving few visits from the health visitor (Data: Table 92B, Appendix 11) whilst higher scorers tended to report that they would have liked more home visits. The supposed link between frequent home visiting and problem families suggested by the sample, would make more frequent visits stigmatising and undesireable. Higher scorers claimed to have a wider appreciation of the health visitor role and relevance, and this may account for their willingness to be visited more often.

The importance of there being a good relationship with one's GP was underlined by the link between reluctance to seek help and advice in general from professional sources and having a **problematic relationship with a GP** (Data: Table 96, Appendix 11), which was particularly marked for the lower scorers. As the clinic and health visitor service was not well understood for the sample as a whole, it could be conjectured that the GP would be the first line of professional assistance sought by first time mothers when problems occurred with their child. Meeting with a poor response from one's GP could be linked with underusage of the services in general.

The increased sense of competence and control suggested by the sample in their intentions to worry less and use the services differently in future (Data: Table 100, Appendix 11) was particularly marked for middle scorers, the main direction of change being towards a **more**

selective usage of and acceptance of service facilities and directions surrounding mothering practices.

5.7. DISCUSSION OF CONTENT ANALYSIS FINDINGS

In this section, the main findings of the content analysis are reviewed and some general conclusions drawn. The main points which emerged from the analysis, provide the terms of reference for discussion and are underlined in the text. Data which supports each contention is referred to by the table number assigned in Appendix 11.

There were a substantial number of complaints and **reservations about service provision** from the sample as a whole, indicating that for the majority, it was not well understood or appreciated. Their expressed intentions to make even more selective usage in future would lead one to anticipate poorer uptake in subsequent pregnancies.

Hospital care remained a distinctly unpleasant experience for many mothers, the midwifery service was almost unanimously praised, and the clinic was regarded as of very limited relevance and usefulness. Poor, conflicting and unreliable advice was a common complaint, as was being unsure of where to go, to whom and for what reasons. Despite its limited usefulness, mothers got what reassurance they could from their visits to clinic, whilst professing to have had to rely on themselves first and foremost. They needed to feel confidence and competence in caring for their child, and were critical of challenges to these from the services.

The lack of significant differences between the three groups of scorers, requires some consideration. The small numbers involved, made statistical analyses operative at the limits of their applicability, however, there was little indication that a larger sample would have led to more distinct groups emerging from the content analysis. It could be argued that the questions asked in the interview schedule did not relate to dimensions on which groups would differ. The questions were formulated after extensive pilot work and literature searches, and were deemed relevant to the extent that they covered the important areas which emerged from the pilot work, and related to past research and comment on underusage. They covered those issues of importance to first time mothers and it is not clear if there are any questions which would clearly discriminate between user groups. The categorisation of responses was undertaken with no regard for the three groups of scorers, and most often emerged immediately as obviously differences in response, the differences were just not clearly along usage lines.

The preferred interpretation of the minor differences in response patterns found which accounts for the data and avoids putting undue emphasis on differences was that overall, the higher scorers displayed a high degree of **concordance with professional perspectives** as embodied in service provision. The middle scorers accepted most of the roles and relevances of provision but with a large pinch of salt. They would make use of what they found to be advantageous and relevant to them, whilst the lower scorers were just not convinced that what was on offer was helpful and worthwhile.

In support of this interpretation of the data, it can be noted that the higher scorers knew more about the professional terms of reference of health visitors, and so had a richer context within which to understand and make use of this service. They were relatively less likely to question such matters and more likely to go along with professionally inspired goals, to see the services as helpful and worthwhile.

Middle scorers were more critical of the services in general, questioned the relevance of clinic and the tests carried out there, and intended to be even more selective in their future uptake. They were willing to regard underusage as a sensible option on the part of some mothers, showing that they did not unquestioningly accept the value of the services for all.

The lower scorers on the whole shared the same concerns as other groups on most aspects of provision, but were more critical and questioning as to its relevance and value to them. They did not hold a particularly convinced or reassuring picture of the services or professionals, questioned the validity and relevance of clinic procedures, found health visitor unapproachable and did not fully understand or accept her roles and relevances to their concerns. They were more convinced by, and appreciative of health visitors who were themselves experienced mothers, and stressed their preference for realistic, experienced based advice.

The issues of **relevance and value** then were the central ones for the sample as a whole with regard to provision and were particularly pertinent to an understanding of the lower scorers views.

The lack of major differences in responses between the three user groups guard against regarding the responses of the lower scorers as pathological or totally distinctive, they offered responses which were essentially along the same lines as the others.

The relationship with their GP was of central importance in these results, being the one most closely associated with **reluctance to seek help from professional sources.** Those having a poor relationship with their GP were more likely to be reluctant to seek help and advice in general. The problems encountered were fear of being put down, not being listened to respectfully and being unable to get past the receptionist, which when put together with the samples main calls for change, for more care and concern to be shown for them, show the way the services would have to improve to encourage willing and effective uptake.

There seemed to be four main features which ran through the interviews and which could be regarded as describing the **kind of service preferred.** These were:

1. where kindly care and concern had been in evidence
2. help that was relevant, and reassuring in kind,
3. personalised care and
4. where the rspondent felt competent and in control.

The preference for **care and concern** to be shown towards respondents was the main call for changes in provision overall (table 98), and was the main way in which it was felt each aspect of provision could be improved, from hospital care to using the general practitioners surgery.

The major complaint about staff was the lack of care and concern shown when the respondents sought help (table 96), whilst those who felt they had good relationships with staff, pointed out how caring they had been.

The need for **help and advice to be relevant and reassuring** was another important feature of a valued service. The relevance of clinic attendance was undermined by the minimal purpose served in attending, i.e. weighing (table 89), whilst those who never considered it a waste of time to go stressed that attendance was confined to relevant and essential tests or injections. Lower scorers were particularly critical as to the relevance of the tests, whilst higher scorers who claimed to know more about the purposes of health visiting did not question the relevance of the service. It could be conjectured that knowing more about the health visitor role and relevances as claimed by high scorers provided the terms of reference within which the relevance of provision could be appreciated.

The contentment evident with minimal home visiting by health visitors could also be linked to the perceived relevance of this service (table

92). If the health visitor only visited those who could be regarded as problem families, then visits were reassuringly minimal, and irrelevant for most respondents. Those who wanted more home visits (high scorers) were the same group claiming to know more about the health visitor role and relevances and did not associate home visiting with being identified as a problem family.

The expressed appreciation for the health visitor being an experienced mother also points to the felt increased relevance of her advice (table 93), whilst the call for more realistic and less confusing advice (table 98), adds confirmation to the importance of relevant help. The major complaints about literature on child care was the lack of relevance to anyone in particular (i.e. it was too generalised) and the inappropriateness of rigid rules and recommendations (Table 95).

It was also important to the respondents that sources of help and advice be reassuring. Weighing was generally felt to be a waste of time, but tolerated because of its reassurance to some (table 89), and rejected as unnecessary and not providing of reassurance to others. Those who attended only for essentials regarded the tests as reassuring, and this was offered as the main reason for having them done (table 91). It can be noted that those who questioned the relevance of testing also often remarked that they were not very thorough, and therefore not particularly reassuring. Those who enjoyed attending clinic, cited reassurance as one of the main reasons for attendance (table 97). One of the main complaints about literature on baby care was to do with its inability to provide reassurance, and in some cases it was felt that it could cause more

worry (table 95). Having a reliable general practitioner was reassuring (table 96) especially when it was felt he cared and was very familiar with the respondents family. Confusing advice was a major complaint overall (table 98) causing worry for respondents.

Aspects of service provision which were **personalised and welcoming in character** were favoured by the respondents. When attending clinic respondents mentioned being pleased to find the health visitor knew them (table 87), and those who would rather have appointments given for attendance (table 88) cited the personal attention they hoped to receive as the main reason. The overcrowding evident in clinic waiting rooms made visits quite impersonal (table 89) and contributed to weighing being seen as a trivial and herded exercise. Those who enjoyed attending clinic felt welcome there and that time was put at their disposal. Higher scorers were particularly likely to find their health visitor approachable whilst lower scorers were more likely to find her unapproachable (table 93). Sitting down and talking with respondents and leaving a telephone number on which she could be contacted were the personal touches mentioned approvingly of the health visitor service.

Literature on baby care was too generalised and impersonal to be of any use to half of the respondents (table 95) whilst personal interest shown to respondents by their GP was valued (Table 96). The health visitors attitude towards respondents was thought to be particularly personal and demonstrating interest by those who felt they had a good relationship with her. (She remembered who they were, what their worries had been and seemed pleased to see them).

A fourth feature of service provision which was preferred were those situations in which respondents felt able to **exercise control and judgement.** In this respect, the pop in arrangement at clinic was almost unanimously preferred to any kind of appointment system, the reasons given being mainly to do with this system preserving their choice to determine if and when to go. This allowed respondents control over uptake and freedom from such an obligation as an appointment (table 88).

Waiting around for long periods of time in an overcrowded clinic or hospital was a major complaint, respondents feeling they had been 'messed about' unnecessarily. One of their intentions for the future was to make use of the services differently, in ways which would be less costly to them, indicating their desire to have matters more under their control (table 100).

Rigid dictates about the rights and wrongs of mothering were not to be tolerated from any source whether health visitor or books (table 95), whilst receptionists controlling access to the GP was a common cause for complaint (table 100). Those who felt they had a good relationship with their health visitor liked the way she approached giving them advice, it was not controlling or dictatorial, and matters were discussed rather than put in terms of what one 'ought' to do. Being ordered around in hospital and forced to do things against their will were the main complaints regarding the time spent in hospital (table 75).

Having enough information can be seen to be linked to feeling in control and competent (table 98). They almost unanimously requested more freely available information, whilst knowing enough about clinic and what to expect was the main reason offered by the higher scorers for their being less apprehensive about attending (table 85).

The services were not well known or understood in general, and may be contributory to the low level of uptake identified for the sample as a whole. Rather than actively making use of provision, respondents spent time familiarising themselves with what goes on.

Problems in obtaining relevant help and advice were shown to be prevalent regardless of decile membership (Table 81), most relying on themselves first and foremost. Apprehension with regard to initial clinic attendance was also related to lack of know how (table 85), those who knew what to expect were not apprehensive about going.

Lower users were more unsure of the health visitor role than others (Table 94) and given the tendency to regard them primarily as a policing agency, (checking one's house and baby), it seems unlikely that a new mother could feel confident in seeking help and advice. Their role was not particularly well understood by the sample as a whole, which helps to account for the relative rarity of staff being consulted on non-routine matters.

The higher scorers uptake of non-routine (i.e. particularly voluntary) contacts with their health visitor would seem to be due to their claimed superior knowledge of her role. Although still regarded primarily as a policing agent, this was presumeably more acceptable

when a wider appreciation of skills and relevances was available. The policing role was within a wider context.

The call for more information from all areas of the services was clearly made (table 98) by most respondents. It became clear that the knowledge of provision gained during the course of this first year would form the basis for change in any future service contacts. They would feel more in control of what was to take place and have less need to worry about their baby and preferred styles of mothering.

Knowledge then was linked to feeling competent and in control, and is at least implicated as conducive to (particularly voluntary and active) uptake as demonstrated by the higher scorers who understood the health visitor role more fully, and made more use of non-routine contacts with her.

Humiliating and degrading treatment was a major source of complaint, regardless of decile membership. Hospital experiences were particularly galling (table 75), calling for more care and concern to be demonstrated by staff (table 98). Plans for any future children included a determination to stand up for themselves (table 100) especially in hospital. Disrespectful, brusque, infantilising treatment were the major reasons for complaint. The relatively few complaints about health visitors were again centred on the quality of treatment the respondents received (table 93A) and were not related to decile membership. Not being listened to, and being ordered around can be regarded as disrespectful and compromising one's dignity. Those who claimed they preferred to avoid going to clinic (whether or not they did in practice) most often reported having had an

undermining experience there, where they felt they had been treated badly.

Those who make use of the services, do so despite holding similar reservations and concerns to those of the under users. They don't like but will tolerate the way in which help is offered, but may well become the underusers of the future.

It would seem then that any changes in provision along the lines suggested by the majority of mothers in this sample, which would make the services more acceptable, accessible, rewarding and less costly, may encourage higher uptake all round.

CHAPTER 6: MAIN STUDY: UNDERSTANDING UNDER USAGE: THE UNDERUSER CASE STUDIES

INTRODUCTION

Each interviewee described her contacts with health visitors, doctors, midwives, and clinic staff in her own particular way; specific instances and stories were offered to demonstrate what it was like. On analysis, certain themes emerged which could typify underusers' accounts. These are presented below, with an outline of how each interviewee related to the theme.

(The themes are the end result of the case study analyses, which were carried out on each of the underuser's interview transcripts. A clearer understanding of how they were arrived at can be gained from reading the detailed example outlined in Appendix 4, before proceeding with the more general results offered here.)

For some the services in general were irrelevant, ignored for the most part and easily bypassable. They were never really considered as of such relevance as to require the individual to even come to an opinion; not of much concern at all. Here it was difficult for the interviewee to acknowledge my interest in them and reply in a fashion which seemed to her likely to be acceptable. They were not aware of any demand on them to attend or otherwise. For others the services were a focus of antagonism, seeming to be of potential benefit but inaccessible or deliberately withheld. In what follows there is an attempt to convey this variability in the perceived relevance of the interview itself.

In section 6.1. the major themes of relevance to the interviewees are presented. Section 6.1.1. details those themes which relate to service provision; how the services were seen and related to by the underusers. Section 6.1.2. details how motherhood was experienced, the major themes which they chose to talk about which numbered 15, in the final analysis. Two further themes are then added at sections 6.1.3. and 6.1.4., as they were deemed important by the group as a whole. There then follows a summary of the themes covered in the section, and a discussion of the main conclusion that there are significant mismatches between the underusers perspectives and those of the services as embodied in provision.

6.1. GENERAL THEMES ARISING FROM THE UNDER USERS ACCOUNTS

6.1.1. The services and interviewees relations with them

There were 9 major themes, which are headed by a phrase from the interviews which sums up the focus of interest. It can be noted here that no attempt was made on the part of the researcher to transform the everyday talk used into more 'official' headings, they are rather closely tied to the way in which they were talked about. Keeping to the tone and near to the vocabulary of respondents presents an honest impression of the data. The material is, of course, essentially and designedly one sided; it is most important to bear in mind the intention of the research to discover the client's viewpoint. The criterion of judgement, then, is not 'balance' or even 'objective accuracy of description of the services', but is a clear presentation of the themes that can be seen in interviewee statements. Effectively, we have here a description of client attitudes. The

'objective accuracy' of their perspective is not at issue, it having been "bracketed" in analysis. The description of the themes is not a system of concepts, as they are neither mutually exclusive nor exhaustive in scope. The reporting of the attitudes is not necessarily an endorsement of them, the researchers perspective being a secondary consideration here. When asked about specific aspects of the services e.g. ante natal classes, child health clinic, post natal check ups etc. the interviewees directed their comments to 'they', referring to carers in general and those they came across at each point. It was unusual for them to refer to any particular individual; however, this is noted when they did.

1. Irrelevance of the services

The services were seen quite simply as having nothing to do with these interviewees. They were an irrelevance (L,120ff), had not even been considered by one;

> "Just never thought about it really" (R,162)

or considered and rejected by others as -

> "not for the likes of us". (A,162)

It was for L (15ff) of little consequence that she didn't know much about the services, where the clinic was or what might happen there, it just did not have any relevance to her life. Thus for L. the midwifes' visit happened, but was of little consequence:

> "She just came..." (L,53)

She is not sure what the health visitor came for (L,149ff) and doesn't really mind what they do, it is all of little consequence. She confesses surprise in being visited at all:-

> "I didn't know you had health visitors when you had babies" (L,63ff)

The opacity surrounding the potential relevance of the services was shared by the others (i.e. A.J.E and R.) but they would have liked to have been part of and included in a caring service. They felt they had missed out here, on potential help.

e.g. E felt that joining an antenatal class may have helped her to be included.

e.g. A would dearly have loved to be able to follow irrelevant advice from the service (271ff)

e.g. J would like to have known someone who goes (28 - 31)

e.g. R wished staff would not exercise favouritism (242 ff) towards others thus excluding her.

The services were similarly irrelevant for W, but she decided this after having assessed their function and saw the irrelevance for herself. She preferred it this way. Her child would be "better off" not coming into contact with the coughs and sneezes at clinic (W,174ff), she preferred to rely on "good sense and intuition" rather than silly regimens (W,245ff) and felt perfectly competent in this (W,127ff)

2. Contact with the services confers membership of inappropriate group

Frequent contact with the clinic and health visitor (and to some extent the comments are of relevance to antenatal preparation, hospitals and general practitioner consultations), were inapropriate for this group, as this would mean they were a certain sort of person

which they could not or would not accept being. Having had contact with service providers, and found this strained and disconcerting, the interviewees reasoned that there must be a group of people for whom the services are provided, as they clearly were not for them. This mythical target group was variously supposed as being: 'favourites of the staff', the status conscious, the social climber, the ignorant and poor, 'those in the know' and the respectable well-off mainstream. The interviewees either could not, or did not wish to belong to such groups.

Those who attend clinic make a show of it, being "into the Smith and Jones syndrome" (R,164). They lack sincerity and are welcome to such despicable behaviour. Such "favourites" of the staff are encouraged to come. Those who attend and are adept at uptake are the respectable well dressed, confident mainstream persons;

> "With babbies with lovely pink outfits...who...I just couldn't compete with them...it's shown me up..." (A,651ff)

They are 'in the know' (E,69ff) who have all the procedural know how of uptake. Ignorance of such matters makes one scared to go, as you "feel a fool". It is hard to get in, and one tends to get overlooked. (E,79ff) and (E,155ff)

For such people the services are very welcoming, and they go mainly to socialise (A,798ff) which is great for those who can fit in.

The staff clearly have their own ideas about mothering which are totally inappropriate (A,190-196). They have "rose coloured" (A,269) and very nice ideas about life which makes their advice, well meant but totally unusable e.g. unbearable predicaments like family

in-fighting are glossed over with off pat solutions like "time will heal" (A,260ff). Moreover such advice implies that the interviewee should be coping and so she must be a failure in their eyes. Feeling that one has failed becomes more tolerable when it is realised that such advice was from another world, where such problems were unthinkable.

"They think it's so easy" (E,141ff)

The usual advice to "go out and enjoy yourself" (A,713-719) must apply to some mothers, but was ridiculous for those who could neither afford the clothes, bus fares or spending money to do so. Baby books are also idealised (A,787-791) giving only the good side in a rosy fashion, which leaves one exasperated.

"Life isn't like that!" (A,787ff)

By contrast, those who need to attend the services are ignorant "puddings" (W,127) who require instruction to cope with motherhood. e.g. those who know nothing about antenatal preparation, (W,19) or need tuition on labour (W,39) are not very competent persons. They tend to be irresponsible and unintelligent:-

> "I'm not one of these...puddings, that have kids like rabbits you know" (W,126ff):

and probably suspect morally too:

> "a lot of people, mainly from ... poor families... who can't be bothered and would rather sit and play bingo.... I imagine that anyway" (W,194ff)

These are the sorts for whom clinic attendance is required.

3. Privileged/inaccessible information surrounds usage of services

The interviewees referred to the existence of 'inside' information which was more or less easily available to them. This covered how to use the services, where to go and what was on offer. For W this was no problem, she considered herself to be an 'insider' and chose not to take part. She knows her doctor well (W,133ff) and has intimate knowledge of medical matters (W,325) shown by her use of common abbreviations, due to her husband's work.

Being an 'insider' confers special privileges: eg. the doctor will make special arrangements in hospital (W,325) and one can get special unusual bonuses like a picture of the child in utero (W,330ff). Staff are especially warm and friendly to those they know socially; e.g.

> "the woman who does the scanning... she's a friend of ours, (which helps) because she were right sort of chatty and she knew you, she were very good ... lovely" (W,328ff).

For L even the questions asked in the interview about the services were difficult for her to relate to, they assumed values, attitudes and specific knowledge which were not a part of her life. She tried as best she could to find relevance in the interview, was not aware of provision, or what needs they it serve, and found it difficult to acknowledge my interest in such matters. She didn't know anything about provision antenatally or postnatally (L,15ff) or about things husbands could get involved in (L,43ff)

For J this was also true, she found it difficult to pin down exactly what it was she didn't like about coming in contact with provision. She had problems specifying points of relevance there being no overall framework of understanding within which to locate the problem. She just felt peculiar and threatened by contact (J,43-46ff)

Others felt deliberately excluded, "favouritism" was exercised in hospital (R,10ff) and information is often withheld (A,700-711) which in itself is a worry.

At the start of her pregnancy A was aware that there must be a procedure for such matters, she just was not sure what it was (A,109-115). Moreover, she was anxious to do the right thing, but was not sure how (A,112ff) Her subsequent problems in fitting in made her believe that 'they' should tell you what you need to know and "Not keep 'owt back from you" (A,700ff)

Being a part of a class was thought to be a point of access; as mothers-to-be were:

> "told things you would never usually have found out... were <u>even</u> taken round labour suites" (E,79ff)

Such inaccessibility seemed unneccessary and promoting of non usage as one put it:

> "Someone should tell you e.g. your doctor should say what will happen, but they don't tell you anything, you just go there feeling a fool" (E,694ff)
>
> and
>
> "no wonder people don't go they're scared to go, like my friend" (E,734)

There is no problem when one knows the ropes e.g. one mother described how working in a chemists allowed her to feel she knew "quite a bit about baby things... knew everything to get... there was no problem there" (E,160ff)

The lack of procedural know-how left them feeling foolishly uninformed

(A,111ff, and E,69ff) and led to embarrassing incidents, e.g. when A went to clinic about a rash she had developed, she was cut short and told to go elsewhere, it was not an appropriate problem for the clinic to deal with.

Having no idea of what was expected of a mother was frightening (A563-569), making potential contact with professionals an alarming prospect (R,122ff) (L,10ff), causing considerable apprehension. It is very threatening to one's self respect to be so ignorant of such matters (R,138ff) making contact with professionals strained and difficult (R,38ff).

It is all too easy to make mistakes under such circumstances. e.g. Questions are not allowed in hospital (A,163ff) as one is expected to know the answers. This is deduced from being "left to sort it all out yourself (E,53-66) and being afraid to ask". One can also get some rough treatment, when you don't know what to do (R,253ff) in a medical encounter.

There is a certain confidence in knowing the ropes, and staff well enough to be sure of what to do e.g. L knew her doctor well, and never had any problem in securing his help, as she could talk to him quite easily (L,153ff). Also a familiar/supportive presence would have been helpful in using the services confidently (J,28ff) and (R,1ff) "You like to go with somebody don't you?..."

4. **The remote world of service provision**

For the under users, the services were seen as an abstract totality, distanced from them. There were no personal relationships with any

particular individuals, and there seemed to be a **whole social world with its own rules and relevances which had nothing to do with them.**

For some this was a perfectly acceptable state of affairs, whilst for others, it was a source of great anxiety and disappointment. This view of the services was shown by four main themes, which conveyed the remoteness.

a) Staff act in socially superior ways

Staff present themselves as socially superior to mothers (,A80ff) A stance which was rued and accepted by some (A,112ff, E,433,) and questioned by others (W,21ff). Such posturing makes it impossible to talk easily with such people as mothers are talked down to, and not taken seriously. (A,700-711) (E,401ff) (W,218ff)

For example A describes how it is unheard of for 'them' to offer explanations for what 'they' do. Problems are not respectfully heard, and one has to plead with them to get anywhere (A,89-92) and even then;

Despite one mothers elaborate depiction of her childs "chestiness" to her doctor, the symptoms were dismissed as a "cold in her nose". Simply dismissing such disturbing symptoms was thought not good enough with a history of TB in the family and child in distress,

> "I went up because well there were that fear of cot deaths going around... and I could really feel it... in her chest, ruttling all 'time... and he (the baby doctor) said oh it were cold in her nose... but she's getting worse and worse.... she is very chesty and it does frighten me sometimes" (A,592-601)

Protests are ignored (A,140ff) one's word is not accepted (A80ff) and

being brushed aside is commonplace (A170-178, J,140ff)

One is made to feel improper and foolish e.g. when asking questions:

> "They don't like you asking, think you have no right to ask, the way they look at you as well.... definitely talk down to you and think you're thick."(E,401ff)

Even when unquestionable technically superior evidence is presented, this is ignored e.g. when W had her childs hearing tested on specialised equipment at the hospital,

> "He had all these bloody specialised tests and everything" (W,216)

this was ignored as evidence that her childs hearing was beyond dispute.

> "She (HV) was so adamant that I had this hearing test.... it were really stupid" (W,220)

This amounted to an insult to her integrity.

b) Staff have authority and power over mothers

Service personnel (health visitors, doctors, the social services, midwives etc) are seen as having both the power and authority to offer, insist on or withhold services as they see fit.

This is shown by their **refusal to provide what one needs:** e.g. a sick note for work (A,86ff) procedural know how (E,69ff) or supervision at the childs birth (E,110ff)

The difficulty of extracting help from them: e,g, help is never freely given, it has to be extracted through persistence and pleading. One must convince 'them' of your needs as real and valid before they will yield and be helpful. (A,90ff) (E,64ff) (R,276ff) (L,150ff)

The way they can impose obligations to be fulfilled despite personal preferences: e.g. attendance at clinic is obligatory "a thing you've got to do" (J,97ff), regardless of reluctance to go (E,297ff) (R,126ff) (L,107ff), and all babies must have unneccessary hearing test (W,213ff)

c) Staff act in morally superior ways

Service personnel behave in a morally superior capacity towards mothers, either confirming ones respectability or challenging it. As judges of one's behaviour it is important that they approve of mothering styles adopted and treat one respectfully.

Personally intimate relations with (e.g. doctors) are particularly rewarding (W,25ff) (W,133ff) confirming of ones worthiness in their eyes. Most clients are seen at random by whichever member of staff happens to be around (W,320ff) and this can cause problems, it being much nicer to have one's own (W,324ff) who has taken a personal interest.

Conversely being treated as of no worth is horrifying; staff often,

"don't speak to you... and then you're out!" (J,110ff)

carry on private chatting with occasional asides in your direction (E,114ff) and "brush you aside" (R,148ff)

Staff moralise and rebuke mothers who fall short of expectations, e.g. When A was worried about having a mental breakdown, the doctor told her she must not neglect her child, but find perserverence and overthrow her problems. (A,649ff)

They order mothers around: 'think you're thick' (E,401ff) which is unacceptable and shocking (E,106ff) and can shout abusively (E,109ff) and (R,253ff) or subject one to public disgrace as when one mother asked for help the nurse shouted 'what d'yer want!". And when another did not quite hear her doctor "he was quite nasty" and shouted his instructions (R,253ff). Another had to publicly admit in clinic to having no money to pay for some second hand clothes that the health visitor had said she could have for free (A,661-668). To avoid possible disparagement its best to keep away. (A,675ff)

d) The services are offensively impersonal

Interviewees felt they were interrogated by staff in a routine fashion (A,129ff, J,13ff, R,191ff, E,392ff), and regimented through the services, as one of many, passed from one person to another as one described it:

> "Like a bag of flour" (A,129ff)

They realised they were not seen as persons to medical staff, just exhibits (A,149-153) of no real consequence (E,113-115).

One incident which made this clear was at clinic when A had to have an examination. The doctor had some students in:

> "and I felt stupid, I'd to remove my dressing gown and they'd taken it right to t'other side of t'room, and I'd to walk across t'room, and I had n'owt on..."

At first she was deeply embarrassed and humiliated by this;

> "but now I believe that a doctor don't see you as a person, he sees yer just like an object" (A,159ff)

Another was when E went for an examination;

> "they just have a feel at your stomach... then straight home... they don't like you asking questions"

It became clear that:

> "they think you have no right to ask" (E,402ff)

Problems are not taken seriously or respectfully (A,90-91ff) which calls for a struggle to be heard and forces one to act in undignified ways.

Mothers were often treated as if they had no sense (A,260ff, W,218ff, R196ff, E,404ff) and dismissed despite protests (A,260ff, R,40ff, E,109ff). Staff also wrongly typify all mothers as "silly hens" assume they go with every trivial problem, and laugh at their concerns, "thinking you're making too much of it all"(A,686-691) Making it necessary to remind staff:

> "I have got a bit of common sense" (A260ff)

5. Staff just don't care about mothers

Even when opportunities are all too evident for needing help, staff seem to turn away e.g. in hospital;

> "they must know how (bad) women feel at that time... depressed after birth... but they don't seem to want to help you... just order you around" (E,104)

whilst in clinic - they have a reputation for being unconcerned, as one interviewee explains:

> "Staff don't seem bothered, ... are that rushed; that they just brush you aside... well that's what I've heard..." (R,148)

The total lack of concern is revealed in grudging responses to calls for help e.g. they "have no time for you" (J,141ff)

> "by the time (the doctor) came, the pain had worn off" (R,192)

and trivial (thoughtless) prescribing e.g.

> "He gave me valium, without really asking why... just wrote down 'money problem' and brushed me off"(R,195)

herding mothers through procedures e.g.

> "the policy is to get 'em out as fast as possible" (R,221)

and refusals to take matters seriously e.g. (A,88ff) when the doctor refused to allow time off work.

This all seems uncalled for, "staff could be more pleasant, and not have favourites...as I was already depressed" (R,239) callous and cruel.

They can be "quite nasty" when they feel like it. e.g. (E421ff) and shout at you when you're "feeling apprehensive anyway" (R,177).

Their lack of commitment is shown by frequent changes of staff e.g. for doctors, "When one makes a bit of money, they're off" (A,770-772). Health visitors change with no warning or explanation (R,177); and it is rare to see one's own doctor in group practices (E,279ff).

It is clear they don't care about patients by the way they are treated as things of no consequence.

> "half of times...they haven't got time for you, he (doctor) couldn't give a chuff...just treat you like a little box in corner" (A,147-149)

There is no real contact (E,260ff) there being long periods of time between HV visits showing they don't care.

6. Severely limited usefulness of the services

The services the interviewees had made contact with were found to be useless to them. This was a source of great disappointment to some (A & E) but as expected by others, who had no particular hopes of help (L & W). The severely limited usefulness of services was shown by three themes as outlined below.

Overall it was unacceptably unpleasant and tiresome to go to clinic, waiting in a crowded room with "kids playing up and screaming" (E,222ff) and all for;

a) <u>exceptionally minimal purpose</u> (W,169ff)

The disappointment was due to the lack of purpose in going. The health visitors only:

> "sort of watch 'em (kids) at clinic, to see if they're alright, and ask you various questions, and that's it, that's all happens really." (E,247ff)
>
> or
>
> "They only weigh 'em" (A,673ff)
>
> or
>
> "they don't sit and talk to you...just go for one thing and then you're out," (J,109ff)
>
> and
>
> "straight in, straight out, that's it..."(L,34ff)

b) <u>Real help is hard to come by</u>:

Help of any consequence was not forth coming;

> "there was no help for you at all there; no-one showed you what to do...how to look after this baby you've just had" (E,92ff)

except for the midwife's visit, she offered "little bits of advice" (E,154ff)

Ostensibly there are facilities available which could be useful e.g.

> "you could have a word with them (at clinic) if you wanted to... if there was anything worrying you"

but this is not really the case, and she would never use this facility.

The health visitor presents herself as an helpful person

> "She's tried to be,... but I've never really had cause to ask anything" (L,151ff)

One's real concerns are made light of (A,686ff) and typified as foolish overactive mothering (E,401ff) Matters of real consequence to mothers are not dealt with at all e.g.

> "What it'll be like afterwards" (J13ff)

and

> "this is what they should give lessons on .... you don't realise what you have to give up" (R,52ff)

or e.g. how to use the services;

> "Your doctor should say what will happen...." (E,69ff)

or e.g. common ailments in infants like colic (E,173ff)

Without such real help, mothers are left ignorant and terrified for their own and their childs welfare (E,177ff)

c) The help that is offered is inappropriate

For W the health visitor was an irritation, demanding to be of use to her (W,250ff). The film shown on how to rear a child was totally inappropriate, confirming there to be no real help or understanding there:

> "you can't go by films.... I mean everybody's got to bring their bairn up their own way... when we'd got plenty of money, probably we could've brought the bairn up their way... but you just can't do it" (A,194ff)

Not only did this make the interviewee realise she could not fit in there, but it was very distressing to have standards set and recommended which she could never reach;

> "that bairn of mine... gets Wheetabix more often than not... when she should be getting meat and fish and stuff like that" (A,197ff)

7. **Staff expertise is questionable**

The services are questioned as to their expertise in helping mothers. This is shown by instances of culpable negligence, useless advice and unreliability. Some interviewees rail against their pretense of expertise, whilst others sympathise that they are well meaning but just useless, e.g. (L,150ff)

a) Instances of culpable negligence were related where the professional was 'proved' to be in the wrong, and where the interviewee would hold them responsible for adverse consequences. (A,75ff) Symptoms were overlooked (A,673ff); receptionists attempt diagnosis (A,773ff) and advice is often rubbish (J,140, A,713ff)

Even life threatening situations are ignored e.g. in hospital one was "told to push.... and abandoned again, the baby could have been dead.... for all they cared...." (E,109ff) Such horrendous experiences are vividly remembered and recalled, often down to the words used.

Pregnancy was diagnosed as "gastric stomach....wind", despite a positive pregnancy test result and this persisted until it became obvious :

> "Up to me really showing" (A,65ff)

This wrong diagnosis could have been dangerous;

> "I'd have probably gone back to work and done something heavy and lost it (baby) again."

Even when such matters are pointed out, staff persist in their idiocy (A,138-142)

b) <u>They blunder and make mistakes</u>

(can't be trusted) and are unreliable.

Staff are often wrong in their professional capacity e.g. "the doctor said it (the injection) would make him (the baby) ill, with a rash'..."but this didn't happen. (R,158)

The hospital can "make a mess" of one's giving birth (W,102) whilst at clinic inept behaviour is the rule:

> "they'd lost someone's notes.... it was in uproar, (W,169)

Staff act improperly (A,661-668) and are very badly organised (A,142ff) so that some symptoms are missed and some mothers get overlooked (E,279-286)

Moreover staff are **essentially unreliable** as a source of help. They often refuse to send a doctor out, even when the child is ill (A,773-784), or by the time he comes the symptoms have worn off (R,192ff). They can't be relied on to listen to your problems, as they have no time for you (J,140-146) Sometimes it's impossible to get to see your own doctor in a group practice (E,279ff) In any case they change staff frequently:

"Once one makes a bit of money" (A,772)

without any forewarning or reason being offered; (R,177ff) or don't bother to visit you at all.

"I only saw her once" (E,156ff)

c) Their expertise is unconvincing

Interviewees agreed with the sentiment that "checks must be important" e.g. (R,152) but this was not held with any conviction, it was not something to go out of one's way to have done. Whilst assenting to an uncontentious 'acceptable' view, the interviewees were able to convey the lack of conviction rather well; (J14ff, J,43-46ff, J123-125, R,152ff, R,183ff, L,53ff)

In this respect all interviewees showed a concern to assert 'proper' attitudes and intentions, some of which implicated using the services e.g. J was apprehensive about going to clinic, but saw it as 'something you've got to do', how she felt, being of secondary consideration (J,96-103).

Most could not however muster up any enthusiasm for such an obligation (E,76ff) (L,129ff) In most cases though, one could do the 'right thing' without going. e.g. ante natal classes were unnecessary as (J,20ff) got enough exercise anyway as she loves walking and had her child weighed at the chemist as did (L,114ff). The 'proper' attitude was held despite not going along with it behaviourally, e.g. W's husband fully intended to join in the ante natal preparation, but was too ill to do so at the time (42ff) .

The hearing test and developmental assessments insisted upon by the health visitor were pathetic and laughable; e.g.

> "seeing if he can build... pass things from one to the other hand... you don't really have to have that done" (W,186)

and

> "stood behind him (baby) whispering 'doggy doggy' - it was really stupid" (W,219ff).

Such farcical behaviour was annoyingly insulting to one's intelligence.

Ludicrous activities were encouraged at classes:

> "Stretching yer ankles and this lot" (A,181ff)

Examinations are not very thorough:

> "it weren't a really thorough check... I mean he never got stethoscope out or examined her chest.... he checked externally.... he didn't check... internal" (A,682ff)

They cover the obvious in any case:

> "it's a waste of time having somebody telling me what I already know" (A695)

i.e. that a child can hear, walk, swap objects from hand to hand etc...

As long as the child is okay and healthy, there seems no need to have this confirmed (J,120ff) (L,150ff) (W,104ff).

8. **Staff can be cruel, callous and punitive**

This was shown by the treatment meted out to mothers when they did have contact with health care personnel and was shown in the four following themes.

a) Staff reprimanded and degraded mothers to keep them in line, a practice which was felt to be totally unacceptable. e.g. in hospital when one mother asked why her child's eyes were filled with pus, the nurse:

> "bit her head off... and sarcastically asked if it was 10 worlds disease".

This was seen as unreasonably nasty as;

> "You're only asking for help and they just don't want to give it" (E,421ff)

Mothers in labour are left alone (R,4ff) and sometimes in agony (E,109ff) which is a "shocking, really disgusting" practice.

Another was rebuked for failing to establish breast feeding;

> "that made a difference...that goes with favouritism"

even though she had

> "had a good try" (R,110ff)

At clinic one mother was made to walk across a room naked, in front of a group of students (A,150ff), an incident she found totally degrading. On another occasion she was publicly rebuked for failing to offer payment for some second hand clothes the health visitor had said she could have (A,661ff).

b) Staff accused one of improper conduct e.g. when one mother asked for help with morning sickness, her doctor suspected her of trying to get undue time off work and refused to help (A,86ff), and when consulted about her depression, he warned her not to neglect her child (A,649ff), which frightened her into trying to overcome it herself.

When another mother did not quite catch her doctors instructions, she was cruel;

> "says 'Oh for goodness sake unbutton yer night dress' quite nasty and you were feeling a bit apprehensive anyway... I don't think they ought to be like that with people"(R,256ff)

Fear of disparagement is sufficient to keep mothers away (A,675ff)

c) Staff refused help when asked e.g. receptionists refuse to send the doctor out (A,773ff) and just don't seem to want to help (E,69ff, R,256ff). Others are disapproving and contemptious when they have to visit mothers, e.g. one midwife was

> "right short and funny" (R,35ff)

leaving the interviewee feeling she dare not ask anything, and as if she had been seen under sufferance, with tongs.

The interviewees either expected (A,734ff, J,117ff, L,130ff) or received retribution for improper conduct e.g. not going to clinic, and all were under the illusion which was corrected later that attendance was obligatory and enforceable.

d) The interviewees suspected that staff had an unhealthy interest in them, believing them to be primarily out to detect child batterers (A,793ff) and were insulted to find them prying into their affairs.

They were thought to be "a bit nosey", as;

> "You look after your own kids don't you... why should they bother ?" (R,160ff)

and challenging of one's integrity (W,213ff). For others, they could not understand what the services wanted with them at all (L,149ff, E,260ff).

9. **Unreasonable demands are made of mothers**

Interviewees felt that unreasonable demands were made on their time (J4ff) and endurance (J,6ff, A,20ff, E,222ff, R,237ff). Visits to the clinic/hospital/GP which entailed a lot of discomfort and timewasting (sitting for long periods in cramped, crowded rooms), were a waste of energy.

> "They just want you in and out... they don't talk to you" (J,109ff)

This is regardless of their obvious discomfort:

> "When you don't feel well anyway... I couldn't stand it" (R,241ff, J,13ff, E,222ff)

Some felt they were expected to know a lot more than could be considered reasonable e.g. about the appropriate use of the clinic (A,170ff) and provision in general (E,66-67).

Their problems were seen as easily solveable, and their continuance was therefore a reflection on their competence. e.g. the midwife and health visitor could not conceive of the gravity of A's problems. (271ff). Advice given assumed life was "straightforward and easy", but belongs to another world. In this way her predicament was made light of and 'off pat' solutions offered indicated that she was expected to be managing better than she was.

W. was expected to have an unneccessary test done, regardless of her assurance that her child had been tested elsewhere. This meant her word wasn't good enough, her integrity was put at risk, and this was felt to be totally unreasonable treatment.

Such unreasonable expectations were undermining to the interviewees self respect and confidence. The services were seen to sponsor an ideal that mothers are expected to embrace. This was not officially the case, but was revealed in other ways, e.g. when badly treated at clinic, they surmised that they must be failing in some way to warrant such treatment; being herded around, and ignored as a person altogether serves to convince them that they are wrong in some way - what these expectations are can only be guessed at, as they are never spelled out.

6.1.2. <u>The experience of motherood</u>

In this section the themes which relate to the experience of becoming a mother for the first time are presented. Fifteen such themes and their constituents are outlined accompanied with quotes from the case study data which help convey their meanings.

1. **Interviewees felt ill prepared for realities of motherhood**

One mother felt **cheated** by those who have information about becoming a mother, (including services, own mother, family etc.), as they deliberately withheld or distorted information in such a way as to cause her hardship. e.g. one of the books from the antenatal clinic "says oh everything you need for your baby" which she followed carefully, only to find she

"Were getting stuff... that I didn't need"(A,565ff)

Sex education was distinctly one sided; and too simple. It wasn't just "a good thing", no mention was made of the pain and disappointment of miscarriage and how it can become boring (A,34-44)

Her own **experience was very different from the advice offered** (e.g. A,619-623) which was out of touch with real life. This led her to believe that in general they try to ease your mind by glossing over problems (A,787-791).

Her plea is for information to be freely available and based on 'known fact' unflavoured by romanticism or drama;

> "I mean you've got to learn, but I don't think people should expect you to learn all by yourself, they should give you advice, fair enough, but not from their experience, but from known fact.' (A,836-842)

E felt ill prepared for the trials of motherhood:

"You don't realise what you have to give up." (E,13ff)

and has found others in the same predicament (E,15ff), it seems to be common place. R was worried at first about how she was going to cope with her baby, because she never thought about it while pregnant (52ff). She felt the shock of it all, and being unprepared was responsible for her depression (263ff)

W felt very well prepared for the advent of motherhood, having everything ready (87ff) lots of information (8ff) and so felt competent and not in need of any particular help. (127ff)

2. **The shock of becoming a mother**

The stressful, demanding job of mothering is easily overlooked in hospital

> I didn't feel as though, I'd got a bairn ...'cos the only time you ever brought 'em out was when visiting time... and they were back in the nursery for you to get a nap" (A,238ff)

E always wanted a child, and never thought it would be so difficult a job. Her life is now unrecognisable to her.

> "It's so strange" (E,28-33)

and W can't imagine what she did with all her time before (280ff)

On coming home R thought "ooer!" (55), and used to get "in a flap spin" (78) trying to cope with her new baby. She felt bewildered, confused and out of control, relying on her mother and a neighbour for help.

3. **Motherhood was a new and frightening experience**

Interviewees felt they lacked confidence on coming home with their child. For A:

> "I felt clumsy, I didn't feel confident at all, in fact it took me 3 or 4 days before I got to love her... I'd never dream of picking a bairn up that small, and I were always frightened to death of dropping her....."(585ff)

Others feared for their childs survival, e.g. E used to think her baby may be dead, and used to look for evidence of breathing (E,165ff), which sounds bizarre but is commonplace in her experience.

One can feel lost through ignorance and fear of the unknown when becoming a mother (E,79ff, 88ff, 69ff, 72ff)

R wondered how she was going to "cope with him"(52ff) feeling a bit ignorant. When her child split it's anus, and she found blood in his nappy R remembers "it frightened me to death" (99)

After the first bath she gave her child, W was no longer frightened and has felt competent since (92ff)

4. Mothering is hard demanding work

The demands of mothering are never ending, a 24 hour a day job with no breaks possible, and even the night time is not sacred (A624-629). This makes it difficult to keep appointments, there being so much to organise and prepare each day. Such never ending demands lead to resentment (E,45ff) and feeling 'lumbered' (E,97ff)
E wondered what had hit her when the crushing demands of being a mother became a reality (172ff)

For L she has not been crushed by the demands of motherhood, her husband is home 4 days a week, and has been very helpful (100ff) she still has her job, and never felt trapped at home (170ff).

It has been "terrible, the hardest job I'll ever do" (123ff) for W "all day every day" (125ff), but she has been able to cope.

> "All of a sudden I'll have a great big, a good cry, or a good night out and I'm back to normal again... I relieve tension like that" (W,163ff)

5. Mothers can be left uncared for

There seems to be a distinct, unfeeling lack of concern of others for one's predicament in the transition to motherhood, leaving interviewees feeling totally uncared for.

For A, the doctor (60-75), (80-89), her boss at work, (92-107), staff at clinic (142ff), in hospital (179ff), social services (340-350) and her husband (728-733) all potential sources of help, turned away from her in her time of need and refused to help her.

In hospital "no-one showed you what to do" (E,92ff) there was no real interest in mothers needs (E,97ff) the doctor did not care (E,279ff), and the health visitor was minimally involved (E,279ff)

R was ignored in hospital (4ff) treated with indifference at clinic (146ff) and overlooked by the services (179ff).

L appreciated feeling cared for, as her mother and husband have taken good care of her (65ff) (85ff), as has W husband and doctor (63ff, 66ff)

6. Mothers' need for reassurance from others

a) A mother needs reassurance from others, but concerns are trivialised

> "they seem to think that a lass whose first bairn it is, goes with every little problem... slightest little problem and they're at doctors,... they think you're just being overactive about it..." (A,686ff)

This seems unreasonable as an inexperienced mother needs reassurance;

> "When it's your first bairn you don't want 'owt up with them you want to find out that they're alright" (A,690-691)

The need for help was spontaneously and sincerely expressed by all interviewees (J,65-68) (E,177ff) (W,66ff)

Where help is readily available, one can cope adequately e.g. R relied on her mother (82ff) who helped her get out of the grossly unsuitable accommodation (29ff) and got her all she needed for the child (49ff).

L stayed at her mothers for months after the birth where she was looked after well (49ff). Her husband has bolstered her self confidence, which she has found very encouraging (191ff). For W her doctor gave her any reassurance she required (167ff).

b) Reassurance and approval are important

Celebratory comments from others are an important boost to one's self confidence;

> "the only thing I felt good and proud and confident about were when I were walking down street and people were saying 'oh let's have a look' ... I felt really great then; when people were saying oh isn't she lovely..." (A,588ff)

Feeling despised and rejected by the respectable world has left A afraid to leave her house (A,713-719). She has been forced through poverty to partake of despised activities e.g. scrounging in jumble sales (A,656ff) and subject to hostile disparagement at clinic (A,631-635) which has been unbearable.

W thoroughly enjoyed being a celebrity at home;

> "he (baby) was the first grandchild, and the first great grandchild, .. so when I had him everybody went mad, he must have had hundreds of pounds spent on him... oh it were lovely" (W,140ff)

7. Mothers feel vulnerable to moral condemnation

The obligations attached to motherhood, and high expectations of a mother, left interviewees feeling very vulnerable to moral

condemnation, in a number of ways.

a) Interviewees expressed their anxiety about being seen to be proper, well informed persons e.g. when the midwife first called (A,109-115) and when going for antenatal care; A. was apprehensive because she was unsure of what was expected of her, and wanted to be accepted (A,28ff)

J adheres to proper attitudes and intentions (2ff, 19ff, 20,ff, 97ff, 117ff) as does E, regardless of any unpleasantness, she felt duty bound to insist on her sister fulfilling the obligations of a mother,

> "I tell my sister to go, I say you ought to go to clinic you know" (E,299ff)

L was unaware of any expectations being placed on her (137ff) whilst W recognised, there are pressures and obligations put on to mothers. e.g. to attend clinic (W,226ff) but felt these could be ignored when one is well informed and not easily intimidated. In fact her refusal to take part in the clinic was part of ensuring she was seen to be a proper well informed person, and not "one of these puddings" who need such contact.

b) Another anxiety stemmed from the fear of "bad press" from the services, e.g. in one instance an interviewees child had a bruised head which was because her second hand shoes had no tread left on them and the child kept slipping on the lino;

> "She (baby) keeps banging her sen' now, and I daren't take her up to clinic 'cos she's got a black eye where she fell against corner of bloody table...'cos you've heard these things about women beating their bairns up and I think well, I wonder if they'll think I've done that" (A,606ff)

Her doctor had already warned her against neglecting her child (A,649-50)

J is suspicious of them (J,160-167) and their motives in coming round to her house.

Social services personnel have reprimanded A for soliciting help as only one of many in need. This is unfair as they are not scroungers and have worked hard (A,295-303) but now there is no work available.

E's husband set very high expectations of her, demanding that she stay at home every night till the child was five, even though; "he goes out", she feels she has to stay in, it is expected of her. Staff seem to think becoming a mother is "so easy" (E,141ff), which is an unrealistic expectation.

Mothers are afraid to ask professionals for help (E,664) as it makes one appear foolish (69-73) and one is left wide open to degrading reprimands (E,421ff). W is aware of the possibility of bad press from the health visitor and hospital staff, but feels competent to stand up to them (309ff).

c) The activities and demands of being a mother often <u>involve partaking in demeaning situations</u> where one's dignity is put at risk.

Having had to beg at clinic for clothes for her child left A vulnerable to public disgrace, which has made her reluctant to go for fear of disparagement (675-678). For E, being forced to take part in the demeaning situation at clinic, where all mother sit in lines looking at each other;

"Like a bunch of idiots" (E,273ff)

was intolerable and too costly to her sense of personal dignity.

W refused to participate in the demeaning activities thrust at mothers, e.g. attending clinic (175ff) or putting up with banal testing (213ff). She will not put up with being treated as an ignorant fool (21ff, 175ff).

A's concern to ensure her child is healthy has allowed staff to belittle her as a pest (A,686-691) wasting their time on trivialities.

d) Contact with services can cause worry and distress

In fact contact with the services causes more problems than it solves.

They cause one to **worry by withholding information** (A,700ff)

> "nobody ever explains what they do, she's (the baby) been having jabs now, and half on them I don't know...they took some blood out of her groin...with this needle...she (the baby) were in right agony... I'd to go and ask what they'd done it for...and nurse said 'Well I've never known 'em to do that love...and it were because she'd (the baby) got 2 sections of her cord instead of 3...it were n'owt to worry about... but there again it was because they hadn't told me..."

They **undermine confidence** by setting ideal standards which are impossible for the poor to follow e.g. regarding diet:

> "We could've brought the bairn up their way if we'd've got money...for meat and fish and stuff like that...(A,194ff)

and undermine the way mothers have been coping (A,260ff) by highlighting the contrast between their base and poor life style and that which others enjoy (A,190ff).

They set unrealistic expectations of coping which make one feel a failure (A,271ff) which is unfair as it is based on an idealised view of life.

Contact with them constitutes a threat to one's self respect; the lack of freely available procedural know how making one "scared to go" (E,72ff) as one just "feels a fool". At clinic one is forced to take part in a demeaning situation;

> "they all sit there in lines, no-one talking...looking at each other like a bunch of idiots...a cattle market, that's what it's like" (E,268ff)

8. **Mothers can suffer disappointment and let down**

Expectations surrounding the advent of motherhood had been dashed by the experience, making interviewees feel let down and disappointed.

For A her husbands reactions had been a source of great disappointment. He was unmoved by the news of her pregnancy, (while she was 'over the moon' (A,77ff), refused to become involved as a parent (A,624-633), or share the responsibilities (A,629-632)

Despite preparations, coming home was a disaster (A,250ff) the house and family were in turmoil, the consequent stress of which led to the loss of her breast milk (A,253ff) and the enjoyment she had experienced in feeding her child this way.

Worst of all, life had not altered in the ways she had anticipated, within minutes of arriving home for what she hoped would be the start

of a whole new life, she was back to the old grind as before (A,254ff), but with an added responsibility which caused new problems.

Social security put paid to her elaborate plans for a better life; unexpectedly and without warning they deducted money from her meagre income laying waste to her planned purchase of necessities (A,351-356)

E felt she should not really grumble, as ostensibly, all is well e.g. financially they have been alright, but this is not how she feels. She feels desperately dissatisfied and disappointed with her lot in life (E,180-182)

9. **A sense of loss accompanies motherhood**

This is shown in a number of ways:

a) <u>The loss of freedom</u> is felt acutely by most interviewees, there being little opportunity to take part in life outside of the house. A misses going out and socialising (A,814ff), J agrees that her freedom "to get up and off when you want" (173ff) has been curtailed. This loss has been a surprise, as mothers never thought it would be like it is, as before it was taken for granted;

"you get used to... you're own freedom" (E,29-33)

The felt need is for a positive participation in life.

L has not felt restricted as the whole family go out a lot, and enjoy doing things the baby can take part in, so

"he's not stopped us in any way" (175ff)

She also still has her job as before, and so has not felt trapped at home.

W has been noticeably less mobile than before, it being problematic getting into town (284ff) which has restricted her freedom to get out and take part in life (289ff). She has applied for a part time job to remedy this.

b) <u>There can be a significant loss of social contact</u>

Being confined to the house, means seeing no-one else all day long (E,214ff) (A,816ff).

J (73ff), could not go out, as she was shy about breast feeding outside, but is not sure she's so bothered anymore (177-184).

The loneliness is crippling, making one desperate "just to meet people again" (E,20ff), as it is just not possible to have much social contact (E,3ff)

W hopes the job she has applied for will help her get back into a more social life style (289ff).

The severely limited life style imposed by (in some cases poverty) and motherhood, **injures one's ability to take part in wider social life.**

Enforced confinement in the house leads to a fear of going out, even when this is offered e.g.

> "We've only been out 3 times...since last Xmas...and one was my sister's wedding...we really had to go to that one but sometimes I just...I get that used to being stuck in t'house I'm scared to go out, I feel as though people are laughing at me...about me"

She cannot afford to go out, is ashamed of her appearance now, not having had time to see to herself and lost her motivation to look nice as there is nowhere to go or look forward to (A,718ff). To cheer herself up sometimes she pretends she is going somewhere and she 'get's make up out, and... it makes me feel a lot better" (A,729ff)

Mothers need a social outlet 'just to meet people again' (E,18-24). The daily round of life is tedious and repetitive;

> "I knit most of the evenings or watch telly, or read, that's about it, my life, or I do housework or washing...it's same every evening...same every night, knitting, ironing, washing, that's it" (E,349-354)

offering a severely limited scope of activities;

> "I go to town once a week, and I go to shops every day, that's about it, I never go out socially or anything... it's about 4 weeks since I last went out, at Xmas, so that's twice this year" (E,344ff)

W hopes her job will help to broaden her life, so she 'can have the best of both worlds' (289ff)

c) Motherhood entails a significant loss of earnings

Full time motherhood means losing one's income (A,816ff), making one financially worse off (E,319ff). Having always been hard up R (86ff) has relied heavily on her parents.

d) Motherhood entails the loss of expressive choices

Even shopping becomes stripped of any pleasure when money is in short supply e.g. A used to enjoy this, but now has a set routine, with no choice of items possible, as there is no money to spare (821ff). The lack of choice must be adapted to, one must accept one's lot, face hard facts and get on with it.

"you have to else you go daft" (E,15-17)

Even going out is severely restricted e.g. by bad weather, as one can't take a baby out in it.

> "if I was on my own I could go, whereas I can't I have to think about her (baby)". (E,329f)

The limited scope of activities is depressingly monotonous; (E,344ff)

e) <u>There is a loss of variety of roles</u>

Being a mother dominates one's life so that other roles have to be forfeited e.g. 'being one of lasses' is not possible (A,815ff), (E,333ff). This makes one feel that a loss of the child would entail the loss of one's whole self;

> "if anything should happen to (baby) ... I'd have nothing" (E,38-41)

This entails a total estrangement from one's previous self; E never thought it would be like this, her life completely changed (E,29ff)

The disatisfaction springs from an inability to accept such a limited variety of roles imposed by motherhood (E,38-41)

f) <u>Mothers can miss chances to work and progress</u>

If A had stayed at work she may well have been a supervisor by now 'earning good money' (A,809ff)

Working was enjoyable (E,20ff) and sorely missed (E,19)

L has carried on working, and is very happy with this, whilst W is hoping to start a part-time job, to have the best of both worlds.

10. **The full weight of responsibility is felt by mothers**

This is shown in a number of ways. From the start, the child was

regarded as A's **sole responsibility** (A,244ff) so that preparing for her coming home from hospital (e.g. airing ready prepared baby clothes etc.) was described as a favour for A from her husband (A,242ff)

Her husband remained unconcerned about the baby's care 'he weren't interested at all' (A,198ff) leaving all the worry about providing for the child adequately to her.

> "I was just like a one parent family, ...bringing bairn up by me'sen..."(A,206ff)

The pressure is put on mothers, not fathers, so that e.g. it is the mothers responsibility to stay in every night (E,334ff). The services don't help either, one being left to sort it all out, oneself (E,66ff) and it can be difficult to trust anyone else with the care of one's child (E,4-10), One is never free of the responsibility (E,360ff)

Reliance on oneself is unavoidable, as there is no-one else continuously involved. (E212ff) and having adapted to this, one can feel a certain pride in the achievement (E310ff)

L felt very competent from the start, was not prone to worry and has coped very well (72ff)

W also was very confident in preparing for her childs birth (87ff) mothering (92ff) and had no need of help from the services (127ff). She is now proud of her achievements (156ff) and sure of her abilities (159ff). She has relied on her own good sense and intuition (252ff) seeing herself as a natural carer (268ff).

Even when one's husband and doctor are very helpful and reliable, at the end of the day it's a question of self reliance (W,159ff).

11. For a mother the childs welfare must come first

Major worries revolve around the childs welfare (E,164ff) and the provision of enough food, warmth and clothing. As A was poor her major concerns were;

> "how am I going to feed it...how am I going to get all proteins and that... that a babbie needs, 'cos she were on solids at 4 weeks old...and I thought well I'm never gonna be able to feed her, and then I thought, well, I wonder if house is gonna be warm enough for her... 'cos it's terrible cold in winter, this house, ...has he (husband) got enough coal for fires..." (A,581ff)

In every way, E felt her child's welfare must come first (E,332ff)

Professionals stress the ideal of putting one's child before all else, as for e.g. when A went to her doctor for help with depression, he warned her to improve herself and overthrow her problems or she would neglect the child (A,649-650). This clarified for her the idea that her problems should not be dwelled upon, she should not spend time feeling sorry for herself, but put the childs welfare uppermost.

This can entail going against one's own best interests. Elaborate strategies (A,318-319) and even despicable activities must be engaged in to ensure all is well for the child. For A this included begging social services to help her feed her child;

> "the health visitor sent me to social services...and...I didn't like I don't like begging...that's what I feel like I'm doing, begging, but I mean I've got a bairn to think about now"

E felt the duty to provide a sibling for her baby (E,21-24) regardless of her personal reluctance to go through it all again. It would not

be fair to put one's own needs first.

12. Motherhood can entail conflicting needs and obligations

E expressed very clearly how a mother can feel trapped, morally, physically, and emotionally by the demands of motherhood. Her needs were impractical, forbidden by her husband, forbidden by the ideal of being a good mother, and would provoke guilt if she tried to fullfil them.

She felt obliged to attend clinic regardless of how unpleasant (E,297, J,97ff) or frightening. (R,126ff) it was; enjoyed having her baby (300ff) but would rather be working (304-309). She believes women should be 'allowed' to go out like men, but "most men don't think that do they ?" So that even when she does go out, she only thinks about her child anyway so she may as well stay at home, there is no escape (360-378).

In order to fulfill the obligations of being a good parent, E felt she should have another child, it is her duty to provide a brother or a sister for her child (23-24) even though she herself does not want another one (34ff).

Conflicting needs and obligations lead to resentment and antagonism. E resents her husbands freedom, to go out (E,334ff) as he pleases and has found it hard to like her baby (471ff). This leads to a rather ambivalent, conflict ridden existence, e.g. E can't unreservedly say her life is better now, she would like to be working, but also to have her baby, so she can't really say, she would rather have more money and be able to do what she likes a bit more (E,319-326).

A recognised it was her own fault she was now a mother (815ff) and that she must take responsibility for this decision. She was very anxious about failing her child (196-200) not having enough money to provide a good diet, but felt helpless to improve the situation (295-303). Attempts to secure a more adequate income, a thing she has to do, means she has to beg for money from social services, a demeaning activity she hates (348-350). When trying to get help she is forced to act in undignified ways in order to be heard (90-91) and worries about looking silly and compromising her dignity each time she goes for help as often one is rebuked (686-691).

W would like to work, and as it is only 3 hours a week, the job she has applied for will not conflict with her obligations as a mother (289ff).

13. **Becoming a mother can be a dehumanising experience**

Since passing through the services, interviewees felt dehumanised.

a) They were treated as of no consequence, (A,129ff) as an object, not worth caring about, ridiculed and humiliated (A,149-153, E,113ff, 109ff). They were not taken seriously (A,170-178), protests were ignored (A,140ff) and being driven about like 'cattle' (E,270ff) was intolerable.

W refused to accept the belittling role of an ignorant patient in need of help (22ff, 175ff, 309ff) demonstrating her knowledge at every opportunity (3ff, 15ff, 70ff, 98ff).

b) Mothers can feel self disgust

A's partner seems to be ashamed of her appearance, being 'reluctant to take me out' (732ff) for which she does not blame him as she feels ugly now with 'stretch marks, and all...I just look like a piece of that cheese with blue veins in it' (A,731ff).

Self neglect is unavoidable as there is no time to look after oneself.

> "I'ave dropped off...I've spent more time seeing to her (baby) properly that I 'aint had enough time to see to myself...when we were first married you'd never catch me like this I'd always be dressed up, with make up on and I'd look nice, but I can tell that I've let myself go with looking after her." (A,720ff).

14. **Mothers can feel under threat of personal collapse**

Interviewees felt under threat of personal collapse, (not L) as problems were made more poignant with a child to care for, there are no solutions to their difficulties and the only recourse is to soldier on.

With all the strain, worry and privations of motherhood;

> "I ended up going to my own doctor in t'end...I were bad with my nerves and I thought well, 21 years old and a bag of nerves and I were having to take sleeping tablets (A,284ff)

The trials of motherhood make one feel one "might go insane" (E,2ff). Feeling deeply depressed (E,148-151) she thought if she didn't "boost herself up a bit" (213ff) and see some friends however infrequently she really would "go daft" (E,337-343).

R suffered from depression (187ff) and strange pains (200ff) which were never really resolved.

The hopeless lack of jobs (A,295ff) irresponsible husband (A,290ff) impossible impoverished circumstances (340-59) threatened eviction(632ff) and fear of hositle disparagement (651ff) all become much worse, much more threatening when one has the responsibility of a child to care for:

> "it wouldn't be so bad, but now we've got a bairn to bring up as well...that's what makes it so...bad" (303ff)

There are no solutions available, leaving one feeling helpless to sort out predicaments (A,305-319)

> "I don't know how we've survived...we have chips more often than not, which is all we can afford, and babbie has Weetabix and chips...I ain't had a joint of meat for....God knows, but it's over a year" (A,333ff)

It is like fighting a losing battle, all efforts to improve matters come to nothing (A,340ff,352ff), childs clothes wear out too quickly (A,602ff) and making food go round is a strain.

> "me and my husband, we've starved so as that she could have sommat" (602ff)

The only way is to carry on:

> "I've just got to keep my willpower up...if I don't I know that next thing I'll be having another nervous breakdown...I couldn't go through all that again...pelleting me'sen with drugs just to calm me sen down...and I thought well...slowly but surely your killing your sen off" (335ff)

One just has to get used to depression, accept it or face madness, a harrowing notion (E,15ff). There was no help for R's depression, doctors just brushing it to one side (187ff)

15. **Mothers can enjoy the fascination and pleasure of child rearing**

Motherhood can be a beautiful experience at times, with unexpected pleasures as bonuses. e.g. A was surprised to find she enjoyed breast feeding, she:

> "loved to just watch her" (A,639ff)

which became a lovely experience.

It can give considerable enjoyment (J,168ff) watching a child grow in competence and ability (A,615-617) and even cause one to re-examine beliefs about children e.g. (E,204ff) and

> "They're a lot brainier than we think" (A,615-617)

This can be a source of help, the child cheering the mother up (E,218ff).

One can feel proud of one's achievements as a mother (E,310-312), seeing the child grow strong and healthy. L has enjoyed all different things about being a mother (166ff) and is happy with this. L feels she has adapted well to being a mother (84) and felt competent in knowing what to do (100)

W has enjoyed motherhood (262ff) and is pleased and proud of her achievements

> "he's (the baby) come on, as you can see, like hulk aren't we" (W,150ff).

6.1.3. <u>The whooping cough dilemma</u>

The decision to take or avoid the whooping cough vaccine was a major source of anxiety for the interviewees.

Information was not readily available e.g. A's child has been having many jabs, and she has no idea what they've been for (700ff)

> "Nobody ever explains what they do".

J had no basis on which to make any decision (139ff). E felt information was withheld "They don't tell you anything" (390ff), and L found a reluctance on the part of the staff to offer explanations; "they didn't bother explaining" (150ff).

Moreover, it is common place to find staff doing things without one's informed consent (A,209-231, 90-91).
Exceptionally minimal and begrudging effort is put into the offer of immunisations to mothers e.g. (L,150ff) they merely "send a letter... saying oh she's (baby) due for a so and so" (A,700ff)
which is disappointing; "Thats's all you get, that's it" (E,232ff).

All except R had heard about the dangers associated with the injection. Alarm was widespread, pervasive and frightening (J,130ff, L,150ff)

> "I'd heard that much about... the bad side effects" (A,700ff)

E remembers everyone seemed to be talking about it.

The lack of information or explanation and the widespread alarm combined to leave mothers bewildered, frightened and unable to make any sort of decision comfortably. It was a major cause of worry (A,706ff, L,150ff, E,244ff) being expected to make such a decision

> "You don't know which way to turn do you ?" (J,130ff)

The conflict and anxiety was resolved by avoiding the injection in fear (A J & L) or apprehensively having it done (E,10ff) and hoping for the best.

E's health visitor scared her into having it done, telling her the gory details of the suffering a child goes through if they get whooping cough (257ff).

R had all her childs injections from her doctor, did not discriminate between them, and was unaware of any dilemma.

W felt she made a carefully reasoned decision on the basis of what her doctor told her when she specially asked him, i.e. few children are damaged by the injection, and whooping cough brings almost certain death;

> "it would kill him (baby) anyway" (W,201ff)

The responsibility for any possible harm to the child was firmly pushed onto the mothers shoulders. e.g. when L asked her doctor if it was wise to have it done, he put the question back to her: "he said it were up to me" (150ff). This was regarded as a ridiculous burden to expect mothers to carry. To make a life or death, essentially medical decision with no knowledge on which to base it.

The interviewees remained unsure of the wisdom of their forced decisions. R was unsure that her doctors advice had been correct (158ff). E now, tentatively thinks it's probably a good idea to have the injections, because her child is okay (244ff). A is still worried that she did not let her child have it (700ff). L wished she had had

more advice about it (150ff) but just didn't dare risk having it done (J,130ff).

Only W felt comfortable with her decision, whilst R, was not aware that one had taken place.

For those who refused, it was better to risk the child getting whooping cough, an eventuality governed by fate, remote and not requiring any active participation by the mother; than to inflict brain damage on their child, by their own hand by allowing them to have it. This would have amounted to them being implicated, an active participant in any disaster, to have actively put their child at risk.

It was an impossible decision to ask a mother to make; "I didn't really know anything about it..." (L,150ff).

6.1.4. Appreciation of help

The interviewees expressed their appreciation and indebtedness to those who had helped them during the past 18 months of first time motherhood.

Where a person had **shown real concern** for their welfare, a **willingness to get involved in their problems,** the interviewees were very grateful.

The health visitor showed real concern about A's marital problems;

"she's been really good and understanding" (A,276ff)

even though the efforts were to no avail as the problem goes on. However, A feels less confused about it all, as she's been able to go and talk about it. The health visitor showed a real willingness to get involved. The midwife showed a caring interest in J's problems with her new baby. She was; "great...fantastic...brilliant" (54ff) as was W's (295ff, 65ff). The health visitors concern was shown by her prompt response to L's call for help, she came straight away and has "always been good" (L,63ff). J's husband demonstrated his willingness to get involved in the routine baby care tasks e.g. getting up with her through the night to feed the child. This pleased her a lot (83-86).

Reliable, ever ready help was much appreciated, especially when there was a **demonstrable readiness to give help/advice.** E's midwife and health visitor were nice and very willing to give advice, which was helpful (154ff) and an auxiliary nurse in hospital was full of useful advice which was enthusiastically offered (E,440ff).

Reliable, ever ready help was available to J from her mum (65ff) which meant she didn't have to worry about anything. This left her feeling strong and confident, even though she felt in need of help, and she learned a lot.

When support is readily available, one can cope very well. R always had a friend and next door neighbour (82ff) and her mother has always helped out (86ff). The number left by the midwife for emergencies was immediately made use of when one occurred (100ff).

The midwife at antenatal clinic was very helpful, and told L all about the services (16ff) She was familiar to L, and a reliable source of help (58ff).

When one is **accepted and respectfully listened to,** by approachable people who are easy to talk to, this is much appreciated.

Both her health visitor and midwife were easy to talk to, and took the trouble to "sit and talk to you" (J,50ff, 61-62).

L's doctor was easy to talk to, and so she has never had any problem getting help (153ff)

Antenatal relaxation classes were good, because they were a civilised pleasant affair, where; "you have a cup of tea and its right nice... lovely like a little social club" (W,31ff).

One nurse stood out from the rest in hospital because she respectfully acknowledged E's status as a human being, with a concern for dignity. The nurse used to close the curtains when E was breast feeding so she would not be on public display (437ff).

Being accepted and respectully listened to is a comfort (A,714ff) even if the advice is a little idealistic and inappropriate.

When **reassurance** is offered, this is highly valued. The doctor had been a source of reassurance to L, giving her child a thorough examination and putting her mind at rest by explaining the source of

her childs discomfort (140ff).

The checks on her child's development were reassuring to A so that she could stop worrying about that aspect of mothering (685ff).

6.2. DISCUSSION OF THE UNDER USER'S PERSPECTIVES

The accounts are to be taken as a representation of the underusers views, and whilst one is not obliged to agree with them, they are a faithful representation of them. Clearly each under user is not adequately taken account of in the condensed thematic summaries which follow, rather the themes identified are regarded as being of importance to an understanding of their experiences, these were the terms within which they talked about their lives, and require serious consideration in relation to provision if their uptake is to be encouraged. These are the issues which must be addressed, they are not necessarily those shared by either professionals or the researcher but they do require one to reconsider and add to the terms within which underusage is discussed.

6.2.1. Aspects of service provision

Service provision was remote and opague

The underusers could not find relevance in the services for themselves. They had not been considered or disregarded by some and were thought to have been overlooked by others. Both privele ged and inaccessible know how was felt to be involved in taking part. As a distant, self enclosed world with its own rules and relevances, they clearly did not fit in.

Inappropriate to them

Under users preferred not to be considered the kind of person such services appeared to be catering for, being regarded as neither good enough or bad enough to warrant attention. Those for whom services are provided must be of questionable ability and/or integrity. Further more the services put unreasonable demands on mothers, sponsoring unreachable ideals of motherhood and leading to one being judged poorly.

Contact could be costly

Contact with the services entailed possible risks to one's self esteem. Staff conveyed both their supposed social and moral superiority over mothers and could be a significant threat to ones well being. They had both the power and authority to withhold or grant help and insist on certain obligations being fulfilled. They could then confirm or challenge one's respectability, and being offensively impersonal in their approach, staff could dismiss and ridicule the unwary. They just did not seem to care, turned away at times of greatest need and begrudged giving any help. Sometimes cruel, callous and punitive in their intent, staff reprimanded, degraded and policed mothers.

Provision was disappointing

Some mothers are overlooked, whilst overall the services were disappointing, of severely limited usefulness and questionable expertise. Instances of culpable negligence, blundering and laughable procedures were commonplace.

Provision can cause worry

The whooping cough dilemma, (where this was acknowledged) was a major

worry for them as they had no adequate basis on which to make a decision, yet had to bear the onerous responsibility for any mistake. This was a ridiculous burden to bear, leaving them as yet unsure as to the wisdom of their forced choice.

Acceptable help

Help which was reassuring in intent, and willingly offered out of a real concern for them was deeply appreciated, as was whenever they felt accepted, respected and understood.

6.2.2. Aspects of becoming a mother

A difficult transition

The experience of becoming a mother had been a difficult and complex one, made worse by feeling ill prepared for the less glamorous realities ahead. Cheated of both help and the truth they soon realised the gap between spurious advice and real life experience. This came as a shock leaving some bewildered at finding their lives almost unrecogniseable. In some ways it was a new and frightening experience which called for both hard work and a growth in self competence to be managed. Either through lack of interest from others or outright refusals to become involved, they felt uncared for, and in need of reassurance which when forthcoming was a great help.

Vulnerability to both moral condemnation and personal collapse

It was a time when they felt vulnerable to moral condemnation, there being both awesome obligations and high expectations to fulfil. The fear of a bad press inhibited asking for help as this could put at risk one's dignity and sense of competence. The full weight of responsibility for the childs welfare was felt acutely, there being no

ready means of sharing it, leading to self reliance. The child, it was felt, must always come first in their lives, a major cause of worry which can necessitate behaving against one's own self interest. There can be conflict between one's obligations and personal needs. Dehumanised and belittled in their passage through the services, and a lack of self worth sometimes exacerbated by disfigurement and an absence of support, left some feeling vulnerable to the threat of personal collapse. Having a child can make any problems much more serious and requires soldiering on in the face of difficulties.

A time of significant loss

There were losses to be endured in becoming a mother, the loss of personal freedom, social contact, earnings, expressive choices and chances to progress all being potentially injurious to the self.

Great pleasure and growth in self competence

The fascination and pleasures in becoming a mother made it often quite a beautiful experience, which had resulted overall in a significant growth in self confidence and competence.

6.3. COMMENT: CONFLICTING/MISMATCHED PERSPECTIVES

From the underusers acounts, it can be seen that there are significant areas of conflict and mismatch between their concerns and making use of service provision. Neither the perspectives of the researcher, nor those embodied in provision can be assumed to be cognisant of the mothers' perspectives, and a number of concrete examples can be offered to illustrate the problem. One of their major goals in becoming mothers and feeling successful is likely to have been to achieve a degree of self competence and confidence in their abilities.

As the services were primarily regarded as supervisory and policing in intent, contact with them was infantilising. Clinic procedures of weighing and testing, routine matters of professional care were never perceived as such; any testing of one's child was always regarded as a reflection on the mother's abilities, as a mother, the child as the visible product of her care. Impersonal, routine and bureacratic procedures intended to provide a service to all, which could include waiting, generalised advice, specific directions to follow, herding and sending out request follow up cards were received as offensive and undermining of their individuality and self respect, revealing that no one really cared.

The desired presence of fathers at ante natal classes can be regarded as a well meant and desireable goal for service providers to pursue. The interviewees reluctance to go along with it reveals another area of misunderstanding. The researcher's preferred interpretation was in terms of sexism, the women being trapped in their traditional female role of child carer; the interpretation of professionals was in terms of clients' supposed ignorance of the benefits of a participating father in modern childrearing. The interviewees' accounts show neither interpretation to be fully cognisant of their position. For some, becoming a mother was the one great contribution to the world they could make, a special position which only they could fill - and they hoped to excel in doing so, to prove their abilities. Bringing fathers in on it would dilute such a possibility, they would no longer have something unique to offer. Provision which stresses the involvement of fathers does not recognise the terms within which these women view their project in life, and neither does feminism. This is not to say that either the professional or feminist perspective is

wrong, clearly the issue can be viewed in various ways which will be more or less useful but it shows that neither is clearly cognisant of the clients' view.

The services brought unwanted conflict into the lives of interviewees and engendered costs to their self esteem. They threatened the security of what they valued most, their self esteem, dignity and personal competence.

Becoming a mother was a potentially discrediting position to assume, which made association with the powerful an ordeal, something to be dreaded and curtailed as much as possible. The services reactions to them and evaluations of them could be negative and so avoidance becomes the preferred strategy for self preservation.

Provision conflicts with the major goal of motherhood, the need to feel competent and in control, both the policing and supervision on offer undermined this goal. Withdrawal, within these terms of reference, need not be regarded as an abnormal/pathological response. From a professional point of view underusage is seen as irrational, indicative of ignorance and imcompetence. The underusers offer a diametrically opposed interpretation, avoidance being rational (why risk potential harm?) an informed decision, which can confirm and enhance one's competence as a mother, high consultation rates being considered indicative of incompetence.

CHAPTER 7: DISCUSSION

INTRODUCTION

In this chapter an attempt is made to integrate and clarify the findings of the study. The chapter begins with a brief overview of the main findings of the study. In the light of this research evidence, the reasons for underusage put forward by previous studies are restated and reconsidered. It is argued that the findings do not support explanations of underusage which stress 'problem persons' or client deficiencies (i.e. the preferred explanatory framework which underlies most comment on the problem); rather, they suggest attention be directed to the human relations involved in service provision, which was the primary focus of concern for the clients interviewed. The human relations involved in provision are considered with reference to the three main complaints clients levelled at the services. These were, the impersonal approach to clients, the threatening power of professionals and the lack of sympathetic understanding of the client perspective. For each complaint, the findings in this study are embedded in other research and comment which it is thought illuminates and clarifies the issues involved. In keeping with the major goal of the study, to focus on the client perspective, the issues of importance to an understanding of underusage highlighted by this research are outlined. The chapter ends with a summary of the main argument pursued in the discussion and some suggestions for further research.

7.1. THE MAIN FINDINGS REVIEWED

The sampling procedure shown in Chapter 4 succeeded in providing a predominantly **lower socioeconomic group sample**, thus directing attention to those least well represented in research. The set of mothers satisfying the selection criteria were reasonably representative of the locality under study as were the 56% actually interviewed, allowing for a more complete and realistic assessment of usage. There are no comparable data known which would allow for an assessment of the generalisability of these results. The study then remains limited to this locality and population, further research being necessary to establish their generality.

In Chapter 4, the **usage index** produced a highly detailed and clarified profile of uptake, showing there to be considerable variability within socio economic groups. Tenuous and carefully guarded conclusions were drawn in view of a) the infancy of the usage index which must be regarded as essentially exploratory and a first attempt to devise an instrument for such a purpose; b) the limited statistical analysis possible due to the small numbers involved; and c) the missing data which reduced complete coverage of all services. There was found to be minimal uptake by a majority of the sample which was particularly geared to the more clearly medical aspects. Uptake was on the whole sporadic and selective. Client initiated uptake requires documentation, and the attempt in this study was partially successful in showing it to be a main feature of underusage.

The **case studies** outlined in Chapter 6 offered very rich and detailed data relating to underusage, and are not immediately and simply comparable to that obtained in the **content analysis** outlined in Chapter 5. However, there are points of concurrence which can be noted which show that even for the extreme underusers, their cares and concerns and reflections on provision are broadly in line with those expressed by the sample as a whole.

Respondents in case studies questioned the relevance of provision, as did the other lower scorers and middle scorers; case study respondents would be part of the majority who felt badly informed about service provision. The problems experienced by the sample as a whole in knowing how where and when advice could be gained are reflected in the underusers accounts, as are the complaints with regard to conflicting and unrealistic advice. The underusers found the services to be offering exceptionally limited help, a theme echoed in the content analysis where the clinic was of very limited usefulness to most. Their preference for the 'pop in' system at clinic was also preferred by the sample as a whole for similar reasons, and their complaint that staff just did not seem to care for them was one shared by the majority of the sample. Their major concern to be seen and treated as competent mothers again was reflected in the majority of responses. Like the majority of the sample the underusers were aware of the supposed link between the services and problem families as the main target client group. They shared the same kinds of problems of coping as the other mothers having new and heavy responsibilities, and were part of those who felt ill prepared for the realities of motherhood.

A more detailed comparison and matching is not possible as the categories of responses for the content analysis are at a very general level, and the issues identified did not occur in the same ways in the case studies. Despite applying statistical manipulations to the limits of applicability, robust differences between respondents in line with uptake could not be found, whereby it was decided to give less weight to the kinds of explanations of underusage which depend on individual differences, and more weight to those which could account for the significant level of complaints among both users and underusers.

7.2. CRITIQUE OF CLIENT DEFICIENCIES AS REASONS FOR UNDERUSAGE

The problem of underusage is often dealt with in ways that are detrimental and critical of the clients. This is mainly construed in terms which show deficiencies in the client which are held responsible not only for underusage but their poor health in general. From the research and comment on underusers, outlined in Chapter 2, that which holds this position can be summarised as maintaining that these clients have neither the intelligence, motivation or skills to avail themselves of good health.

7.2.1. The Claimed Deficiencies

Clients are thought to **lack intelligence** in general, **and specifically in relation to health matters.** They are poorly educated (Baric 1967), fail to understand medical terminology or instructions (Jeffrey 1971) hold ridiculous beliefs (Wynn Williams 1982) and have become 'dull' as adaptation to deprivation (Lipton 1974), being unable even to state their case.

Clients don't understand the link between the services and good health, or that of preventative action today which will accrue future benefits, having little knowledge of disease and illness states (Smith 1970), high alarm thresholds (McWeeny 1977) and mistake the purpose of provision (McConachie 1977, McKinlay 1970a, Wilson 1973). They display irrationality, as despite being at high risk of medical complications they don't come for care (McKinlay 1972b). They do not limit their family size according to financial capability, speak well of health care but don't use it, and have inconsistent views (Aitken Swan 1977).

Clients are thought to **lack the motivation necessary to securing good health**, having become apathetic, irresponsible and alienated. Their apathy is regarded as an adaptation to powerlessness (Aitken Swan 1977) whereby they regard events to be outside their control (Jay 1980) fatalistically living in the present with no proper regard to planning ahead in a provident manner (McKinlay 1970a). Their unstable life styles make usage of the services impossible (Jay 1980). They are thought to suffer from personal alienation and low self esteem, feeling inferior to the rest of society and out of place at clinic (Bramall 1978), whereby they quickly lose what little confidence they may have.

Clients are thought to **lack the skills necessary to secure good health.** They seem unable to avail themselves of help when this is needed (McWeeny 1977) being both reluctant and unable to secure a doctors attendance on them (Logan 1971). Being unable to initiate or secure help, they fail to act as effective consumers actively

exploring options open to them, and in any case do not have the drive and motivation to be healthy (Wynn Williams 1982) often preferring questionable family advice.

Each of these contentions has been heavily criticised by those who do not seek explanations of underusage in some form of what Holman calls 'problem persons', or Riley 'blame the victim' approach.

7.2.2. Assumptions underlying 'client deficiency' explanations

In relation to the findings in this research, it can be noted that the lower socio-economic groups could be found at both ends of the usage scale, some making substantial use of the services available. Any explanation would have to take account of both. McKinlay 1972a identified a particular group within the lower socio-economic group which was regarded as displaying the negative characteristics outlined above in contrast to the others in his sample. In this study the under-users were not so distinct from the remainder of the sample as to constitute a separate group. The similarities were more marked than the differences, so that it seems unlikely that they are pathologically distinct, rather it would seem that they behaved differently, in terms of usage, in situations that were perceived and felt in a similar way by others.

7.2.2.1. Irrationality is construed in professional terms

Charges of irrationality levelled at the underusers rest entirely within professionally construed notions of rationality, adequate information and correct values, as when viewed from the underusers perspective underusage was portrayed as essentially rational.

Attending for care early, limiting family size and taking control of ones physical well being have all been identified in professional terms with professionally defined goals in mind. Oakley (1980) questions the link between attending classes and 'good outcomes' in pregnancy and Graham (1984) has shown that taking control of one's lifestyle in the pursuit of physical well being in line with professional recommendations can be an ill conceived notion for many women who do not have the final say in family life.

The lack of congruence between professed beliefs and behaviour (thought to be indicative of irrationality) can be more properly be regarded as a fact of life, a robust finding in most research on attitudes. The underusers in this study spoke well of their health visitors, and in particular noted how they meant well; the staff presented themselves as helpful, but the help was irrelevant to their concerns, and/or challenging to their sense of competence.

Withdrawal from use of the services cannot simply be regarded as irrational. It could be seen to be preserving of the underusers self esteem, as their basic integrity was at stake in encounters with care for some clients.

Assertions regarding the intelligence of clients have been ill-defined and of questionable objectivity (Oakley 1980), whilst the misunderstanding of medical terminology need not necessarily be regarded as **their** problem. It has been argued that the use of jargon by staff can be both unnecessary and preserving of client mystification (Strong, 1977). The problems of communication between

clients and their carers can be regarded as a fault on either side, it being quite reasonable to regard professionals as lacking in the skills necessary to deal effectively with their clients.

7.2.2.2. Charges of irresponsibility undervalue client's efforts

Charges of irresponsibility have been heavily criticised by those who work with the very poor, e.g. Family Service Units publications stress the planning and strategic budgetting which is evident in their ways of managing meagre resources (Pahad, 1981, Burghes; 1976). The acute sense of responsibility felt by the respondents in this study was a major theme in talking about their lives, and has been a salient feature of other studies (Graham, 1984). Furthermore, there was no evidence in this study which clearly indicated that underusers were more or less responsible than others, or that their lifestyle was distinctly unstable.

Reluctance to seek professional help when needed (taken to be an irrational stance) was not confined to the underusers. Afraid of being put down and subject to hostility, over one third of the respondents in this study claimed that they would think very carefully before calling for help. Important aspects of this reluctance were not knowing when and for what reasons it is appropriate to make contact, and uncertainty surrounding the legitimacy of their needs. The services were not well understood, respondents professing to being unsure of where to go for help and advice.

The link between usage and one's sense of responsibility was found in clients accounts, but in quite a different way. This was alluded to by both Birkel (1983), and Green (1984), in their studies of consumer

perspectives. Using the health visitor and clinic was related to clients sense of competence as mothers. Making extensive use of help would have indicated to both themselves and others that they were failing in some way at least, and at worst that they could be classed as a 'problem family' with all the attendant stigma and repugnance that would entail. Their sense of responsibility and felt need to be competent and confident as mothers was directly opposed to making use of the services. Their major complaints as to how they were treated by staff, are also instructive in this respect. They objected to being ordered around, told what to do and infantilised by condescending staff who seemed to think they had no sense. The services seemed to be catering for those who might warrant such treatment; failures and no-hopers who required this kind of attention. It certainly was not the place for a competent and responsible mother to frequent, it was incomprehensible to them to think that this treatment could be meted out to all regardless of personal competence, therefore they must be in the wrong place with the wrong group of people.

7.2.2.3. <u>The concept of alienation may refer to low self esteem</u>

Only two members of the underuser sample could clearly be regarded as feeling inferior to others due to their impoverished circumstances, and even then they did not accept the negative stereotyping they felt they were subject to. However, one feature of alienation, low self esteem, was found to be a feature of becoming a mother for a majority of the respondents. This was linked to their felt need to sacrifice themselves for their childs welfare and in other research has been linked to the way mothers were treated by the services (Oakley 1980) and the limited variety of roles and undervalued work of mothering

(Weidegger 1977). It is difficult to know what kind of significance to attach to such findings as those specifically engaged in helping women with their mental health problems regard low self esteem as a main feature of growing up in this society for females which can be exacerbated by becoming a mother (Orbach 1983).

7.2.2.4. The over emphasis on professional health care

There is a danger in research and comment on underusage of equating the reluctance to involve professional health carers in one's concerns, with a lack of motivation to be healthy. The underusers in this study did not accept the link and could see little benefit to be gained from contact. Where the service was well understood and regarded as relevant and important, all respondents made efforts to secure it. Trivial and frivolous contact with the clinic was thought to be both unnecessary and ridiculous by a majority of the respondents. Graham (1984) bemoans the confusion in research whereby health care is regarded as a professional perogative, preferring to see the services as only a small part of the health care work put in to children's welfare. The major contributions are regarded as those of the parents who carry the day to day burdens of the work. The respondents in this study did indeed see themselves as the prime carers with total responsibility for their childs welfare. The underuser's accounts of "scrounging" for money from social services could be regarded as an attempt to secure better health, a feature which would not be recognised by an exclusive focus on professional efforts.

7.2.2.5. The active participation of clients may be discouraged

Certain barriers to obtaining health care have been identified which limit the likelihood of clients being able to use the services confidently and effectively, as active decision makers. Some writers have specifically criticised provision on this count, seeing patients as discouraged from active participation in their health care. They see them as being effectively prevented from exercising any choices (Oakley, 1980; Graham, 1984). In their studies, women were rarely given sufficient information on which to make choices and encouraged to regard both pregnancy and childbirth as medical emergencies best handled by professional staff.

7.2.3. Summary and Comment: Blaming the Victim

The underusers accounts were not totally distinct from the rest of the sample. Charges of irrationality, ignorance, irresponsibility, alienation, laziness and passivity held responsible for underusage and poor health status in general were questioned in view of research which has addressed such issues and the findings in this study. The major problems with such interpretations were: the questionable objectivity employed in accounting for clients behaviour; the preference to impose professionally inspired concerns on data; the lack of understanding of clients life circumstances and preferences and appreciation of their efforts, and the poor appreciation of the ways in which provision itself can pose problems for clients.

As the underusers did not hold a distinctly idiosync ratic perspective on issues of relevance to all respondents, and faults can be located on both sides depending on preferred orientations to such issues, both the legitimacy and usefulness of the 'problem person' formulation has been questioned.

In some ways this study could be taken as in the best tradition of blaming the victim as it directs attention to the defaulters rather than the wider social context (as suggested by Ryan 1976); the features of the social world which would lead one to anticipate underusage rather than be surprised by it. However, it would seem to be more accurate to regard the problem as lying in the **kind** of attention one draws to such people, the assumptions one brings to a study. Those studies identified as 'blame the victim' sought to identify what was wrong with these people, their deficiencies, which amounted in many cases to a documentation of the ways in which they differed from the successful middle class consumer. Directing attention to them in order to listen to their views, to seek an understanding of them in their own terms is not the same approach as judging them in terms of identifying deficient features. They are not usually heard or included in studies in this way. What is wrong then with the 'blame the victim' psychological approach is not the fact of turning attention to the client, rather than the political and institutional structures of society, but how this is done and with what aims in mind. The phenomenological approach adopted in this study guarded against a victim-blaming schema by requiring the researcher to 'bracket' judgements of the sort which would lead to the identification of deficiencies, and having the explicit goal as a faithful articulation of their perspective.

7.3. THE CLIENTS PERCEPTION THAT RELATIONSHIPS WITH HEALTH PROFESSIONALS ARE PROBLEMATIC

When the underuser's accounts are taken seriously they direct attention to certain issues which would seem to be important to an understanding of their perspective. These can be illuminated with

reference to other research and comment which has addressed similar issues. In particular, their accounts show a preoccupation with the human relations in service provision, which directs attention to the client/professional relationship in general. It can be seen that the relationship between clients and their professional carers is a problematic one.

The social distance between clients and their professional carers has been regarded as an important factor in accounting for problems in communication and sympathetic identification between them. This is thought to be due to both the tendency for professionals to come from different cultural backgrounds to their clients and the adoption of a professional identity and approach to them (Doyal, 1983; Strong, 1977).

The nature of professionalised care has been investigated with a view to detailing features which contribute to such problems and a number have been selected for consideration in relation to the findings of this study. These are the main complaints levelled at the services; that they are impersonal, threatening and not cognisant of the clients perspective. They are treated separately in this discussion, but should more properly be regarded as intimately related to one another.

7.3.1. Profferred care is perceived as coldly impersonal

The nature of professional care as a service for all, with global goals, can make it of questionable relevance to any particular individual. There were unintentional costs to clients, in terms of their self worth, in being 'processed' through the system.

In what follows, attention is focussed on four features of a routinised service which clients identified as contributing to their problems with provision. These are elaborated where applicable with theory and comment from social psychological research which it was thought illuminated the issues, by providing a context of relevance within which they could be discussed.

7.3.1.1. The lack of emotional involvement with clients

The complaint about the impersonal service on offer can seem trivial, a frequently made and worn out matter, but when attention is turned to what this can mean to the client, it is restored to a position of importance. **The lack of emotional involvement on the part of staff** was a major complaint, which is identified as a professional ideal for carers; a feature of work in institutions (by Goffman, 1958, who saw it as a solution to the problem faced by providers of treating persons as serviceable objects); and a coping strategy adopted by carers for reducing the stress of such work (Menzies 1976). It could then be regarded as a commonly found and accepted feature of the services. One consequence is the way in which individual needs are translated into averages and routines (Ong, 1983, page 28ff) which may serve the needs of the staff, but not necessarily those of the client.

Personal and particular characteristics are put to one side, as clients are treated with the technical approach thought appropriate to all. The underusers felt stereotyped by service providers, typified in disrespectful and belittling ways. The lowest common denominator of needs then can result in those who do not feel they need the provision on offer feeling insulted, that anyone should think they might.

7.3.1.2. The offensive impersonality of routinised care

The routinised care which was presumably designed to give a uniform service to all is experienced as offensive to the clients sense of personal dignity, merely serving to convince them that they must be culpable in some way. Each underuser felt that they may have been selected out from the uniformity for exceptionally degrading treatment; the alternative retrospective reasoning being that the services must be there to deal with the ignorant and worthless. Regardless of their personal needs and abilities, as they saw them, they were treated as if they had none, or were a member of a particularly unattractive grouping.

7.3.1.3. Impersonal care leads to a questioning of the value of the care on offer

Dismissive and cursory treatment are features of routinised care of which clients were particularly critical. They were deeply concerned about the manner in which they were treated. Routine advice was regarded as inappropriate, their particular circumstances rendered such advice as ridiculous.

Balint (1957), in his accounts of the doctor patient relationship, stresses the futility of 'reassurance which is routine, well meant, wholesale and totally ineffective'. Wholesale advice which could be regarded as viewing any disorder impersonally, as no-one's fault, is never perceived as such by mothers being questioned about the health of their child. Where a child's welfare is at issue, the mother feels acutely responsible and implicated, and given the wide range of areas of relevance on which she can be questioned (habits, equipment, preferences), it is very difficult for them to regard queries as merely technical matters.

Fitzpatrick (1983) has identified the importance of impersonal care for many patients. He found that patients primarily judged doctors by their 'affective' behaviour, rather than any criteria of clinical competency. Others have taken the issue even further, arguing that care and concern on the part of staff is a necessary ingredient to patient compliance (Haigh, 1977). Without it, there seems no good reason why the client should place any trust in staff. Strong (1977) describes the way in which the routinisation of care can in and of itself lead to a questioning of professional expertise, in that the less time allotted to a patient, the less confident she can be in any decision made, as the doctor is less able to take her full story into account. Such an interpretation is confirmed in Fitzpatrick and Hopkins' (1983) study where the main complaint was about cursory and dismissive investigations which felt 'too quick' to be of any use.

The routine/impersonal care on offer then, when viewed in terms of the social meanings conveyed shows that such care can be inappropriate, it can lead to a questioning of professional expertise and be threatening to the clients self worth.

7.3.1.4. <u>The meaning of waiting for clients</u>

The waiting incurred in fitting in with service provision was irksome to all interviewees, and as a feature of routinised provision, it can be seen to entail considerable costs to the client in terms of increased anxiety levels (Coffey, 1983); damage to self esteem (Schwartz, 1974; Packard, 1959), and is implicated in promoting disappointment with the service.

In his exhaustive account of status and how this is transmitted in every day life, Packard (1959) shows how waiting can be degrading and undermining. It is formalised in the military where the wives of high ranking officers are never kept waiting by medical personnel; whilst others can be left to wait interminably. Schwartz (1974) clarifies the social meanings involved in what he refers to as 'ritual waiting'.

To be kept waiting an unusually long time is to be subject to an assertion that one's own time, and therefore social worth, is less valuable than the time and worth of the one who imposes the wait. The waiting serves to accentuate an initial inferiority:

> 'The client is compelled to bear witness to the mortification of his own worthiness'

The waiting can also be viewed as a form of mystification whereby the value/worth of the service is accentuated, inaccessibility promoting reverence. This combined with the anticipated expertise of health professionals may serve to elevate the clients expectations of receiving a really worthwhile product. To find clients almost universally disappointed and feeling let down by what they are offered requires some sort of explanation. This interpretation is given added weight when one also takes into account the interviewees perspective on hospital care. They were bewildered, amazed and sometimes alarmed by the high technical wizardry in evidence there, and then totally unimpressed by what was on offer at clinic, for example watching a child walk or swap bricks from hand to hand seemed very obvious matters, hardly requiring of an expert; thus the deep disappointment.

7.3.2. The threatening power of professionals to clients

There seemed to be rules and norms of participation for the interviewees, but were unsure of what these were, and felt them to be both ideal and professionally sponsored and so could find themselves wrongfooted. This might not have mattered, but as there are power differentials involved it did. Institutions have the power to insist on the legitimacy of their perspective (Berger et al, 1971) whereby being unable to fit in can amount to a challenge to one's integrity. Where the institution matters, then, not knowing the ropes can make contact an alarming prospect. Interviewees felt ill equipped to make use of the services with any sort of ease. There was felt to be an appropriate way to use them, which was never clearly spelt out, but known when anyone violated it.

The acknowledged power imbalance in favour of staff can result in clients having little control over what is to take place at any time. The professional usually owns the time, sets the tone and relevances of each encounter and this can put the client at a distinct disadvantage.

7.3.2.1. The clients' lack of familiarity with service provision

Clients' lack of know how with regard to service provision can be seen as a serious matter, for which there may be no easy remedy. Familiarity is not only to do with dates and times of attendance, names of staff etc. but with how to behave in the social situation presented: what kind of reaction others are likely to have, and the fear of making costly blunders.

This kind of familiarity has been termed 'distinctive stock of knowledge at hand' (Berger, et al, 1971, p.56ff.) and is to be found in any group where members feel they belong. Mere comprehension of what goes on is not enough to ensure a sense of predictability and comfortableness. This was lacking and contributory to underusage.

Not only were the interviewees unable to predict or favourably interpret the intentions of the staff, but they felt the staff were unable to do likewise. Interviewees felt they were treated with little understanding. The stock of knowledge serves as a source of security and assurance where questions about chosen conduct are rarely raised. In attending clinic, interviewees could be caught on the hop, and their own schemes potentially invalidated, a cause for considerable concern when the professional was perceived as powerful and legitimate.

7.3.2.2. <u>The imputed group identity rejected by clients</u>

Goffman (1958), suggests one approach to participation in an organisation which shows the way an organisation entails a certain conception of the participant, the asylum being an extreme example of how the physical facts of an establishment can be explicitly employed to frame the conception a person can take of themselves. This was clearly a point at issue for the interviewees, they did not want to embrace the unflattering and undignified implications of going to clinic as part of themselves. To go, would be to join an inappropriate group. They also felt that in order to use the services they were required to have a trivial, limited and easily solveable, preferably technical problem, brought to the right person at the right

time. The fact remained though that 'life isn't like that!' and thus the irrelevance. Whatever the sort of person who went to clinic was like, it was not for them, they felt that staff acted on the wrong assumptions about them which was threatening to their self esteem.

7.3.2.3. The effort demanded of clients in participation

The complaint that it was just too much to take part in service provision, makes more sense when viewed in this way. When unfamiliar with a part of the social world, it takes effort to participate. Such an interpretation could serve to clarify a common misconception in previous research. Those who have claimed that it was too much effort to go to clinic were referring to a lot more than the physical hardship involved in attendance, e.g. long expensive, tiring journeys on infrequent and inconvenient bus routes. Effort expended can be more to do with trying to feel easy in such a potentially stressful environment stemming from inadequate knowledge of the hidden aspects of the clinic world and personnel. It is however, far from clear how such 'knowledge' is or could be passed on.

7.3.2.4. The stressful nature of encounters with care

Within a similar explanatory framework, Strong (1977) offers a detailed outline of the ways in which fulfilling the role of 'patienthood' can be arduous and precariously liable to failure. He identified some of the duties and obligations which the competent patient should meet; not to take up too much time, to pesent problems in a clear and accurate fashion and to answer questions straightforwardly. These requirements can be likened to the properties of 'focussed gatherings' identified by Goffman (1972), which when laid out give a clear idea of the kind and amount of work a

client must engage in to carry off an encounter of this sort: maintenance of poise, capacity for non distractive communication, adherence to role codes and the maintenance of continuous engrossment in the official focus of activity. Most important of all he identifies the desire to do the right thing. The medical/professional encounter when viewed as problematic, can be seen to be a special kind of social encounter where the stakes are high and for some the guiding rules obscure. The idea of 'popping' into clinic does not do justice to what goes on in such situations. However passive a patient may seem, then, "being a patient can entail a great amount of difficult work" (Strong, 1977).

7.3.2.5. Clients' preferred sources of help

A number of studies mention in passing the anomaly of mothers avoiding asking official experts for advice, e.g. Kurtz (1981), documents several studies which found that new mothers in hospital prefer to approach more junior staff and even cleaners and visitors, to ask for help over feeding and many other "less-medical" matters. They said that as a matter of routine they were given little advice and that even this was often conflicting. Soliciting advice from unofficial experts can be seen to be part and parcel of everyday life, and a much less threatening exercise, where the rules and obligations are well known and enacted in our relations with others. No special time or place is set aside and there are no wide power differences to cope with.

When viewed in these terms, borrowed from other areas of social psychological research and theory, the problems confronting interviewees become more understandable. The power of professional

health carers and the lack of familiarity on the clients part can result in uptake being a considerable chore for some, where in failure to act competently can be costly.

7.3.3. The client's perspective may not be well understood

All of the above can be seen to apply to any lay person who seeks professional help, but in some ways mothers can be regarded as particularly vulnerable to stressful and threatening encounters; not least because they also have a child to 'manage' in such encounters. The child cannot be relied on to back up ones performance in any way, and in fact can be a constant source of risk to comportment. Interviewees stressed that they felt they were under scrutiny, especially with regard to how they handled their child.

7.3.3.1. Clients felt they were under moral review

Clients felt they were under moral review from professionals, so that the promise of help was paired with fear of recrimination, which could range from being suspected of child abuse to clearly not being able to fit in or rebuked for inappropriate behaviour. Their abilities as mothers were thought to be under scrutiny, making attendance potentially dangerous. Attendance in view of these matters is never a trivial occurence, but something for which special arrangements are made and about which mothers may have thought a great deal prior to going.

7.3.3.2. Help seeking was related to notions of incompetence

A number of researchers have drawn attention to the meaning for the client of seeking professional help. Voysey (1975), Graham (1984), Hales (1982) and Green (1984) note the documented reluctance of

clients to involve others in their affairs. Seeking help, however this is framed, is related to the capacity of the mother to contain her problems. It is a decision which implicitly/explicitly raises questions about the commitment and competence of the mother, a reflection on her mothering skills. The consequences for a mother of being judged incompetent can be great and include the possibility of having one's child removed. It is to be expected then that they will exercise caution in such circumstances. Requests for help then can be seen to be related to judgements of competency, an acknowledgement of ones own inadequacy and an appreciation of the possibility of unspecifiable involvement in one's affairs. Interviewees in the present study stressed the policing role of health visitors, who checked their houses, their children and mothering adequacy. This was not conducive to the sharing of intimate and threatening worries, as asking for help could have been very costly.

7.3.3.3. The problems of motherhood may not be well understood

Other researchers have presented evidence which suggests that professional approaches to motherhood do not embrace an adequate understanding of mothers' problems. Graham (1984) found the prominance of postnatal health problems to be overlooked, whilst the loneliness, loss of work, social life and widespread guilt experienced by most mothers was rarely acknowledged.

Goffman suggests one explanation for apparent lack of understanding on the part of pr ofessionals. It is thought that the cultivation of a trustworthy, disinterestedness by professionals can lead to ideal conceptions of clients' interests, which, when combined with professional standards of taste, can conflict with the clients' view.

Charges of irrelevance were prominent in the interviewees accounts, especially when the advice given them was regarded as unrealistic. Some problems were tangled emotional matters which were to be lived through rather than pronounced upon. They objected to books offering rules and simplistic solutions. Interviewees questioned at root the services' expertise, which was unconvincing, and objected to the unreasonable demands being placed on them.

Graham (1984) outlines one example of a health campaign which she sees as totally missing the reality it was meant to be addressing. In leaflets promoting the protection of family health, she found the full burden was placed on mothers to plan diets with varied menus, encourage sports and generally take on more responsibilities. For many the recommended changes would require a radical restructuring of daily life. One of the most pertinent observations Graham makes is that the advice assumed women had the degree of control necessary over their lifestyle and families choices to make such changes.

In this study not only did interviewees consider advice absurdly irrelevant to their life circumstance, but they were caused considerable distress when they could not match the ideals proposed to ensure good health for their child, e.g. dietary requirements which were expensive.

For many, the experience of becoming a mother had been regarded as a time of significant vulnerability. There was much to be done, heavy responsibilities and worries, and much at stake. Comer (1974) offers a rare outline of just how difficult coping can be for some mothers, whilst other researchers identify various features of the social world

which are thought to act against a mothers best interests. For the poor, the strains involved in doing one's best for one's child can be considerable (Burghes, 1980). Motherhood then can be a difficult time for many women being both physically and mentally taxing, (Doyal, 1983; Taylor, 1985; Oakley, 1979). It can be a time of both meaningful gain and very disturbing loss and challenging to one's self esteem. Many report the shock which can accompany the transition to motherhood, making this a very common reaction, whilst the advent of motherhood is now generally acknowledged to be related to poor mental health (Oakley, 1985). It seems that overall it can be a time of considerable vulnerability from the interviewees' perspective, when they feel they should put the needs of their child first above any consideration of their own wellbeing.

7.3.3.4. Service preferences from the client's perspective

Both the almost unanimous preference for the pop in system at clinic and problems encountered with the whooping cough vaccination can be reinterpreted from the clients perspective, showing that their preferences were not particularly well understood.

The almost unanimous preference for the pop in system expressed by the respondents in this and other studies requires further consideration. Whilst all claim to prefer it to any other more structured system, few of the target groups actually do pop in. From what has gone before, it can be seen that it is the system which preserves their autonomy. They prefer to exercise choice, which any other more structured system would erode, and create more obligations. More naive accounts in research, which have not explicitly sought the clients perspective on the issue, try to see the pop in system as being more in harmony with

their chaotic disorganised lifestyle, as evidenced in the suggestion that services be located in accident departments. These are reputedly frequented by the poor, who are considered prone to accidents and haphazard contacts with provision. From a consideration of their perspective, it does not seem that this is the case, the pop in system is preferred as it can then be ignored.

From the interviewees' perspective **the whooping cough dilemma was caused by service providers** who showed little appreciation of their position. During the whole process of becoming a mother, going through pregnancy, hospitalised birth and post natal care, mothers were not encouraged to be active participants in 'health' matters dealt with by professionals. They were not encouraged to ask questions, actively explore options available to them; rather they felt they were being a nuisance, troublesome or uppity when they attempted to take a more active part. This led them to surmise that in certain respects the experts know what they are doing, and that some matters were too complex/specialised for them to have an authoritative contribution to make. This is shown by the way they felt that there were things they 'had to have done' even though they weren't sure why or to what end, and on most counts, however reluctantly, it was left to professionals to do what they thought best.

All of a sudden and without preparation, the mothers were then faced with a highly dangerous procedure, which had been singled out by professionals for particular comment. Help was minimal and reluctantly given about the issue and the mother was expected to make

a decision herself. She was asked to become the prime mover in what was to take place, become a very active participant. They felt they had no way to assess such matters, it being unusual to be asked to judge medical matters of probability. In addition there was the possibility that the child's life would be actively put at risk by the mothers own hand, and never having been in such a situation, fear was the most common reaction. The mothers then either backed off and refused in fear, or submitted to the procedure in fear, but remained un-nerved by the whole episode.

Those who refused to have the immunisation carried out can then be castigated for irresponsible behaviour, putting their childs health at risk, and the issue of enforced immunisation is suggested as the remedy. This was the ludicrous scenario described by interviewees in their accounts of problems they faced in trying to ensure the welfare of their child, and clarifies their complaints of ridiculous expectations made of them, and how undermining contact was to their competence.

7.3.4. Particular groups may be offered a worse service than others

As outlined above, it seems, if we are to take clients perspectives seriously, there can be problems for any lay person in making effective and confident use of professional services. There are also some writers who have identified particular groups of clients who are unlikely to be well served, viz women and the lower socio economic groups. The respondents in this study would for the most part fit this category and there is some evidence to show that they can be treated differently and with less respect than others.

The class bias detected in the recruitment and delivery style of professional health carers is thought to shield them from a clear understanding of certain clients problems and perspectives. This has been explicitly acknowledged in some services such as psychotherapy and personal counselling services where special training in understanding clients of different social backgrounds is included. Professionals and clients are regarded as sufficiently removed from one another to require special efforts to bridge the gap, as otherwise their interventions are found to be both unhelpful, not reality based, and potentially damaging.

There is some evidence to indicate that the services are not necessarily equally responsive to all clients; and that service providers can lack sympathetic identification with their charges. These features are thought to make contact with professionals much less threateneing and costly to the middle class client whose similarities with the carers are thought to be capitalised upon (Strong, 1977).

Those interviewees who were visibly poor and of low social status felt they were despised and rejected by the respectable world of the services, a feature stressed by other commentators on the role of status in society e.g. Packard (1957). There is some evidence to indicate that those of lower social status can expect a poor service response to their needs.

Doyal (1983), claims there is continuing discrimination in service provision to the detriment of those of lower social status. Graham (1984) presented evidence which suggested that the professional

network was not equally responsive to the needs of all families, whereby the middle classes could be regarded as receiving more care at a lower personal cost than those from lower socioeconomic groups. Cartwright (1964) showed how in hospitals and G.P. surgeries patients were treated differently, to the detriment of the lower status patients. Tulkin (1971) described how obstetricians appeared to treat those patients whose case notes recorded a manual occupation differently from others, and Oakley (1980, p33ff) drew attention to the surprising fact that, despite the known increased risk of obstetric problems in lower classes, the poor were not singled out for special antenatal attention if this would entail access to greater privacy, more space, more doctors time, or more chance of seeing a higher status doctor. In fact more middle class women were likely to be found in the special clinic, as were patients with any kind of medical status. Holman (978) reviews the evidence which indicates that the most needy face considerable barriers to securing help from uncooperative staff.

The consensus in those few studies which directly confront the possibility of there being discrimination in provision to the detriment of those in the lower socio-econimic groups, is that they can indeed be offered a different and worse service than others.

Kerr's (1982) work on clinic encounters is of special interest here, as, in examining the role of fathers in child health care, she uncovers some important differences regarding the way in which women and men are treated by staff. The fathers were trusted to be more receptive to 'objective' information and advice. Their presumed distance from child health matters being linked with attributions of

objectivity and rationality. Clinic staff even tried to gain the fathers' allegiance with regard to vaccinations whilst their views were not sought on 'minor' issues like feeding. A number of assumptions about the fathers' competence were thought to be behind the strategies staff employed to handle the atypical event of a fathers presence at clinic. They were directly approached, guided and encouraged through the clinic process, and routines were carefully explained and even justified. The mothers in her study were not treated similarly.

In such a situation where presumably mothers are meant to be expert or at least better informed than fathers, they were not accorded the dignified and respectful treatment called forth by the father's presence.

The lack of sympathetic identification between professionals and low status clients has attracted some comment. Holman (1978) outlines ways in which low status clients are known to have been subject to punishments and humiliations rarely experienced by others; being judged in detrimental and stereotypical ways which results in professionals seeming indifferent to their plight. This claim is also made by Packard (1959) and Doyal (1983) who stress the increased likelihood of their being judged negatively and punitively sanctioned.

The discriminatory treatment meted out to such groups and the lack of sympathetic identification between them and professionals is thought to result in their being offered a worse service than others, in terms of it being less likely that they are listened to, attended to in a

respectful manner, given special attention or helped with good grace, resulting in a much higher personal cost to the client.

Evidence in support of these contentions is sparse, but suggestive and worthy of further research. Although it would be useful and illuminating to have more information on the possibility that certain clients are offered a much worse service than others, which could be responsible for keeping certain groups away, it is sufficient for the purposes of this study simply to recognise that the nature of professionalised care can pose considerable problems for any client; that these problems are likely to be considerably worse for those least au fait with professional matters, and that these are most likely to come from the lower socio economic groups.

7.4. ISSUES OF IMPORTANCE TO AN UNDERSTANDING OF UNDERUSAGE

In this section, some of the issues highlighted in this research which are important to an understanding of the under users are summarised. They are given from the clients' perspective; no attempt has been made to balance issues from any other relevant perspective on such matters. The presentation of the underusers' viewpoint was felt to be a worthwhile goal in and of itself and, whilst not leading to any obvious solutions to the problem of underusage, the results may be of some use to those whose task it is to find one.

7.4.1. Self preservation as the main goal of underusage

Attending clinic did not offer the underusers opportunities to feel positive about themselves, or enhance their self esteem. For some this was put at risk at each visit. They felt challenged as worthy, competent persons, being in need of help was unglamorous and their

abilities to judge and decide matters was undermined. Both feeling competent and in control were important aspects of motherhood, which were put in jeopardy by contact with the services.

Some interviewes stressed that they had opted for motherhood as a way in which they could prove their independence, competence and abilities, which were seriously undermined in contact with the services which questioned them in so many ways. The esteem enhancing possibilities of motherhood were undermined by contact, and unwilling to face humiliating and deprecating negative encounters, some interviewees protected themselves from harm by not taking part.

In some ways the services created yet another set of problems for the interviewees. They felt another set of imposed standards to which it was impossible to aspire were being advocated.

Some interviewees could be regarded as defending themselves, establishing distance between potentially mortifying situations and themselves. From their point of view this was achieved by minimal uptake. Graham (1984) in making the unusual point that a mother's decision not to make use of provision could be a reflection of her superior knowledge of her own needs and situation supports such an interpretation. There were indirect costs in using the services for most mothers, whilst for the very poor the situation was much worse, they had no decent clothes to go out in, no money to buy presentable ones and were loath to advertise their miserable circumstances.

7.4.2. The value of presenting the under user's perspective

The results presented in the under users accounts are to be taken as their perspective on the issues discussed, not as an attempt at a balanced consideration of all perspectives on the matter. In putting together the section, no account was taken of the rationality, fairness or 'truth' of their assertions, rather the aim was to produce a faithful rendering of their perspective. No special effort was made to maintain an approving stance towards the services, which is an important consideration to take into account lest the results be seen as simply biased or deliberately critical of provision.On the other hand, special effort was made to present the respondents' case as they saw it, the particular method employed being particularly suited to a suspending of the hierarchy of credibility whereby the perspectives of those traditionally ignored or discredited are given the same weight as those higher up.

It can be noted that the "sad tales" from interviewees which were taken seriously in this study, tend to be discredited by researchers in general as mere excuses or lying. Goffman(1956) insists that they be more accurately regarded as defensively bringing the person into appropriate alignment with the basic values of society. From this perspective it is recognised that all members of society are obliged to pay lip service to the common morality of their time. The underusers claim that attending clinic is morally praiseworthy, but do not themselves attend. The lowly can openly default on their obligations, but more commonly one would expect them to embrace basic values whilst allowing their disaffection to be seen, which is not the same as lying. Sad tales can reflect meanings of importance to an understanding of clients' concerns whereby their desire to fit in

could be a major consideration, and one would no longer expect there to be any simple correspondence between observed behaviour and stated beliefs. Furthermore the analysis is not prescriptive, as no attempt was made to find solutions to the problem of underusage, the aim being to explore clients views which could be of value to those who must seek solutions.

The features of importance to the under users discovered in the analysis could be put in the service of a number of varying formulations of the problem, which would be more or less critical of underusers. For example the lack of congruence between professional and client perspectives could be presented as a lack on either side. Such a conclusion is not within the competence of this study. Where there appears to be some mismatch, however, we avoid placing blame, and look instead to the features of professional health care which may put provision out of step with clients and to the features of the under users lifeworld which may weaken correspondence.

In view of this, the facts of provision are not as important as the mothers perception of them, whereby well intentioned services may not be received as such. The analysis placed the subjective experience of clients as the focal point for discussion, clients' interests, as they described them, guided the relative importance with which issues were addressed.

In the discussion an outside organising perspective was used which did not come from the underusers accounts directly but which, whilst not the only interpretation possible, was the one which fitted the available data and made sense from the research perspective. The

interviewees' concerns do not neatly and unproblematically relate to the research interest in its specifics. It was possible however, to relate this data to the questions posed by past research whilst bearing in mind that they do not arise in the same way for respondents. In this respect in particular, part of the analysis was concerned with rethinking and reformulating the original research questions after contact with the data, as and when it was clear there was a mismatch. The most obvious example would be the relevance and importance of provision to the respondents, in that it was clear in many instances that focussing on the services as an important aspect of their lives was inaccurate.

Prefigured areas of relevance then, were avoided and where necessary revised especially where it became clear that meaningful parallels between the research and the clients perspectives was brought into question. In practice this was brought under direct scrutiny, in contact with the data. At each stage in the analysis the questions the research was addressing were open to change, whereby simple questions (for example, planned parenthood) were subsequently left out of account as they were revealed to be nappropriate and misrepresenting of the clients' perspective.

The aim was an interpretative one, which proceeded by seeing how and in what ways the themes identified as of importance to an understanding of the clients' perspective could be illuminating with regard to the research questions posed.

7.4.3. Solutions to underusage may overlook the client's perspective

The results presented in this research do not lead directly or clearly to any particular solution to the problem, they were not intended for this purpose, rather the study was attuned to a logically prior task, that of filling the most conspicuous gap in research, a documentation of the underusers perspective. Research directing efforts to finding solutions would be conducted in quite a different way. However, such research may benefit from an informed consideration of the perspectives of those it is hoped to attract to the services.

There is some evidence to show that a target groups health status can be improved by 'at risk' registers and positive outreach, e.g. in one study the infant survival rate was improved by such a programme (Emery, 1976). Some of those not reaching the medical help they needed were picked up. Here the initiative was taken away from the mothers, and crisis intervention was secured. The problem of underusage however, was not solved, rather the clients reasons for underusage were ignored and overruled. In some ways the redirection of staff entailed in this project may nevertheless have ensured that underusers' needs and worries were taken seriously.

It may also be the case that taking into account mothers' felt vulnerability as new mothers, and potential consumers of the services, will lead to the avoidance of solutions which are adversary or punitive in intent, and which might only add to mothers' anxieties and therefore be unlikely to succeed.

7.5. SUMMARY OF MAIN ARGUMENT OF THE DISCUSSION

In this discussion, without placing blame on either the services or the clients, there is an attempt to show how well intentioned services could prove difficult to use and potentially damaging to some mothers. To this end, some theory and comment from other areas of social psychology was included as it seemed to provide an adequate framework within which to discuss the main findings of the study.

Taking the clients perspective seriously, forced a reconsideration of the terms within which underusage is discussed, whereby it was revealed that, the services were remote and irrelevant to the mothers' concerns, contact with the services could be costly and some features of provision promoted underusage. To use the services would conflict with one of the major goals of motherhood, both the policing and supervisory aspects undermining their competence and confidence. Within these terms of reference, avoidance could be viewed as a reasonable response.

Attention was drawn to the pertinent **imbalance in power** between the mothers and the sevices, basic divergences in interests and priorities between them and the major difficulties which can be involved in using services, especially with regard to the way the clinic was viewed as a tier of authority to which they were accountable.

Evidence which would broadly concur with the underusers views, which guards against regarding them as totally without foundation in the social world and thus indicative merely of personal problems was sparse, sometimes unintentional but nevertheless illuminating, showing at the very least, that the problem of underusage cannot solely be

attributed to 'problem persons' and that other considerations must be taken into account. Such considerations temper attributions of blame; professionally inspired goals, practices and preferences are not necessarily shared by clients or particularly well attuned to their needs. Demands were made on mothers which were not enhancing of their self esteem. The power of professionals to define areas of relevance and rules of conduct can be threatening to mothers, and discourage contact. Underusers shared with a majority of the sample certain orientations to health care provision, as episodic and fragmented contact was the norm. Most preferred not to regard provision as a central feature of their concerns, and questioned the relevance of the services to them. In some cases, non uptake was regarded as a product of provision, especially with regard to immunisations, and even those who complied were still unhappy about the decision.

There are considerable problems in the relationship between clients and their professional carers which make securing relevant help difficult for all lay clients and very difficult for certain groups.

It is not clear how a client can achieve an adequate and workable familiarity with the world of professional care, those not au fait with such a perspective questioning both their supposed expertise and neutral benevolence.

One point of general importance which is revealed by this study is how becoming a mother and using the services are seen as essentially moral matters with many aspects causing dilemmas for the interviewees. Their concerns were to do with what kind of person should I be, how I am seen by others and what sort of person the services are for. Their

concerns were primarily to do with the human relations in provision, which convey such meanings.

The qualitative feeling of self value, put in jeopardy by contact with service provision, has been regarded as of central importance by some psychologists, whereby considerations of status and role require attention, especially with regard to the problem of maintaining a positively valued self from an inferior power position, (Harre 1979). From this perspective, practical needs do not outweigh such matters, making underusage a preferred strategy for those who felt threatened.

7.6. FURTHER RESEARCH

This study could be regarded as primarily having provided a context of understanding which could lead to new starting points for research, which is cognisant of the underuser's perspective. One promising line of enquiry might be to broaden the field to other welfare services.

Encouraged by the lack of major differences between groups in this study, and the mothers preference to avoid stressing any clear divisions between professional carers (i.e. social security, general practice, hospitals and clinics were all referred to as 'them'), it would seem that attention should be directed in further research towards identifying the features of professionalised care which are trans situational, and related to non uptake in any service. The problem of non compliance for example has been identified in schools, psychiatric provision, social services initiatives, and drop in centres, with essentially the same lower socio economic groups preferring to stay away. An attempt was made in this discussion to identify such features, but it was selective and closely tied to the

studies findings, and only of relevance to maternity and child health care provision. Further research then could benefit from adopting a broader goal which could identify the features of professional care which are common to all services which meet the same problem, and in particular to any initiatives which have overcome it successfully.

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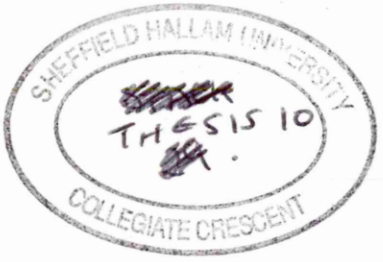
SHEFFIELD HALLAM UNIVERSITY
THESIS 10
COLLEGIATE CRESCENT

VOLUME 2

UNDER-UTILISATION OF MATERNAL AND CHILD HEALTH CARE

BY

TERESA HAGAN

APPENDICES

APPENDIX 1

COMPILATION OF USAGE SCALE

Referred to in text 3.5.2.

Contents

36 Collegiate Crescent
Sheffield S10 2BP
Telephone Sheffield 665274 (STD Code 0742)

Department of Health Studies
Head of Department Miss J. Challinor BEd (Hons) SRN SCM HV Cert

Dear

Re: 'Positive Pathways' Research Project - Selection of 'Users' and 'Non-Users' of Child Health Services.

You have probably already heard something of the above study, which is a research programme into factors affecting maternal take-up of local child health services during the first postnatal year. Part of the study will involve interviews with a sample of mothers to obtain their views of the services. Interviews will be carried out with both 'users' and 'non-users' of the relevant services. Therefore, one important step in the design will be systematically to divide the mothers into 'users' and 'non-users', so that equal numbers of each may be identified, and their responses compared. It is in devising an instrument to carry out this 'user'/'non-user' separation that we would be very grateful for your help.

Accompanying this letter is a checklist of possible contacts which a mother may have with the services during the first postnatal year. The items are in no particular order, and we would be very grateful if you could assign a relative weighting to each by writing its number in ONE of the five boxes athe the top of the page. The significance of each box is explained on the checklist, at the bottom of the page.

Please allocate each of the 20 items to an appropriate box, adding to the list any items of importance which you feel to have been missed; and allocating them, too, to an appropriate box, by writing in the number(s) which you have assigned to each extra item.

If you feel any item to be irrelevant, or not applicable in your area, please indicate this by placing a cross in the left hand margin beside the item.

When all completed forms are received, we will arrive at a consensus weighting of the checklist, and use it to 'group' the mothers.

NB: Responses will be used anonymously and in the strictest confidence. All we ask is that you indicate to which professional group you belong by deleting appropriately at the top of the response sheet before returning it in the envelope provided.

Please accept our grateful thanks for your most valuable help.

Yours sincerely,

'POSITIVE PATHWAYS' PROJECT: CHECKLIST FOR SELECTION OF 'USER'/ /'NON-USER' GROUPS OF MOTHERS. SHEET NUMBER:.....

This sheet has been completed by a HEALTH VISITOR / SENIOR HEALTH VISITING or MIDWIFERY STAFF / CLINICAL MEDICAL OFFICER / GENERAL PRACTITIONER (Please delete as appropriate).

LEAST IMPORTANT	FAIRLY IMPORTANT	IMPORTANT	VERY IMPORTANT	ESSENTIAL

INSTRUCTIONS:

Below is a checklist of items numbered from 1 to 20. Please enter the number of each item in the box above which you think most accurately conveys its importance for ensuring adequate surveillance and health of mother and child during the first postnatal year. Please put a cross in the left-hand margin beside any item you feel is irrelevant (i.e. does not apply in your area). PLEASE ADD ANY ITEM(S) YOU THINK HAVE BEEN OMITTED, and put the corresponding number in the appropriate box. Thank you very much for your help.

CHECKLIST:

1. Attended third (11-month) immunisation session
2. Attended social and other similar events at clinic
3. Attended antenatal relaxation classes
4. Visited GP in connection with pregnancy/antenatal care
5. Attended for baby hearing test(s)
6. Baby has received BCG inoculation
7. Mother accessible for Health Visitor visits (e.g. at 14,21,28 days)
8. Baby has received DPT inoculation
9. Attended second (tenth-month) medical examination by doctor
10. Responsive to advice on first visit by Health Visitor
11. Attended first (sixth-week) medical examination by doctor
12. Baby has received polio immunisation
13. Attended for three-month developmental check
14. Mother initiated early booking for delivery
15. Attended for two-month developmental check
16. Attended second (fifth-month) immunisation session
17. Attended parentcraft classes
18. Attended first (third-month) immunisation session
19. Baby has received measles inoculation
20. Attended other antenatal groups/classes (besides parentcraft and relaxation classes)
21. .....
22. .....
23. .....

(Please continue on separate sheet if necessary)

KEY TO BOXES:

LEAST IMPORTANT = item desirable, but could be missed; FAIRLY IMPORTANT = item fairly important, should not be missed if possible; IMPORTANT = item should really be taken up; VERY IMPORTANT = item should always be taken up; ESSENTIAL = item essential, and it must be ensured that it is taken up.

Following interdisciplinary discussion, a 20-item checklist of 'significant' features of maternal contact with the child health services was prepared. This checklist was subsequently submitted to a multidisciplinary panel for ordinal rating of its individual items. 18 out of 24 professionals approached submitted completed ratings - a response rate of 75 per cent. The validation panel consisted of:

Consultant Paediatricians:	2	Senior Health Visiting staff:	5
General Practitioners:	2	Senior Midwifery staff:	1
Clinic Medical Officers:	2	Health Visitors:	6

Items on the checklist were ordinally rated by assigning numerical values to qualitative responses as follows:

LEAST IMPORTANT 0 FAIRLY IMPORTANT 1 IMPORTANT 2 VERY IMPORTANT 3

ESSENTIAL 4

INFORMANT NUMBER:	CHECKLIST ITEM NUMBER:																			
	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	2
4 CMO	3	0	2	4	4	0	4	3	3	2	2	3	0	3	0	3	2	3	0	
5 CMO	4	2	2	4	4	0	2	4	3	0	4	4	0	1	0	4	3	4	0	
6 HV	3	0	3	4	4	0	4	3	2	2	4	3	1	3	0	3	1	3	2	
7 HV	3	0	4	4	3	4	3	0	4	3	3	3	2	3	1	3	3	3	3	
8 HV	3	1	2	4	3	2	2	2	2	1	4	4	3	4	1	3	2	4	3	
9 HV	4	0	1	4	4	1	4	3	3	2	3	3	3	3	0	4	1	4	3	
10 GP	3	0	2	4	3	0	4	3	0	2	4	3	3	4	2	3	0	3	3	
12 HV	4	0	2	4	4	0	3	4	4	3	4	0	0	3	0	4	2	4	3	
13 SHV	4	0	2	4	4	4	4	0	3	3	4	4	3	4	2	4	3	4	4	
15 SMW	0	0	2	4	0	0	3	0	0	3	0	0	0	4	0	0	2	0	0	
16 SHV	3	0	2	4	4	3	4	3	2	2	3	3	2	3	0	3	2	3	2	
19 GP	4	0	1	3	4	0	2	3	1	2	3	4	3	3	2	4	1	4	1	
20 HV	3	0	3	4	3	0	2	3	1	1	2	3	0	4	0	3	2	3	0	
21 SHV	1	1	2	4	3	0	4	1	2	3	4	1	3	3	3	1	2	1	0	
22 SHV	2	0	2	4	2	0	4	2	2	2	3	3	3	3	0	2	2	2	3	
23 SHV	4	0	2	3	4	0	4	4	2	2	1	4	3	3	3	4	2	4	2	
25 C PAED	2	0	2	2	4	1	3	2	4	3	4	3	3	3	2	2	3	3	2	
TOTALS:	50	4	36	64	57	15	56	40	38	36	52	48	32	54	16	50	33	52	31	2
$\bar{X}$:	2.94	0.24	2.12	3.76	3.35	0.88	3.30	2.35	2.20	2.12	3.10	2.82	1.88	3.20	0.94	2.94	1.94	3.10	1.82	1.20
RANK:	7.5	20	12.5	1	2	19	3	10	11	12.5	5.5	9	15	4	18	7.5	14	5.5	16	17

The hierarchy of checklist items thus became as follows:

(contd)

CHECKLIST ITEM NO:	RANK NO:	CHECKLIST ITEM:
4	1	Visited GP in connection with pregnancy/antenatal care
5	2	Attended for baby hearing test(s)
7	3	Mother accessible for HV visits (e.g. at 14,21,28 days)
14	4	Mother initiated early booking for delivery
11	5•5	Attended first (sixth-week) medical examination by doctor
18	5.5	Attended first (third-month) immunisation session
16	7•5	Attended second (fifth-month) immunisation session
1	7•5	Attended third (11th-month) immunisation session
12	9	Baby has received polio immunisation
8	10	Baby has received DPT immunisation
9	11	Attended second (tenth-month) medical examination by doctor
3	12•5	Attended antenatal relaxation classes
10	12•5	Responsive to advice on first visit by Health Visitor
17	14	Attended parentcraft classes
13	15	Attended for three-month developmental check
19	16	Baby has received measles immunisation
20	17	Attended other antenatal groups/classes (besides parentcraft and relaxation classes)
15	18	Attended for two-month developmental check
6	19	Baby has received BCG inoculation
2	20	Attended social and other similar events at clinic

The original checklist had sought to be as inclusive as possible of items advanced by health professionals as potentially important features of 'effective' maternal contact with the child health care services. In addition, participants invited to assist in validating the checklist were requested to add any further items which they personally felt to be important, and which had been omitted from the original checklist. This 'open-ended' invitation produced the following additional items:

(1) 'Mother's post-natal examination' (Clinic Medical Officer);

(2) 'Made acquaintance of Health Visitor before birth of baby' (a Senior Health Visitor and a Health Visitor);

(3) 'Mother should be given the telephone number of her Health Visitor, and be encouraged to ring when worried' (Health Visitor);

(4) 'Attended for antenatal care at GP/antenatal clinic on a minimum of six occasions' (Senior Midwife);

(5) 'Responsive to advice from midwife in antenatal period and in first 28 postnatal days' (Senior Midwife);

(6) 'Establishment of early relationship between mother and Health Visitor.....accessibility of Health Visitor during first six weeks of baby's life' (Health Visitor);

(contd)

(Senior Health Visitor);

(8) 'Mother seen by Health Visitor during antenatal period' (Senior Health Visitor);

(9) 'Mother able to recognise illness in her own child.... understands how to contact appropriate services..... able to monitor her own child's progress and to give a good account to the Health Visitor/Medical Officer' (Consultant Paediatrician).

However, inspection of proposed new items showed that in the main they either:

(a) described desirable changes in care patterns over which clients could not be expected to exert any control, rather than describing 'desirable' features of individual client behaviour within the existing child health care context (cf. e.g. Items (2), (3), (6), (7), (8) above): or

(b) proposed criteria of 'effective' takeup so subjective as to be difficult or impossible to describe in operational terms (cf. e.g. Items (5) and (9) above. Problems relating to this type of item were well put by a Senior Health Visitor:

> 'It is difficult to ensure 'response' to advice, especially if the advice contains foreign concepts concerning health or behaviour. This may take many visits.....'

and by a Consultant Paediatrician:

> 'I don't know any objective way of measuring this (Item 10 on original checklist), and it is out of place in that the other items are concerned with uptake of services rather than response to advice given. There is also no way of telling whether the advice given was actually appropriate for that particular mother and her particular baby!'

Thus the only proposed additional item not falling into either of these 'difficult' categories was that concerned with antenatal care (Item (4) above), which it was felt was taken up under certain other items in the original checklist (e.g. Items 3, 4, 17).

An interesting procedural suggestion concerning infant immunisation records was made by a General Practitioner:

> 'We asked for the Child Benefit Book to contain the immunisation record of the child. If this had to be completed and signed by a given GP or Health Visitor (where signature was known at the relevant Post Office), it would provide a good lever to persuade parents to have their infants checked. Unless payment/non-payment is made a stimulus for having babies checked, a significant number of parents will never use the services properly. Compulsion sadly is now necessary!'

SIMPLIFICATION OF THE CHECKLIST:

At this stage, preparing and ranking the checklist had accomplished two objectives: firstly, it had assembled a number of fairly clearly-defined features of client behaviour about which there existed a professional consensus regarding their 'importance' for effective child health care contacts. Secondly, it had indicated relatively 'high-ranking' and 'low--ranking' behaviours within that number, from the perspectives of a multidisciplinary group of health care professionals closely connected with the child health services. However, a checklist of 20 items is very large; especially bearing in mind that if it is to exercise a useful selective function for 'user' and 'non-user' groups, it would be necessary to compare every first-time mother with a child aged 12-15 months in every health care context under study on every item of the checklist, in order effectively to define the parameters of usage for comparative purposes. Clearly, what was now needed was a means of reducing the number of items on the checklist, whilst retaining its essential selective features and eliminating only relatively 'low-ranking' and imprecise items. This it was felt could be achieved by a dual process of elimination of 'low-ranking' items and appropriate conflation of some related 'high-ranking' items. This part of the process was carried out with the valuable advice and assistance of a Consultant Pediatrician to the Area Health Authority, who prepared a detailed critique of the checklist as it stood at this point.

(A) Elimination of 'Low-Ranking' and Imprecise Items:

Items 2, 6, 19 and 20 were eliminated on the basis of the discussion so far. Similarly, it was decided not to include the proposed new item on 'responsiveness' to midwifery advice for related reasons.

(B) Conflation of Related 'High-Ranking' Items:

Item 14 ('Mother initiated early booking for delivery'), though important with a rank of 4, was considered rather vague, and was sharpened by specifying an appropriate stage in the pregnancy, becoming 'Mother initiated booking for delivery before 20 weeks with either GP or hospital'. Items 3, 17 and 20 (ranking 12.5, 14 and 17 respectively) were brought together as: 'Mother attended relaxation, parentcraft or other antenatal preparatory classes'. These revised and conflated items were then brought together into a sub-section of the checklist dealing with care in the antenatal period.

Item 7 ('Mother accessible for HV visits, e.g. at 14, 21, 28 days') was ranked highly at 3, and clearly had to be represented, as had the equally important accessibility to midwifery visits hinted at in one of the newly--proposed items (cf. Item (5), Page 2 above). A doctor comments:

> 'Item 7 is imprecise. Many mother are out when the Health Visitor calls for perfectly innocent reasons. It is those mothers who consistently refuse or avoid access whose babies are most likely to be 'at risk'. Secondly, a small proportion of babies are in hospital for the first month, and it is worth specifying 'the first month following the baby's return home'. The accessibility of the midwife is as important as that of the Health Visitor'.

Thus Item 7 becomes two items, both relating to maternal accessibility for home visits: 'Mother accessible for midwife's home visits at least twice in the week following discharge from hospital': and 'Mother accessible for HV home visit at least once during the first month following the baby's return home'.

Item 4 ('Visited GP in connection with pregnancy/antenatal care'), ranking 1 on the checklist, had now been taken up in the first conflated item (cf. Section B, first paragraph, Page 4 above). The item on baby hearing tests, Item 5, ranking 2, was allowed to stand as a most important feature of developmental care. Item 11 ('Attended first (sixth-week) medical examination by doctor') and Item 9 ('Attended second (tenth-month) medical examination by doctor') were re-phrased for flexibility and comprehensiveness, as: 'Attended for first medical examination by doctor between four weeks and three months, either at child health clinic, GP's surgery or hospital baby follow-up clinic': and 'Attended for second medical examination by doctor between six months and nine months, either at child health clinic, GP's surgery or hospital baby follow-up clinic'. Items 13 and 15 ('Attended for three-month developmental check': and 'Attended for two-month developmental check'), both referring to Health Visitor developmental checks , ranking 15 and 18 respectively, were conflated as a single new item: 'Attended for at least one HV developmental check in the first six months'. These four items were brought together into a sub-section of the checklist dealing with uptake of developmental examinations.

Finally, Items 18, 16, 1, 12, 8 dealing with immunisation programmes and ranked 5.5, 7.5, 7.5, 9 and 10 respectively, were conflated as a single new item: 'Attended child health clinic or GP surgery for two or more immunisations within first year, whether immunisation actually given or not'. A doctor comments:

> 'I don't see the point of listing each individual immunisation attendance. Attendance without immunisation being given has to be distinguished from failure to attend for immunisation. Items 6 and 19 are inappropriate as most children are not offered BCG and the measles vaccination is normally given after one year of age'.

REVISED CHECKLIST:

Thus the revised checklist in its final form includes nine items in place of the original twenty items, as follows:-

SECTION A: CARE IN THE ANTENATAL PERIOD.

1 Mother initiated booking for delivery before 20 weeks with either GP or hospital

2 Mother attended relaxation, parentcraft or other antenatal preparatory classes

SECTION B: MATERNAL ACCESSIBILITY FOR HOME VISITS.

3 Mother accessible for midwife's home visits at least twice in the week following discharge from hospital

4 Mother accessible for HV home visit at least once during the first month following the baby's return home

SECTION C: UPTAKE OF DEVELOPMENTAL EXAMINATIONS.

5 Baby hearing test completed

6 Attended for first medical examination by doctor between four weeks and three months, either at child health clinic, GP's surgery or hospital baby follow-up clinic

7 Attended for second medical examination by doctor between six months and nine months, either at child health clinic, GP's surgery or hospital baby follow-up clinic

8 Attended for at least one HV developmental check in the first six months

SECTION C: IMMUNISATION PROGRAMME.

9 Attended child health clinic or GP surgery for two or more immunisations within the first year, whether immunisation actually given or not

SUGGESTED SCORING SYSTEM:

In its final concentrated and flexible form, the checklist represents nine basic items of considerable importance in ensuring effective health surveillance during the antenatal period and first year of life. In this sense, it would seem invidious to attempt a weighting of such highly disparate and equally important items one against the other; and in any case the ordinal character of the ranking data does not sustain such numerical comparison in a meaningful sense. It was therefore decided to score each item on the checklist on an 'all or nothing' basis, assigning equal weighting to all items included, and deriving mean and deviant clinic scores accordingly during the process of selecting 'user' and 'non-user' samples of mothers for the purposes of the study.

DEPARTMENT OF HEALTH STUDIES: 'POSITIVE PATHWAYS' STUDY

CHILD HEALTH CARE SERVICES: CHECKLIST FOR SELECTION OF 'USER' AND 'NON-USER' MATERNAL SUB-SAMPLES

HEALTH CARE CONTEXT:..... DATE:.....

CLIENT NAME/REFERENCE NUMBER:.....

CHECKLIST COMPLETED BY:.....

SECTION:	ITEM NO:	ITEM:	SCORE:
A	1	Mother initiated booking for delivery before 20 weeks with either GP or hospital	YES 1 NO 0
	2	Mother attended relaxation, parentcraft or other antenatal preparatory class(es)	YES 1 NO 0
B	3	Mother accessible for midwife's home visits at least twice in the week following discharge from hospital	YES 1 NO 0
	4	Mother accessible for HV home visit at least once during the first month following the baby's return home	YES 1 NO 0
C	5	Baby hearing test completed	YES 1 NO 0
	6	Attended for first medical examination by doctor between 4 weeks and 3 months, either at CHC, GP's surgery or hospital baby follow-up clinic	YES 1 NO 0
	7	Attended for second medical examination by doctor between 6 months and 9 months, either at CHC, GP's surgery or hospital baby follow-up clinic	YES 1 NO 0
	8	Attended for at least one HV developmental check in the first six months	YES 1 NO 0
D	9	Attended CHC or GP surgery for two or more immunisations within the first year, whether immunisation actually given or not	YES 1 NO 0
TOTAL SCORE ON CHECKLIST:			

NB: Please complete by ringing appropriate score by each item on checklist and entering total score in space provided above.

A checklist should be completed for each first-time mother in the health care context whose child will be aged 12-15 months during the period in which the health care context is under study.

APPENDIX 2

COMPILATION OF REVISED USER SCALE

Referred to in text 3.5.4.

Contents

THE REVISED USER SCALE:

(1) HEALTH VISITOR ASSESSMENTS:

8 voluntary takeup of four assessments (i.e. 3, 6, 10, 18 months)
6 voluntary takeup of any three assessments
4 voluntary takeup of any two assessments
2 voluntary takeup of any one assessment
0 no assessments taken up

(2) TAKEUP OF IMMUNISATION:

4 three or more entries on immunisation card
2 two or less entries on immunisation card
0 no record of immunisations

(3) HEARING TEST:

4 hearing test voluntarily taken up
0 hearing test not voluntarily taken up

(4) CLINIC ATTENDANCE:

	PERCENTAGE POSSIBLE ATTENDANCES:	FREQUENCY OF ATTENDANCE: (N=60)	(N=30)
9	90-100	54-60	27-30
8	80-89	48-53	24-26
7	70-79	42-47	21-23
6	60-69	36-41	18-20
5	50-59	30-35	15-17
4	40-49	24-29	12-14
3	30-39	18-23	9-11
2	20-29	12-17	6- 8
1	10-19	6-11	3- 5
0	0- 9	0- 5	0- 2

(5) 'GAP SCORE':

15 no missing months of surveillance
14 one missing month
13 two missing months
12 three missing months
11 four missing months
10 five missing months

9 six missing months
8 seven missing months
7 eight missing months
6 nine missing months
5 ten missing months
4 eleven missing months
3 twelve missing months
2 thirteen missing months
1 fourteen missing months
0 fifteen missing months

(6) AGE OF BABY AT START OF CLINIC ATTENDANCE:

15 began in first month
14 began in second month
13 began in third month
12 began in fourth month
11 began in fifth month
10 began in sixth month
9 began in seventh month
8 began in eighth month
7 began in ninth month
6 began in tenth month
5 began in eleventh month
4 began in twelvth month
3 began in thirteenth month
2 began in fourteenth month
1 began in fifteenth month
0 never attended at all

(7) AGE OF BABY AT END OF CLINIC ATTENDANCE:

15 fifteen months and over
14 fourteen months
13 thirteen months
12 twelve months
11 eleven months
10 ten months
9 nine months
8 eight months
7 seven months
6 six months

5 five months
4 four months
3 three months
2 two months
1 one month
0 never attended at all

(8) DURATION OF CLINIC ATTENDANCE:

15 attended for fifteen months or more
14 attended for fourteen months
13 attended for thirteen months
12 attended for twelve months
11 attended for eleven months
10 attended for ten months
9 attended for nine months
8 attended for eight months
7 attended for seven months
6 attended for six months
5 attended for five months
4 attended for four months
3 attended for three months
2 attended for two months
1 attended for one month
0 never attended at all

(9) FIRST MEDICAL EXAMINATION OF BABY:

4 attended clinic for the examination
0 did not attend clinic for the examination

(10) NON-ROUTINE CONTACTS WITH HEALTH VISITOR:

The score equals the absolute frequency of contacts, given by the equation:

TOTAL CONTACTS WITH HV IN CLINIC (minus) ('WEIGH ONLY' ENTRIES (plus) ASSESSMENT VISITS (plus) HEARING TEST VISITS)

(11) NON-ROUTINE CONTACTS WITH MEDICAL OFFICER:

The score equals the absolute frequency of contacts, given by the equation:

TOTAL CONTACTS WITH MEDICAL OFFICER IN CLINIC (minus) MEDICAL EXAMINATION VISITS AND IMMUNISATION VISITS

APPENDIX 3

INTERVIEW SCHEDULES

Referred to in text 3.6.

Contents

SHEFFIELD CITY POLYTECHNIC

DEPARTMENT OF HEALTH STUDIES: 'POSITIVE PATHWAYS' STUDY

MATERNAL INTERVIEW SCHEDULE

HEALTH CARE CONTEXT:..... INTERVIEW NO:.....

INTERVIEWER:..... DATE:.....

SECTION A: INTRODUCTORY

INTERVIEWER: We're trying to find out what it's really like for a mother when she has her first child - what sort of problems she has, what kind of help she gets with these problems, and so on. The idea is to look at what sort of help mothers really need at this important time, and try to find out the best ways in which this help can be given. So we wondered if you could tell us a little bit about your own experiences? This sort of information can help us to improve the services for (young) mothers - help us really to give the sort of help that's needed most!

Everything you say will be ABSOLUTELY CONFIDENTIAL - nobody else except me will hear this tape - and I shan't be putting anybody's name in the report, only the sort of comments made and the sorts of problems discussed. We think that what mothers feel is very important if you're to get the sort of help you really need. So could you help us? We'ld be very grateful if you could!

SECTION B: BACKGROUND INFORMATION

B1 SURNAME:..... FORENAME(S):.....

B2 ADDRESS:.....

.....

B3 AGE LAST BIRTHDAY:..... D.O.B.:.....

B4 AGE AT BIRTH OF FIRST CHILD: Under 16 16-21 22-25 26-30

(please ring as appropriate) 31-35 36-40 41-45 Over 45

B5 EDUCATIONAL BACKGROUND: Secondary Modern | Comprehensive School | Grammar School | Other (specify)

(please ring as appropriate) .....

B6 AGE LEFT SCHOOL:.....

B7 QUALIFICATIONS (please specify):

C.S.E.:	'O' Level:	'A' Level:	Other:
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

B8 HEALTH EDUCATION AT SCHOOL: Human Biology | Domestic science/ /cookery | Sex Education

(please ring as appropriate) Baby Care | Other (specify).....

.....

B9 JOB(S) SINCE LEAVING SCHOOL: .....

.....

CURRENT OCCUPATION (where appropriate): .....

.....

EARNINGS:..... MATERNITY ALLOWANCE:.....

HOW OLD WAS BABY WHEN WORK RESUMED?:.....

PARTNER'S OCCUPATION:.....

PARTNER'S EARNINGS:.....

Does N's father work long hours? Do you see much of each other?

B10 PLACE OF ORIGIN:

WHERE BORN:.....

(Where appropriate) How long have your parents lived in this country?

.....

LENGTH OF TIME IN PRESENT ACCOMMODATION:.....

LENGTH OF TIME IN PREVIOUS ACCOMMODATION:.....

Where did you live before?:.....

Have you moved about a lot?:.....

CURRENT CONTACTS: Do you have

Family/mother nearby? | Close friends with young children? | Regular Visitors? | (please ring as appropriate)

B11 ACCOMMODATION: Private house | Private flat | Council house | Council flat | Owned property

(please ring as appropriate) Rented property | Separate accommodation | Shared accommodation | (with family/ /with others)

Number of rooms:..... Number of people resident:.....

BRIEF DESCRIPTION OF PROPERTY:.....

.....

B11 ACCOMMODATION (contd):

DISTANCE FROM CHILD HEALTH CLINIC:.....

DISTANCE FROM G.P.s SURGERY:.....

MODE OF TRAVEL TO CLINIC/SURGERY:.....

COST OF TRAVEL TO CLINIC/SURGERY:.....

Mother possesses car / has access to a lift / is dependent on public transport (please delete as appropriate)

B12 DOMESTIC FACILITIES:

Q: Do you like living where you are now?

PROBE: Are there any particular problems with the accommodation - does it seem too small, crowded etc?

(If NOT happy) What sort of accommodation would you really like?

Q: Do you have: Hot water Fixed bath Inside WC all of which work?
Cooker
(please tick as appropriate)

Q: Do you have a telephone? (If NOT, where is the nearest place you can phone from?)

Q: Do you have a washing machine?

PROBE: Are there good facilities for drying and airing clothes? (If NOT, how do you manage?)

Q: Do you have a pram/pushchair for N?

B13 MARITAL STATUS: (NB: This can be delicate. Decide whether or not to obtain relevant information from HV before the interview)

Married Single Divorced Separated Widowed Common law partner
(tick as appropriate)

YEARS WITH PRESENT PARTNER:.....

LENGTH OF TIME MARRIED BEFORE BIRTH OF CHILD:.....

B14 PERSONAL EXPERIENCES OF CARE: (NB: Try to obtain prior information from HV regarding family stability of respondent's parents; if herself/partner have been/are under any statutory supervision. DO NOT QUESTION THE RESPONDENT ON THESE MATTERS)

Q: Have you any brothers/sisters? (NO: .....)

Q: Do you feel you learned a lot from your own mother about bringing up children - for example, by watching/helping her to look after younger brothers and sisters?

B14 PERSONAL EXPERIENCES OF CARE (contd):

(NB: This is a gentle probe to ascertain whether the mother was brought up in an ordinary family, or 'in care')

Q: How long were you in hospital when N was born?

(NB: This may be a partial index of professional perceptions of the mother's need for continued support, where the stay was relatively long in absence of specific pathology)

B15 FAMILY CHILD CARE:

Q: Do you get any help in looking after N? (please tick)

Mother alone	Help from mother	Help from father	Help from sister	Help from grandmother

Help from other(s) (specify):.....

SECTION C: PRIOR/CURRENT KNOWLEDGE OF CHILD HEALTH FACILITIES

C1 PLANNED PREGNANCY:

Q: Could we start right back at the beginning, when N was first expected. Did you plan for N to come along when he/she did? Or did you really want to wait a bit longer before starting a baby? Had you had any other 'scares'?

PROBE: If she says she wanted to wait, then: 'Some of us don't get much family planning advice at school. Was there any in your school? How did you get to know about it?

C2 REALISATION OF PREGNANCY:

Q: How long had N been 'on the way' when you first found out? How did you first get to know for sure?

PROBE: Was it your family doctor - or a nurse etc - who first told you for sure? What advice did he/she give you at that time?

C3 EARLY CONTACT(S):

Q: Who did you go to first when you found out you were pregnant?

PROBE: Did she go to a member of her family? A friend? Or did she seek professional advice? What advice was she given?

C4 EARLY KNOWLEDGE OF HEALTH FACILITIES:

Q: Looking back right to the beginning, can you remember how much you knew about where to get help at that time?

PROBE: Did she know what a 'health clinic' was? Where it was? Who worked there? What sort of things went on there? If so, where had she got this information?

C5 REASONS FOR ATTENDANCE AT CLINIC:

Q: Were there any relaxation or parentcraft classes at your clinic? Or what else did you mainly go to the clinic for before N was born?

C6 EARLY IMPRESSIONS:

Q: Thinking about your very first visit to the clinic - what did you expect would happen when you got there? What actually happened?

C7 CURRENT KNOWLEDGE OF HEALTH FACILITIES:

Q: I guess you soon got to know a fair bit about it! Could you tell me a bit about your own clinic?

PROBE: Whereabouts is it? Who works there? What sorts of things go on in the clinic? When are the clinics/other sessions held?

C8 STAFF ROLES:

Q: There are a number of people working in the child health clinics - doctors, nurses and Health Visitors for example. Could you tell me a bit about the Health Visitor - what she does etc?

PROBE: Probe similarly for her knowledge of doctors' and nurses' roles.

C9 CONTACT WITH HEALTH VISITOR:

Q: Who is your own Health Visitor? (PROBE for name) Does she visit you very often? When did you first meet her? Is it your Health Visitor who asks you to come to the clinic, or do you get written invitations - or just go when you feel like it?

PROBE: Do you keep the Health Visitor's card somewhere handy? Have you got her telephone number? Do you feel you could ring her anytime? Is she the sort of person you can talk to freely, without embarrassment etc? Is her card up-to-date, so you know where you are?

C10 WEIGHING AND CHECKING:

Q: There's a lot of weighing and other checks which go on in baby clinics. Do you think there's too much, or do you think it's important?

PROBE: Weight checks? 'Screening' (does she know what sort of screening and why? 'Milestones' (can she give an example?) (Note her non-verbal communication here).

C11 MEDICAL EXAMINATIONS:

Q: How many medical examinations is N meant to have up to now? Has he/she had them all? Where?

C12 IMMUNISATION:

Q: One thing we have/haven't already mentioned is N's injections to stop him/her getting various illnesses. Does N get those at the clinic, or at your family doctor's?

PROBE: Does she know what the immunisations are? When they should be given? How they protect her baby?

C13 CONSTRAINTS:

Q: Do you still feel that the Health Visitor wants you to go to clinic regularly? If so, why? How often are you expected to go to clinic? Do you feel 'obliged' to go/guilty if you don't go?

C14 CHILD CARE LITERATURE AND EDUCATION:

Q: Looking back, would you say you've learned a lot about looking after baby from the doctor, Health Visitor and others, or not? Did you get any baby books, or read anything else to help you look after N? Did any of this material come from the clinic? Or from your family doctor?

C15 CURRENT ADVICE-SEEKING:

Q: Who would you go to now if you needed advice about N? Would you contact the Health Visitor for any reason? Have you ever asked for a home visit by a clinic doctor or Health Visitor? Why do you feel the Health Visitor comes to see you now?

SECTION D: CHILD CARE EXPERIENCES DURING THE FIRST YEAR

INTERVIEWER: Now let's think a bit about everything that's happened during N's first year.....

D1 DISCHARGE FROM HOSPITAL:

Q: .....first of all, right back at the time when you were getting ready to leave hospital after having had N. Were any arrangements made to make things a bit easier for you when you went home from hospital?

PROBE: Was transport arranged? Did N's father/yourself get to know when you were leaving in good time? Did you have any home help arranged, either officially or by the family? If not, did you feel you could have done with some? How long was it before you were visited?

D2 WORRIES ON DISCHARGE:

Q: When you knew you were going home, did you have any particular worries?

PROBE: Did you feel well/confident/able to cope, or not? How did you feel when you arrived back home? Were you glad to be back? Was anyone at home to meet you?

D3 EARLY COPING:

Q: Most mothers seem to find the first few days at home a bit difficult - not quite knowing what to do, and so on. Did you feel like this?

PROBE: If anything happened during those early weeks, where did you go for help or advice? What did you feel was the worst time with N? Who was most helpful to you at that time/these times?

D4 EARLY PROBLEMS:

Q: What would you say was/were the biggest problem(s) for you and N when you got back home?

PROBE: Practical 'coping'? Financial? Lack of advice/help? Attitude of N's father/others? Illness of self/baby? Coping with other responsibilities, etc?

D5 WORRIES DURING FIRST YEAR:

Q: What sorts of things have worried you concerning N during the rest of his/her first year?

D5 WORRIES DURING FIRST YEAR (contd):

PROBE: Practical 'coping'? Financial? Lack of advice/help? Attitude of N's father/others? Illness of self/baby? Coping with other responsibilities, etc?

D6 BABY CARE - FEEDING:

Q: Did you bottle-feed N? Did N take his/her food well, or were there any difficulties there?

PROBE: If a problem, who advised her? How successful was the advice? Would she, with hindsight, have approached somebody else?

D7 BABY CARE - SLEEPING:

Q: How long did N sleep at night when you first came out of hospital?

PROBE: If a problem, was it because you felt he/she wasn't getting enough sleep? Or was it because yourself/N's father/others were disturbed, getting up tired? How long did the problem last? Who advised her? How successful was the advice? Would she, with hindsight, have approached somebody else?

D8 FEELINGS OF COMPETENCE:

Q: Did you feel you were the one who really knew what was best for N?

PROBE: Or were there things you didn't feel too sure about? Who was most helpful in bolstering up your self-confidence?

D9 LAYETTE:

Q: When N was on the way, did you know what sorts of things to buy ready for his/her arrival? Did you manage to get everything ready?

PROBE: Who advised you on the sorts of things you'ld need?

D10 FINANCIAL ASPECTS:

Q: Was having N more expensive than you expected?

PROBE: How did you manage to find the extra money you needed? Did you put any money to one side for N? How did you budget for the extra things you've had to buy? How helpful was the maternity grant?

D11 OTHER DEPENDENTS:

Q: I expect you've had to look after N's father during this first year pretty much as usual. Have there been any other people besides N and his/her father that you've had to devote your time and attention to?

PROBE: What other people/things have you had to look after? How well have you managed to fit all these other things in?

D12 ADAPTATION TO BABY:

Q: How do you think yourself and N's father have adapted to having a new member of the family - not 'just yourselves' anymore?

PROBE: Do you find you cope with the extra work okay? How does N's father 'get on' with him/her? Does N's routine fit in with your work/his-her father's work?

SECTION E: THE FIRST YEAR - PERSONAL RETROSPECT

E1 CONFIRMATION OF ROLE:

Q: Looking back, have you enjoyed this first year?

PROBE: If she has, what has she enjoyed most about the first year? Would she do the same again? If she hasn't, what hasn't she enjoyed, and why does she think this is? Would she rather be doing something else?

E2 BETTER OR WORSE?:

Q: On the whole, would you say your life has changed for better or worse since having N?

PROBE: What has she missed most since having N?

E3 SOCIAL CONTACTS:

Q: Some mothers tend to feel a bit 'trapped' in the home because of the baby. Have you ever felt like that?

PROBE: Have you ever felt a bit lonely or isolated at any time this last year? Since N arrived, have you found much time for other things - social life and so on? Or does everything seem to revolve around N? Have you had to give up doing things because of N? Do you find you get any free time to do the things you like doing? Is it fairly easy for you to get out and about?

SECTION F: CHILD HEALTH CARE - PROFESSIONAL PROGRAMMES

F1 REACTION TO HOSPITAL CARE:

Q: When you had to go into hospital for N's arrival, didyou enjoy your stay there?

PROBE: Or were there things you didn't like about it? What did you like about it? What did you not particularly like about it? Had you ever been in hospital before? (Probe for reason, and quality of prior experience) Would you rather have had N in hospital, or at home?

F2 HEALTH CENTRE/HEALTH CLINIC - PHYSICAL LAYOUT:

Q: You go to X (Health Clinic/Health Centre) with N. Tell me a little bit about the clinic/health centre. What kind of a building is it?

PROBE: What is the waiting area like? Is there a place for prams? Are there refreshments available? Do you feel it's private enough? Is it on the way to the shops, or on the way to anywhere you'ld normally go?

F3 HEALTH CENTRE/HEALTH CLINIC AMBIENCE:

Q: Is the clinic/health centre a nice place to visit? Do you enjoy your visits there?

PROBE: Do you feel 'welcome' there? Or do you perhaps feal raluctant to go? (If so, why?) Do you feel it 'does you good' to go? Or do you perhaps feel worse for having been to the clinic/health centre? What do other mothers you know feel about going there? How does N behave in the clinic/health centre?

F4 CONTINUITY OF CARE:

Q: Do you generally know who you will see at the clinic/health centre? Do you always see the same doctor/nurse/Health Visitor there?

PROBE: (If NOT) Would you prefer always to see the same person(s) there?

F5 MAIN REASON(S) FOR ATTENDING:

Q: What would you say are the main reasons for which you go to the clinic/health centre now?

F5 MAIN REASON(S) FOR ATTENDING (contd):

PROBE: Attendance at classes/other groups? To get advice or leaflets etc about how to look after N? To get baby foods etc? Worries about N's health? To check on N's development? Immunisations? To meet other mothers? Any other reasons?

F6 OTHER REASON(S) FOR ATTENDING:

Q: What other things go on at the clinic/health centre which you've been to, or like to attend when you can?

F7 CLINIC ROUTINES:

Q: Thinking back to a typical visit to the clinic/health centre with N, say in the last few months or so, can you tell me what happens from the time you arrive at the clinic/health centre until it's time to leave?

PROBE: Do you spend much time just 'waiting about'? About how long, would you say? Is the routine always the same?

F8 APPOINTMENTS SYSTEM:

Q: Are you given an appointment to go to the clinic/health centre, or how do you go about getting one?

PROBE: Are appointments rigid or flexible? Do you find the session times convenient for you to get there? Do you have to plan in advance to be able to go, or are you able to 'pop in' while you're shopping or just passing by? What happens when you don't go? Do you get any reminders for clinic sessions? (If YES, for what activities? Who do the reminders come from?)

F9 SOCIAL FEATURES:

Q: Have you made many friends at the clinic sessions?

PROBE: Do many other people go - have you met many other mothers there? Do you get talking much to the other mothers there? Do the mothers you've met and talked to seem to go about as often as you - or more often or less often?

F10 SOCIAL FEATURES - INVOLVEMENT OF OTHER FAMILY MEMBERS:

Q: Do you ever feel able to take any friends or relatives with you to the clinic - N's father for example?

F11 RELATIONSHIPS WITH STAFF:

Q: How well do you know your own Health Visitor/Clinic Medical Officer?

PROBE: Do you feel you know her pretty well? Do you like her? Would you have preferred a choice? Do you feel she knows you pretty well? Who is the person you like seeing most at the clinic/ /health centre? Do you enjoy the visits paid to you at home by your Health Visitor?

F12 PERCEPTIONS OF HEALTH PROFESSIONALS' ROLE-PERFORMANCE:

Q: Do you find your own Health Visitor's/Clinic Medical Officer's advice helpful/useful?

PROBE: How do you mainly see her - I mean, as a friend? as an adviser? as a teacher? - or perhaps as 'a bit of a pain' sometimes!? Do you feel free to ask her advice about anything? (If NOT), What sorts of things do you feel you couldn't really ask her about? Do you feel she knows much about looking after a baby from a practical point of view?

F13 CONSTRAINTS IN INTERACTION WITH HEALTH PROFESSIONALS:

Q: Which of 'the professionals' would you turn to first if you had a problem with N?

PROBE: Family doctor? Clinic doctor? Nurse? Health Visitor? (In relation to each of these staff), Do you ever feel 'stupid' to ask him/her anything? Do you ever feel afraid to ask questions? Does the Health Visitor spend most time with you, or with N? Do you feel important to her as a person in your own right - not just as a 'mum'?

F14 HEALTH VISITOR CONSULTATION:

Q: If you had a problem with N, would you ring up Y (the Health Visitor) without hesitation?

PROBE: Would it just 'come naturally' to do it? Do you feel more confident having her around, or does it work the opposite way - perhaps make you a bit nervous? Will you go on seeing her quite happily when necessary during the second year?

F15 FAMILY ATTITUDES TO HEALTH CARE:

Q: What does N's father/your mother/(other close family member(s)) think of the clinic/health centre?

F15 FAMILY ATTITUDES TO HEALTH CARE (contd):

PROBE: Does your mother/N's father think it's a good idea for you to go? Has your mother ever talked about what it was like when she went to clinic with you and/or your brothers and/or sisters? Do you/ /she think it's changed a lot since then or not?

F16 PEER-GROUP ATTITUDES TO HEALTH CARE:

Q: Have you talked to any friends who've got young children about the same age as N, about the clinics they go to? What do they think about going to clinic?

PROBE: What do the other mothers at your own clinic/health centre think of it? Do you feel a sort of need or obligation to go.....feel guilty at all if you don't go? Would you personally advise anyone else with young child(ren) to go?

NB: The probes here are intended to pick up more practical aspects of other mothers' attitudes to health care received, as distinct from their reactions to clinic ambience, discussed in F3.

F17 RESPONSE TO GP/OTHER HEALTH CARE:

Q: Would you say that your experiences with other types of health care - I mean, for example, visits to your family doctor - have made you more keen or less keen to go to the clinic/health centre, and be visited by a Health Visitor?

PROBE: Are you happy to go to your family doctor for most things, including advice about N? How do you 'get on' with him/her? Do you think that he/she knows you very well? Did N get examined/immunised by your family doctor? How often do you go to see him/her for advice about N? Is there any other health professional - a nurse etc - who you would go to for advice/help with N?

F18 NON-ATTENDANCE:

Q: Can you tell me why you prefer NOT to go to the clinic/health centre with N?

PROBE: Was it difficult to find time to go? Or do you feel you don't really need their help? (If NOT), Why not? Is the advice you get useful, or perhaps a bit confusing? Who/what would you say is your main source of advice about N? Do you now feel that the clinic could have helped you in any way?

F19 NON-TAKEUP OF IMMUNISATION PROGRAMME:

Q: Have you any particular reason(s) for not getting N immunised?

PROBE: Had anyone told you anything about it that made you not want to have it done? Had you read anything about it? Did you perhaps feel it might be harmful to N in some way? Did your mother get you immunised when you were small? (If NO to all these, probe for other reasons, religious or conscientious).

SECTION G: SUGGESTED IMPROVEMENTS AND FUTURE PLANS

G1 SUGGESTED IMPROVEMENTS IN CHILD HEALTH CARE:

Q: Looking back on the sort of care that you and N have received during this last year, are there any changes you would like to see happen - I mean, is there anything you feel might have helped you more?

PROBE: More continuity of care - seeing the same people all the time? A 24-hour phone-in service? More flexibility in the appointments system? Sessions a bit more private? Seeing a doctor who is able to prescribe for N/yourself? More contact with the doctor, or see the doctor every time you go? More contact with Health Visitor/other staff? Warning given before a home visit? Or anything else?

G2 FAMILIARITY WITH SERVICES:

Q: Looking back again, do you feel you 'know your way around' the services better now than you did a year ago?

PROBE: What would you do differently next time? Do you think it will be 'easier' next time? What problems do you think you will be able to avoid which you experienced this time, if you have another baby?

G3 FUTURE PLANS:

Q: What would you do in future - say, if N seemed ill?

G4 IMMUNISATION PROGRAMME:

Q: Will you have N's future immunisations done or not?

PROBE: (If YES) Who will you ask to do them? (If NO) Why not? (if not already picked up in F19)

END OF MATERNAL INTERVIEW SCHEDULE

SHEFFIELD CITY POLYTECHNIC

DEPARTMENT OF HEALTH STUDIES 'POSITIVE PATHWAYS' STUDY

MATERNAL INTERVIEW SCHEDULE

HEALTH CARE CONTEXT.....INT. NO.....

INTERVIEWER.....DATE.....

SECTION A INTRODUCTORY

We're trying to find out what it's like for a mother when she has her first child - what sorts of problems she has, what kind of help she gets with these problems and so on. The idea is to look at what sort of help a mother really needs at this important time and try to find ways in which it can be given. So we wondered if you could tell us abit about your own experiences? This sort of information can help to improve the services for mothers so that they get the sort of help that's needed most!

Everything you say will be absolutely confidential, noone else except me will hear this tape and I will not use any names in the report, only the sorts of comments made and the kinds of problems discussed. Also please feel free to tell me if there are any questions which you would prefer not to answer. We think that what mothers have to say is very important if the services are to provide the sort of help that's really needed, So could you help us? We'd be very grateful if you could!

SECTION B BACKGROUND INFORMATION

B1 AGE LAST BIRTHDAY.....B2 AGE AT CHILDBIRTH.....

B3 EDUCATIONAL BACKGROUND

Secondary Modern Comprehensive Grammar Other(Specify)

B4 AGE LEFT SCHOOL.....

B5 QUALIFICATIONS

CSE O'LEVEL A'LEVEL PROFESSIONAL OTHER (SPECIFY)

B6 HEALTH EDUCATION AT SCHOOL

Human Biology D.S. Sex Education Baby Care

B7 OCCUPATIONS 1.Since leaving school.....

2.Current occupation.....3.Earnings.....

3.Age of child when work resumed..... .....

4.Maternity allowance.....

5.Partners occupation.....6Earnings.....

7.Does N's father work long hours? Do you see much of each other?

B8 MOBILITY 1.Length of time in present residence.....

2.How many houses have you lived in altogether?

B9 CURRENT CLOSE CONTACTS 1.Do you have any regular visitors? Are your family or friends nearby?

2.Do you have any friends with young children nearby?

B10 ACCOMODATION 1.Type of property; Private house/ Private flat/ Council house/ Council flat/ Other

2.Number of rooms.....Number of people.....

3.Seperate or Shared 4.Condition of the property.....

.....

5.Distance from Child Health Clinic.....

6.Distance from G.P. surgery.....

7.Mode/cost of travel.....

B11 DOMESTIC FACILITIES 1.Do you like living where you are now?

2.Are there any particular problems with this accomodation?

What sort of accomodation would you really like?

3.Do you have; Hot water,Fixed bath,Inside W/C,Cooker,Telephone Washing machine,Facilities for drying and airing clothes, Pram/pushchair for N?

B12 MARITAL STATUS (Delicate, ask HV)

1. MARRIED/ SINGLE/ DIVORCED/ SEPERATED/ WIDOWED/ COMMON LAW

2.Years known present partner.....Years married.....

3.How long married before birth of child.....

B13 PERSONAL EXPERIENCES OF CARE

1.Do you feel you learnt a lot from your own mother about bringing up children?

2.How many children were there in your own family? Position in family, younger members of family to look after?

SECTION C REALISATION OF PREGNANCY

C1PLANNED PREGNANCY

Could we start right back at the beginning,when N was first expected.1Did you plan for N to come along when he/she did? Or did you really want to wait a bit longer before starting a family?

2.Had you ever had any scares before when you thought you may have been pregnant?

3.Some of us don't get much family planning advice at school did you? How did you get to know anything about it?

C2 FIRST CONTACT WITH THE MATERNITY SERVICES

1.How long had N been on the way when you first found out?

2.How did you know for sure?

3.Who did you tell the news to first?

4.Which health care professional did you see first? Why?

5.What advice were you first given by your family?

by your doctor?

C3 KNOWLEDGE OF WHAT TO DO

1.Can you remember how much you knew at first about where to get help and advice should you have needed it?

2.Did you know what a health clinic was, where yours was, or who worked there?

3.Can you remember where you got all this information from? Family / friends / HV / GP ?

SECTION D ANTE NATAL CARE/ HOSPITAL CARE

D1 ANTE NATAL SERVICES

1.I'd like to talk a bit about the care you recieved during the nine months you were carrying your child, Did you have any checks by your doctor? How many?

2.Did you attend ante natal classes at all?

3.Did you attend any parent craft classes at all?

4.Did your husband get involved at all?

D2 HOSPITAL/HOME DELIVERY

1.When you had to go into hospital for N's arrival, did you enjoy your stay there? Were there any things you did not like about it?

2.How long were you in hospital for?

3.Had you ever been in hospital before for any reason?

D3 DISCHARGE FROM HOSPITAL

1.When you were getting ready to leave the hospital, were any arrangements made to make things a bit easier for you when you got home?

2.Was transport arranged? Who took you home?

D3 continued

3. How long was it before you were visited by the Midwife? and the Health Visitor?

4. Did you know what sorts of things to get ready for N? Who advised you on the sorts of things you would need or the cheapest places to get hold of baby things? Did you manage to get eveything ready in time?

SECTION E MAIN PROBLEMS IN COPING WITH A NEW BABY

E1 WORRIES ON DISCHARGE

1.When you were going home did you have any particular worries? Did you feel well / confident / able to cope?

2.How did you feel when you arrived at home with the new addition to your family?

3. Were you glad to get home?

E2 WORRIES DURING THE FIRST YEAR

1.Most mothers seem to find the first few days at home a bit difficult not quite knowing what to do and so on, Did you feel like this?

2. If anything happened during those early weeks, where did you go for help and advice?

3. What sorts of things have worried you concerning N during this first year? What would you say has been your biggest problem?

4. Have any of the following presented problems for you?

a) Practical day to day coping with demands,tiredness?

b) Lack of help or advice?

c) Financial problems? Was having N more expensive than you anticipated? How did you manage to find the extra money that you needed? How useful did you find the maternity grant

E2 continued

d) Attitude of N's father or other members of the family?

e) Illness of yourself?

f) Illness of N?

g) Have you ever lost much sleep with N?

h) Did feeding ever present any problem? Did you bottle feed?

i) Has there been anyone else you have had to devote your time and attention to this year? If yes how did you manage?

E3 CONFIDENCE

1. Did you feel most of the time that you knew what was best for N? or were there things you just weren't sure about at all?

2. Who would you say has been most helpful in bolstering your self confidence?

SECTION F POST NATAL CARE

F1 EXPECTATIONS OF THE CLINIC

1. Thinking about your very first visit to the clinic, what did you expect would happen when you got there? Were you apprehensive about going at first?

2. What actually happened when you got there?

F2 CURRENT KNOWLEDGE OF THE CLINIC

I guess you soon got to know a fair bit about the clinic, Where is it? Who works there? What sorts of things go on there? When are the sessions held for you and N?

F3 PHYSICAL LAYOUT/ EASE OF ACCESS TO CLINIC

1.What kind of a building is the clinic?

2. What is the waiting area like?

3. Is there a place for prams?

4. Are there any refreshments available?

5. Is it on the way to the shops or any where you would normally go?

6. Is it possible to have a private consultation with the Staff at the clinic?

7. Are you ever given an appointment to go to the clinic for any reason?

8. Do you prefer just being able to pop in, or would you rather have specific appointment times?

9. Have you ever recieved a reminder to go for any reason?

F4 POSSIBLE REASONS FOR NON ATTENDANCE

1. Have you ever preferred not to go to the clinic for any reason? eg Was it ever difficult to find the time to go?

2. Did you ever think it was just a waste of time when you did go?

3. Why do you think some people never go to the clinic?

F5 HEALTH CLINIC/CENTRE AMBIENCE

1.Is the clinic a nice place to visit? Do you enjoy your visits there?

2. How do other mothers you know feel about going?

F6 WEIGHING/CHECKING/SCREENING

1. There's a lot of weighing and other checks which go on

F6 continued

1.cont'd
Do you think there's too much or do you think it's important?

2. Do you understand what they're doing or looking out for with the checks etc?

Can you give me an example of one of the tests they carry out and why it is done?

3. How often did you go to the clinic at first? and now?

4. Did you have to spend much time just waiting about?

5. How many medical examinations (by a doctor) has N meant to have had up to now? Has N had them all?

F7 IMMUNISATIONS

1. One thing we haven't covered in anym detail is N's immunisation (injections and sugar lump). Where has N had them done? Why?

2. Has anyone explained to you what the immunisations are for, in what way they help your child?

3. Have you had any problem with them or cause to worry?

4. Will you have all future immunisations done? Which ones has N to have in the future?

5. Did your mother have your injections and other immunisa -tions done? Where?

6. Did you recieve invitations to attend the clinic? If you did not manage to go did you recieve reminders?

F8 ATTENDANCE AT CLINIC

1. Do you still feel the Health Visitor wants you to go? How often are you expected to go and for what reason?

2. Did you feel obliged to go to the clinic, or ever feel

F8 Q2 continued

.....guilty for not going? Why?

3. Have you made any friends at the clinic? Do you manage to get to talk to any of the other mothers there?

4. How often do other mothers go? Would you say they went more or less often than you?

5. Have you ever been to the clinic for any other reason eg. jumble sales, social evenings, talks or any other local events?

SECTION G RELATIONSHIP WITH STAFF

G1 RELATIONSHIP WITH HEALTH VISITOR

1. Who is your own Health Visitor? (Probe for name)

2. When did you first meet her?

3. Does she visit you very often?

4. Is it your Health Visitor who asks you to attend clinic?

5. Have you her telephone number? Do you feel you could ring her at any time? Is she the sort of person you can talk to freely without embarasment?

6. Do you keep her card handy? Is it kept up to date so that you know where you are with her?

7. How well do you know her? Do you like her or would you have preferred a choice?

8. Do you feel she knows you fairly well?

9. Do you enjoy the home visits she has paid to you or would you prefer to see her at clinic?

10. Could you describe how you see the Health Visitors job? What sorts of things does her job entail? Is it just with mothers and young children?

G1 continued

11. Could you say that you have found her advice useful? Has she helped you with anything in particular? Does she understand your problems?

G2 RELATIONSHIP WITH DOCTOR AT CLINIC GP/CMO

1. Who is your own Doctor? (Probe for name)

2. When did you first meet him?

3. Do you visit him very often?

4. Have you got his telephone number? Do you feel you could ring him at anytime? Is he the sort of person you can talk to freely without embarasment?

5. How well do you know your Doctor? Do you like him or would you have preferred a choice?

6. Do you feel your Doctor knows you fairly well?

7. Could you say you have found your Doctors advice useful? Has he helped you with anything in particular? Does he understand your problems?

8. Have you ever asked for a home visit by your Doctor? What happened? Did you feel quite happy about calling the Doctor out?

G3 RELATIONSHIP WITH GP IF DIFFERENT FROM CLINIC DOCTOR

REPEAT ALL OF G2 QUESTIONS FOR GP

G4 PREFERENCES FOR CHILD CARE AND ADVICE

1. Looking back would you say you learnt most about looking after your baby from your Health Visitor, Doctor Family, Freinds or books?

G4 continued

2. What about baby books, did you find them very useful? Where did you get baby books from?

3. Who would you go to now if you needed help or advice with N?

4. Have you ever asked for a home visit from any of the health professionals?

5. Have you ever felt reluctant or afraid to go and see anyone when you needed some help?

6. Do you feel that the staff spend most time concerned with N, yourself or both?

7. Do you feel better having these people around to help you or does it work in the opposite way? eg. perhaps make you a little nervous?

8. Do you generally know who you will see at the clinic? Do you always see the same Health Visitor and Doctor at clinic? Would you prefer always to see the same person or do you sometimes find it easier to talk to someone you don't know?

G5 FAMILY AND PEER GROUP ATTITUDES TO THE HEALTH SERVICE

1. What does N's father think of the clinic, Health Visitor and others you have had contact with in the care of your baby? Does he approve/disapprove?

2. Has anyone ever accompanied you to the clinic eg. N's father, your mother or any of your friends? Do you prefer to go alone?

3. Have you talked to any friends about the clinic they attend? What do they think about it?

G) continued

4. What do other mothers at your clinic think about it?

5. Would you personally advise other new mothers to go?

SECTION H THE FIRST YEAR PERSONAL RETROSPECT

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1. Looking back, have you enjoyed this first year?
Could you say what you have enjoyed most about it? If anything what would you rather be doing with your life?

2. Do you feel you have adapted well to being a mother, and all the responsibilities that entails?

3. What about N's father. Have you both managed to adapt to having a new member of the family, not just being the two of you anymore?

4. On the whole would you say your life has changed for the better or the worse since having N?

5. What have you personally missed most since having N?

6. Some mothers tend to feel a bit trapped in the home because of the baby. Have you ever felt like that?
Have you ever felt a bit lonely or isolated at any time?

7. What about your social life. Does everything revolve around the baby?

8. Is there anyone you can rely on to look after N if you do want to go out any time?

SECTION I FUTURE PLANS AND SUGGESTIONS

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1. Looking back at the sort of care that you and N have recieved are there any changes you would like to see -
I mean is there any way you think the services could have helped you more, or been more appropriate to your needs?

2. Here are some suggestions that have been made in the past, could you let me know what you think of them..

Continuity of care, seeing the same person regularly:

Flexible appointments, able to pop in anytime;

See more of the Health Visitor;

Prescribing Doctor at clinic;

Warning before a home visit;

ASK MOTHER FOR ANY SUGGESTIONS SHE MAY HAVE THOUGHT OF

3. Do you want to have more children or has this time put you off?

4. Do you really feel you know your way around the services now?

5. What would you do differently next time round? What sort of problems do you think you could avoid having the knowledge that you do?

END OF MATERNAL INTERVIEW SCHEDULE

APPENDIX 4

EXAMPLE PHENOMENOLOGICAL ANALYSIS OF ONE UNDERUSER INTERVIEW

Referred to in text 3.6.2.1. and chapter 6.

Contents

4.1. INTRODUCTION

The main goal of the method is to make sense of the data, rather than test hypotheses, and each step of the procedure is to be understood as serving this aim. Researchers who have adopted the phenomenological approach to interview data analysis follow a similar procedural process, but will vary to some extent in the application to their particular concerns, the aim being to tie the analysis very closely to a) the kind of data under scrutiny, and b) the aims of the research.

The level of abstraction is chosen as that which serves the research goals e.g. in this study the end product was to be kept as close as possible to the concrete descriptions offered by respondents. The procedure outlined below was arrived at in working through the general principles of anlysis (as outlined by Giorgi 1975) in relation to this particular research project, and so differs in some details when this was found necessary.

The procedure is divided into 3 stages, each of which is presented in full to show how the findings of the study were arrived at from the raw data generated in interview.

In stage 1, the verbatim transcript of interview data, which constitutes the text to be analysed is marked by division into meaning units. This stage encompasses steps 1 - 3 as outlined in the procedural outline.

In stage 2, the organised text is restated in the third person, and initial labelling of topic areas is carried out, which corresponds to step 4 in the procedural outline.

In the third stage, the central themes of relevance to the research interest are laid out, as they emerged in the analysis. This stage corresponds to steps 5 - 7 in the procedural outline.

4.2. THE PRINCIPLE STAGES OF THE PROCEDURE

1. Focussed, open ended, semi structured interview with respondent

Taped (where possible) from beginning to end

Tasks of the researcher

Focus on the topic of interest to the research, i.e. becoming a mother and relations with the services.

The interviewee is to be allowed to describe freely any areas of importance to her, to choose her own areas of relevance when asked to talk about such things. The interviewer pursues any ambiguous areas, asks for clarification when necessary and may return the subject to her descriptions when necessary to gain a deeper understanding of how she experienced the events. The questions asked should not primarily structure the conversation, but merely direct the interviewee to an area for her comments on it. The primary aim is to understand as fully as possible what is being said.

2. Verbatim transcript of the interview

This is the text to be analysed.

Tasks of the researcher

Both the interviewee and interviewer contributions are presented for later analysis, typed as a conversation, where the emotional tone of each part is recorded and breaks in the flow of talk noted.

3. Initial discrimination of natural meaning units

(a means of organising the text for analysis)

Tasks of the researcher

The text is divided into naturally occurring exchanges between the interviewee and interviewer, where one point has been made, at each change of focus of the talk this is marked with a number in sequence. A lively awareness of what is taking place in the conversation is to be maintained and notes put on the text to show major pauses, breaks, and other features of the situation (e.g. others coming in or out, any distractions.)

4. Discovering and labelling the central meaning of each unit as intended by the interviewee

The meaning units are restated in the 3rd person to facilitate identification of the main meaning.

Tasks of the researcher

An attempt is made to establish the interviewees self understandings, and the main meaning conveyed in each meaning unit. Obvious irrelevances can be put to one side (e.g. asking for a cigarette). The researcher attempts to summarise in short phrases the interviewees main concern at each point, a phrase which captures the meaning rather than transforming it with reference to other concerns. This can involve backtracking to other parts of the text and using imaginative variation to ensure the cenral meaning has not been distorted. The researcher must bracket any presuppositions, judgements and bias which occur as the text is read, the focus being tied firmly to the interviewees concerns at each stage, regardless of the researchers views.

5. Each meaning unit is taken in turn and interrogated for its relevance to understanding the interviewees experience, and the text is reorganised, regrouped around similar central themes.

Tasks of the researcher

The central meanings are the focus of interest to the researcher, and each meaning unit must be accounted for. Where the same meaning is being expressed in different parts of the text, these are put together as similar themes. An attempt is made to relabel the parts put together where a more accurate summary statement is arrived at e.g. 2 meaning units may be found on being put together to be revealing 2 aspects of a similar more general meaning which when relabelled can subsume and accurately convey them both.

6. The researcher adopts a particular 'set' towards understanding and analysing the text

Tasks of the researcher

The particular set of this researcher was a search for any meanings of importance to the interviewees relations with health carers, and becoming a mother. Each central meaning identified in step 5, is compared with the whole text, to see if there are interrelationships which could deepen an understanding of the issues. Importance is assigned on the primary basis of where the interviewee does to her concerns. The 'set' of the researcher is to articulate this individuals central meanings which convey how motherhood and contact with the services was experienced by her. The attitude adopted contains presuppositions and organising principles, but these are not specific enough to delineate precisely specific categories for selection. Each variation of a central theme is interrogated for its relevance to the research interests, so that the researcher is better able to see what is essential to an understanding of this individual.

7. Researcher restates the central themes identified in step 6

Independent analysis of the data is carried out for comparison.

Tasks of the researcher

These are the results of the individual case study, a regrouped and labelled text which summarises the interviewees relations with the services and experience of motherhood as found in the text. The themes so identified are considered to be the qualitative findings of the study which can then be compared with those of an independent observer who has followed the same procedure. Any differences being noted and a consensus established.

8. Comparison of general themes across interviews (N = 6) to establish transituational themes and those specific to individuals.

Tasks of the researcher

Whilst keeping contact with the original transcripts to avoid over generalising, the researcher sees if there are any relationships across the analysis which could be abstracted into more general themes. These would be regarded as general orientations shared by the respondents which can then be illustrated with the dimensions important to each one from the individual case studies. Revision and elaboration of the themes is carried out as found necessary, whilst parts are never to be forced together, there must be a clear link in meaning between parts.

9. For presentation of results, the results of step 8 are then laid out in relation to the research interest specifically.

Tasks of the researcher

Specific areas of interest arising from the research project are illustrated from the general themes which it is thought illuminate the problem. The focus then throughout is on a particular aspect of the more complex reality to be found in the text, the particular 'set' of the researcher setting limits to what is considered relevant, which implies presuppositions but not of the sort which specifically delineates precisely specific categories.

10. Past research results and comment can be compared with these results to establish correspondeces, divergences and any new knowledge gained from the approach.

Tasks of the researcher

The results are not directly comparable to past research results especially those which concentrated on quantitative factor analysis, as the results are different in kind. However, the explanations offered for underusage can be compared with the study's results to see if they are confirmed or brought into question. If totally divergent, then an attempt at an alternative explanation may be offered which is consonant with the results of the analysis.

4.3. STAGE 1. VERBATIM TRANSCRIPT OF THE INTERVIEW

(Corresponding to steps 1, 2 and 3 in the procedural outline).

The open ended interview is transcribed from beginning to end, preserving both the respondents and researchers contributions. The text is divided into meaning units (naturally occurring exchanges between the respondent and researcher) which are numbered, as a means of organising the text for further analysis.

INTRODUCTION:

Cathy (*) the young mother concerned, had been forewarned of the interviewer's visit by means of a note left at her house on the preceding day: and seemed very willing to share her thoughts with me. As Cathy had only just arisen, there was opportunity for an informal chat whilst she lit the coal fire and made some tea.

She asked about the nature of my work, remarking how unusual a job it was: and I made it clear that I was not a health professional myself, but simply interested in her own feelings and experiences for their own sake. During this talk I discovered that she was 21 years old, married and not currently in paid employment.

Each topic was introduced, Cathy took the opportunity to expand and elaborate: e.g. she had very few visitors, only her husband's companions who '...used the house to dump stolen goods'; the house was very damp and difficult to heat; repairs were '...never done'; the neighbours were very unfriendly and hostile and '...had sent the police' to her home on a number of occasions.

At the start of our conversation, the tape recorder was switched on with her permission at the beginning of Section C of the interview schedule. Thus the transcript begins in mid-conversation at this point. Bracketed numbers refer to meaning units in the subsequent analysis of interview material.

* Throughout the transcript, the fictitious name Cathy (the mother) and Teresa (the interviewer) are employed.

TERESA: (indicating the tape recorder): It's a bloody big thing to carry around!

CATHY: It is, yeh (mumbled)

TERESA: I could have got a smaller one but they didn't have one. Right (returning to the subject)...right back at the beginning when your first baby was expected, did you plan ?

CATHY: No...

TERESA: Plan to have her then ?

CATHY: No (3) - we'd been trying for about two year - well, before we were married we were trying (4) and, er, I had three miscarriages and I thought I wouldn't be able to have kids (serious)

TERESA: (sympathetic): Did you, oh that must have been awful (5)

CATHY: (pursuing the story): ...and I'd been off t'pill like and I thought, well, we'll never be able to have kids (6) and the (meditative)...(7)...I think we must ha' been tryin' too much (8)... thanks a lot (accepts a cigarette)

TERESA: (encouraging her to carry on): Yes ?

CATHY: ... and then we dropped off (6)... I just got caught on with her (9) (fatalistically)

TERESA: (laughs sympathetically): Yes...

CATHY: Yeh, because... (hesitates)

TERESA: It's funny how it happens (implying 'I know what you mean') (10)

CATHY: (wishing to return to her explanation - there is more to it than the interviewer is making out): I think with miscarriages though... (pauses) ...I er... 'cos I knew I were pregnant right at t'beginning you know...

TERESA: Mmm mmm (indicates agreement)

CATHY: ...and I were trying to be careful and I must have...(10A)...but, er, with her I ...I didn't know I were pregnant up to being about four month on... (11)

TERESA: (encouragingly): Mmm...

CATHY: ...you see, so I carried her, I carried her pretty well (12). Y'know, I didn't expect to have a bairn (13)...

TERESA: Mmm...

CATHY: ...and now I'm breeding like a rabbit... I can't stop (giggles) (14)

TERESA: Mmm. (laughs) Right, would you rather have waited a bit longer before starting a family ?

CATHY: (quiet and serious) Ooh no, no I wanted one (15) while I were young mese'n you know (16)

TERESA: (quizzically): Mmm? (does she really mean this?)

CATHY: (sensing the need to explain): ...'cos I think, well, these older people that have bairns, I mean it's a tow (difficult task) for 'em, and there's t'age gap and that - I mean, I'm only really a bairn in mese'n, you know what I mean ? And so I can bring her up and she can bring me up (17)

TERESA: Mmm... Had you ever had any 'scares' before, when you thought you might have been pregnant, apart from your miscarriages - when you wouldn't have wanted to be pregnant ?

CATHY: No...Oh! Yeh I did, yeh, well...(18)... when (hesitates before an obviously sensitive disclosure)... when I were sixteen I were raped and that's when I had one of me miscarriages (pauses)

TERESA (expresses shock and fright): God, you poor thing!

CATHY: I got...I got er...I'd just left school and, er, this lad got hold of me and, er, I were pregnant to him and I lost, I lost t'bairn (20) - I were going' to get rid on it, anyway (20A)

TERESA: I don't blame you

CATHY:But I've had two... (an interruption here by child). (22)

TERESA: (righteous indignation): What hapened then - did the police deal with it ?

CATHY: Oh no, no I daren't tell t'police (23) because he were one of them sort that'd knife you or summat like that, so I just left it (coughs). (24) I ought to have done, but... (25)

TERESA: Has he bothered you since?

CATHY: (seriously): No...(pauses)...no, he's not bothered me at all (26)

TERESA: Did he know you before ?

CATHY: He knew me before, I'd been out with him before... (27)

TERESA: They say that, don't they - that most rapes are the people that you know ?

CATHY: (perfunctorily, probably not having heard this before): Yeh (28)

TERESA: (sympathetically): That's awful - were you not terrified ? (meaning during the attack itself)

CATHY: (taking Teresa to mean after the attack): Oh aye, yeh - it took me seven weeks to tell me Mam and Dad (29): and I lost it (had a miscarriage) when I were about eight week on, about three or four days after I'd telled Mam and Dad (39). I lost it at work - I were lifting heavy boxes or summat (31)

TERESA: (awed tone, quiet and intimate): I bet that was painful

CATHY: It were. Me, I can't get me job back through it 'cos I had that much time off, I've tried for me job back and they just wearnt (won't), you know, they wearnt have nowt to do with me. (Pauses, then defiantly) Min'st you though, I'm not bothered...I'm happy now, so... (33)

TERESA: Oh dear...Right, about family planning lessons at school - you said you didn't do any sex education. How did you find out anything about contraception ?

CATHY: Well, I found out...well, I'll be blunt with yer, I picked a Durex up that had been used when I were about thirteen, and I thought it were a balloon, and one of me mates telt me all about it then (35)

TERESA: Yes, that's how many people find out

CATHY: ...you see... and then me mother telt me when I were about

fourteen or so (37). I really knew before (38), but I didn't get to know all t'bad parts of sex education and I only got to know t'good parts, do you know what I mean ? (39)

TERESA: (probing for clearer information): What sort of bad parts do you mean ?

CATHY: Well...miscarriages and things like this (40) - you know you only get to know that sex is a good thing and... (41)

TERESA (encouragingly): Mmm, yes

CATHY (pauses): But I mean, once you're married, sex is just a routine (42), it's not , it's not a pleasure any more, you know what I mean (42A). It's just like having a cup of tea in a morning and that's what sex is to me (42B)...so, but (43)

TERESA: Whereas before you used to enjoy it? (matter of fact)

CATHY: Oh yeh, I...I think you do when you're courting because you're pinching it (44), you know, but once it's legal and that, er, all t'excitement goes out on it (45)

TERESA (laughs): Mmm, right (pauses, then continues in quite a bookish tone, as if reading from the page) Have you ever used any contraception at all ?

CATHY: Yeh, I used t'pill for a...(47)...when I was about fifteen I went on t'pill (48), and I come off when I was sixteen (49) and that's how I got caught on when that lad raped me (50), I'd only been off pill two days when it happened (50A)

TERESA: Oh... (meaning oh dear)

CATHY: ...and, er, I went back on t'pill up to being about seventeen-and-a-half (51), and then when I met B. I come off it...(52)

(the door opens and B. - her husband- comes in)

....and then when I had this, this child I couldn't go back on t'pill because I were breast-feeding(53)

TERESA: Mmm (meaning 'Oh yes, I see')

CATHY: ...so we were using just ordinary contraceptives from there (54) (laughs) but with this one it were t'pulling out method that we used, wasn't it, B. (laughs again) (55)

TERESA: (apparently not hearing or understanding): It was what ?

CATHY: ...You know, t'pulling-out method

TERESA (resorting to labelling): oh yes, what's that called - is it withdrawal or...

CATHY: Yeh, withdrawal, aye, that's it, summat like that

TERESA: Mmm...so you didn't really want to get pregnant again this

time ? (matter-of-factly)

CATHY: Oh no, I could have done with it like a year, a year and a half, summat like that, you know (57)

TERESA (adding what was expected): You needed some time...

CATHY: Yeh, some time to get used to this one first (indicating her daughter) (58)

TERESA (returning to interviewer style to move the discussion along): Mmm, right - so how long had your first baby been on the way when you first found out - you said it was about four months, didn't you ?

CATHY (rather vaguely): Yeh, well...

TERESA (pressing the point): Was it about four months... and how did you know for sure ?

CATHY: Well, I were on a diet, and I'd been on a diet for some time, and I went down from a size 16 to a size 12 - and then suddenly I just started banging it back on again...(69)

(Teresa laughs)

...and I thought, well, it can't be t'diet because I'd got used to it you know - it'd taken me about four or five months to lose that weight, and I thought, well, I'm eating t'same stuff and I'm putting it back on (61) - and then I started with morning sickness

TERESA (seriously): Mmm...

CATHY: Well, I got it every morning after that (62): but t'doctor at, er, (names health centre) said it were wind I'd got (63) and, er, even when I told him I've (you know these chemists that do 'em and you pay so much, well, I had a test done there, and it come back positive)... (64,64A)

TERESA: Mmm, yes ?

CATHY: ... and it said on t'bottom "if you are pregnant tell your own doctor", so I went up (64B); and, er he says, er, 'Oh it isn't - it's gastric stomach you've got' (65). Well, B. went barmy 'cos I'd been badly (66), you see, and I thought I were losin' t'bairn (67), I were frightened to death of losin' t'baby (68); and he more or less had to carry me up to t'doctors (69), and t'doctor still insisted it were wind (79)- and up to me really showin' you know (71) - and then they changed their minds (72), but same as I said, I had a bit o'trouble carrying her (73). She were all right (74), but, if that doctor had of insisted it were wind (75), I'd have probably gone back to work and done summat heavy and lost it again (76), so...

TERESA: Mmm, right - who did you tell the news to first ?

CATHY: Er, me husband were there when I went and got t'results from that chemist (77)

TERESA: And what did he say ?

CATHY (laughs): He were as calm as owt; (laughs again) I were over t'moon, me, but he were, he were as calm as owt (78,79)

TERESA: Did your doctor give you any advice when he did confirm your pregnancy ?

CATHY: Not really, no. (she is obviously unsure of what Teresa means; did not apparently expect any advice from this source) (81)

TERESA:...just sent you to the hospital ?

CATHY: Yeh

TERESA (seeking fuller information): ... and booked you in and that ?

CATHY (misunderstanding): Well, I were working (83) and I were being badly-like (84) and I thought it were with carrying her (85), and, er, I went back to me doctor's (86) and they just turned round and says, well "pregnancy is not an illness" (87), and they wouldn't give me a sick note (88), and, em, I nearly got sacked through it for having time off (89). But, er, they don't give you any advice (90), you've got to go up and say "Look, I'm pregnant and I'm having problems..." and this, that and the other before they do try to sort owt out for you (91)

TERESA: Was this at the sewing factory where you worked ? (seeking clarification)

CATHY: Yeh, I were at (names a firm) when I were carrying her, and as soon as they found out I was pregnant they give me all...

(Breaks off the discussion to speak to B)

B: Are you going up to yer Mam's ?

CATHY: Yeh, I'll go up this afternoon

B: Right, I'll come back up there then (B. goes out)

CATHY: Er, I've forgotton what I were on about now (94)... oh aye, as soon as I found out I were pregnant (95), they took me off t'machines and they give me a right job (96), I had to, I was stood up all day - well, I used to have these fainting, dizzy spells you know (97)

TERESA: (encouragingly): Mmm ?

CATHY: ... and I asked for a chair and they wouldn't give me one (coughs) (98), so I caused a right stink-up about it (99). I started having time off work and that (100); and they were threateneing me with t'sack (101) but I weren't bothered (102). I mean, I was stood up eight hours a day on me feet, and I couldn't wear slippers or owt (103), so I thought "Bugger it!" (194). They even had to try, try to keep me; they used to try to make me clean the lavs out and that (105), and I thought, well, I'm not doing that (106). They were right ones with me - I wouldn't go back there, no chance! (107)

TERESA (sympathetic): It sounds horrible. (Moving the discussion on) Right, at first - when you fist knew you were pregnant - did you know where to get help or advice ?

CATHY: No - I didn't know

TERESA: You didn't know anything ?

CATHY: I didn't (109). I didn't know if there was sombody that come and booked yer into hospital or what (110). In fact (coughs) when t'midwife come and she says "How long 'ave your been booked in for ?" I didn't know what the bloody hell she were on about (111), because nobody telt me nowt - they just expect you to know (112)

TERESA (encouragingly): Yeh... ?

CATHY: ...and with yer second (child) it's even worse (113) - they, you know, they expect you to... (assumes the character of 'them') 'Oh, she's been through it before, you know - she'll know what to do' (114) (in posh voice)

TERESA (matter-of-factly): And you don't, of course.

CATHY: You've got a good idea, yeh (116): but little things like (117), like that, er, exemption certificate (117A) now, when I were carrying' t'first child I had that given to me (117B). Now, I don't know where to go and see about it this time (117C) and nobody's said nowt to me (117D) - I mean, one of t'lasses says "Oh, you should get it from t'hospital - they should gi' it yer" (117E) - but they've never even mentioned it to me (117F). You've got to keep asking! (117G)

TERESA (offers worldly wisdom): Yes, keep asking, mm...make sure you ask. (Encouraging her to pursue this matter) Otherwise you'll end up paying through the nose, won't you?

CATHY Yeh (unconvinced).

TERESA (moving the discussion on): Right - had you ever been to a (child) health clinic before?

CATHY: No I hadn't, no (118)

TERESA (echoing her reply): No... antenatally, when you were carrying your baby, did you have any checks by your own doctor?

CATHY: Yeh, well I were under me own doctor (120) for about two months, summat like that (120A), and I were going to clinic at (names clinic in neighbouring health authority) - they have an antenatal there, like - and I were going through and seeing them, and it were okay (120B) because I didn't have far to travel (121). But with this one (emphasises child she is carrying) they've made me stop (i.e. continue to attend) at (names more distant hospital-based antenatal clinic) (122), so I've got to catch two 'buses now if I want to go (123) - and plus me appointment is for nine in t'morning, so I've got to set off from here about quart' t'eight to get there (124) - and it's a bugger! (laughs) (125)

TERESA: So, were the midwives with the doctor when you went to see him? (trying to discover if she attended antenatal clinic proper).

CATHY: Yeh

TERESA: (in the vernacular): And what were they like when you went? (i.e. what was their attitude towards you?)

CATH (interprets question as referring to whole clinic context): Well, it were a bit strange at first 'cos I, I didn't know what were expected of me, you know (128). It were all questions t'first time I went, I know that (129), and I were in there ages (130); and they give me (an) internal (examination) and this, that and the other (131). But afterwards I didn't see me own doctor when I kept going to (names clinic in neighbouring health authority). I saw (pauses - names doctor) I think it were - yeh (names doctor) (132), and her sister (133). But (previously) I'd got used to seeing this... (134)... her brother, you see (135): 'cos he were right nice, I could have a good talk with him (136). But - with her being a woman - I think a woman seems to think "Well, she's only the same as me" - you know what I mean, they're rougher with yer (137) whereas a fella seems to be a lot more gentle (137A). Aye, yer just..yer just treated like a bag of flour passed from one place to another - and that's it! (137B). (giggles, both amused and exasperated by her own imagery)

TERESA: Hmmhuh (affirmatively - then pursues the question area) What...em...did you go to the hospital as well?

CATHY: Yeh I were. Well, it were silly really, because they were giving me appointments for t'antenatal (clinic) at (names clinic in neighbouring health authority) as well (138). I had to go to t'antenatal at t'hospital on morning (139) - then rush like bloody hell to come back for t'antenatal at (names clinic in neighbouring health authority) (139A) (raises her voice here to emphasise the ludicrous nature of the situation)

TERESA (empathic - laughs and repeats): At (names clinic in neighbouring health authority)

CATHY (affirmatively): At (names clinic) on t'same day! And I kept telling 'em (140), 'cos by t'time I got to (names clinic) they used to say (141), "Well, you've been to (hospital antenatal clinic) this morning, so there's no point in us doing owt (anything) to yer!" (142). But it were me having time off work, you know, and we had to clock in and clock out and that, and (her exasperation increases as she remembers) oooh, it were a bugger! (143)

TERESA (empathic, affirmative): Uhuh, uhuh... What did you think of the hospital when you went for your checks?

CATHY: Well, to be honest, it were (like) a load of women lining up to be slaughtered! (laughs) (145)

TERESA: Yeh, really?

CATHY: You found you were waiting there hours and hours (146); and if you were frightened about owt, it just used to make you worse with

waiting all t'time (147); and then half of t'times t'doctor (well,I were under (names consultant obstetrician) for t'first one (148A)), he hadn't got time for you, he couldn't...he couldn't gi' a chuff (i.e. was completely disinterested) you know - he just treat(ed) you like a little box in t'corner (148)

TERESA: Really? yeh..yeh?

CATHY (suddenly remembers): I know one o' t'times when I went he'd got some students in (149) and I felt stupid (149A). I'd to remove me dressing gown (149B) and they'd taken it right to t'other side of' t'room (149C) and I'd to walk across t'room (149D) and I had nowt on (laughs embarrassedly), to t'other side (149E). (explaining) I'd to get me dressing gown and I felt stupid (149F)

TERESA (seriously): That's really embarrassing

CATHY (also serious): It is, yeh. I'd, I'd... (pauses) (150)

TERESA (intuits what Cathy may be trying to say): None of them made an effort to get it for you or anything?

CATHY (bitterly): No. They just...they just treat you like little boxes, that's what it is (151)

TERESA (echoes C's feelings): That's awful

CATHY (philosophically): I know - I were embarrassed at first (152), but now I believe that a doctor don't see yer as a person; he sees yer just like an object (153)

TERESA (interrogative): Mmm?

CATHY: ...you know what I mean? So it doesn't bother you...(pauses) (154)

TERESA (echoes her, righteously indignant on her behalf): It doesn't bother you, yeh mind, I think that's bad, don't you, to be treated like that at all? (pursuing the outcome)... So did you mind going to the hospital then? (i.e. how did you feel about it?)

CATHY: I didn't <u>mind</u> (object to) going to t'hospital (156), but it were just all t'waiting and that (157), you know with me working (158). Like as now (without a job), I don't mind going, 'cos it's a break...

TERESA (affirmative): Mmm, uhuh (yes I see that)

CATHY: ...you know (159), and I don't mind waiting. But now with this one I'm in and out like nowt, whereas I were waiting longer with our N. (baby) (160)

TERESA (stumbling a little): Uhuh - did they em, answer any... (recovering) ... were you allowed to ask questions and stuff when you went - could you ask questions about anything?

CATHY: You could ask (162), but you very rarely got an answer - you got a question back for your answer... do you know what I mean? You

were just no wiser when you walked out of t'room (163). It's stupid really - you were expected to know; that were it, that's what it was (164). I mean same as this, this rash here (indicates rash) (165) - they don't know what it is (166) but they expect me to know what it is (167) 'cos he (the consultant obstetrician) says to me, he says "We'll have to send you to see a dermatologist (168). He says "Is it irritating?" (169) I says "'Course it's irritating!" (170). I says "I had treatment for scabies (171) and it's still spreading" (172) I says, er, "and it's driving me batty!" (173) I says "I'm going to be no good having this bairn 'cos of (lack of) sleep (174). I get, you know, I'm only getting one or two hours (each night) (175); and with a bairn to bring up and all (176), and with a husband as well (laughs) (177), it's a bit much you see..." (178). (addresses Teresa directly) But they're just not bothered wi' you. "Go and see yer doctor" they said (179).

TERESA: And that was it (Cathy nods). Did they, em, were there any antenatal classes - you know, the relaxation?

CATHY: Er. I went to one (180) - I only...I only wanted to go and find out how you do yer breathing when you actually have t'bairn, you know, and that's all I did - I went to that one to learn how to (181)

TERESA: ...do the breathing?

CATHY (affirmative): Mmm, 'cos I thought all the rest were really a waste of time - you know, stretchin' yer ankles and all this lot (slightly comtemptuous) (182). So I just went for to find out what t'breathing were (183) and then I didn't go no more (pauses) - so, that were it (184)

TERESA: Who asked you to go?

CATHY: I think it were (names a health visitor), I'm not sure (185)

TERESA: At the hospital or something?

CATHY (remembering): No, it were (names sister at hospital antenatal clinic) - she asked me to go (186)

TERESA: Uhuh - and so you didn't...did you enjoy the one you went to?

CATHY: It were okay, yeh (188) - they showed you films and this, that and t'other (189) (reflects on content) - "Bringing a child up" (190) and ... (decidedly)...but that's it, you can't - you can't go by films (191). I mean, everybody's got (to) bring their bairns up their own way - d'you know what I mean? (192)

TERESA (Affirmative): Uhuh?

CATHY: And (supposing) we were both working and we'd got plenty of money (193), probably we could have brought t'bairn up their way if we'd got money (194) - but with him losing his job and then me havin' to jack me job in...

TERESA (sympathetic): Yeh...

CATHY: ...we went from two wages to none, so we had to struggle (195). I mean, that bairn of mine, she gets Weetabix more often than not, and cornflakes, when she should be getting meat and fish and stuff like that (196) (becoming distressed) - but you just can't do it (197)

TERESA: I know - that's terrible...

CATHY (recovering herself but clearly not wanting to pursue these issues):
Come on - next question! (laughs) (198)

TERESA: Right - did your husband get involved antenatally? Did he go to any of the...?

CATHY (interrupts decidedly): He weren't interested at all. In fact he never, he never used to come and visit me when I were in hospital.

TERESA: Really? (honestly)

CATHY: Yeh (199). He, he'd just that calm about it as though...as though he'd got a thousand kids of his own, you know what I mean, he was... (exasperated)...men, they're unbelievable! I mean, to me it were t'best thing that ever happened in t'world! (200)

TERESA (sharing her enthusiasm): Yeh (I know!)

CATHY: I were on cloud nine, me, half o' t'time - but "Oh shurrup", he used to say, "let me watch t'telly" - you know, things like that (201) - and I wanted to share it with him, but he just weren't bothered (202). I think now, now she's talking and she's saying "Daddy" and this, that, t'other, he's taking more notice (203) - well, whereas when she were first born, as soon as she roared (cried) (imitating her husband handing back the baby) "Here, to yer Mam!" (204). He wouldn't change her or nowt, you know what I mean. (205) I was just like a one-parent family, just bringing t'bairn up by mese'n (206) - but now she's talking and clouting (hitting) him and that, he's takin' a lot more notice on (of) her (207)

TERESA: Right...when you went into hospital for the baby's arrival, did you enjoy your stay in hospital?

CATHY (very definitely): No, I didn't, no (absolutely not!) (208)

(Teresa laughs at her definiteness)

CATHY (laughing in response): On no - well, I went in before, because she were three week overdue (209); and they couldn't make up their minds what date I were due on (210); and I'd been in (hospital) all Thursday and they says, "Oh, if yer - if yer haven't started in labour (soon) we're gonna set yer off" (211). Well, I wanted to get it all over and done with (212), 'cos, I mean, nine months is long enough, without nine month and another month on top of that (213), so I thought "Great!" (214). And they never tell you nowt at hospital (215), because they'd got me on the side monitor machine and what I thought were tightenings, <u>they</u> were contractions (216) - I'd been in

slow about for two days and they'd said nowt to me (217). And then they were rushing about on Sunday (218) and they'd to...they had to put me on a six-hour drip and rush me or I'd have lost her (219) - but they never said nowt (to me) (220); they just kept comin' tearing strips off (the monitor readout), running back, bringing t'doctors looking at t'chart, bringing...tearing more strips off, you know (221). And I, I were really shittin' mese'n...

TERESA: I'll bet!

CATHY: ... thinking, well, I wonder what's going off (happening) here? (222); 'cos normally they don't set anybody off (induce labour) on a Sunday (223), they wait while (until) Monday, while t'consultants come (224): and I thought, well, I wonder what they're doing here? (225) Anyway, it were quart' to twelve, and for (by) half-past twelve (226) they'd got...they'd broke me watters (waters) (227), they'd got me on t'drip and t'whole lot (228) - so I thought well, they must be doin' summat here (laughs) (229) (winding down); but they set me off on Sunday (230)

TERESA (acknowledging her harrowing experience): That's terrible... Right, em, how long were you in for - just the week?

CATHY: I were supposed to be, aye (231). I went in on Thursday, I were in a week and me ninth day was due - (informative) you know how you've got to keep babbies in for nine days? - it were due t'day after, so I were in (hospital) roughly a week and a day, you could say (232)

TERESA: Had you ever been in hospital before for any reason?

CATHY: No, I'd only...well, stitches and bumps and things like that; but I'd never... that were t'first time I'd ever <u>stopped</u> in hospital (233)

TERESA: Yeh, yeh - so it was frightening?

CATHY: It was (234), 'cos everybody seemed to be coming and having their bairns and going home (235); and you see she, she were full of jaundice, so they kept me in longer with her (236); and I thought, well, this is bloody marvellous - I come in first and I'm going out last! (237) You know, I were beginning to (think like that). Now, eeh, when I look back, I'm glad really, becos' it were a break, you know what I mean? (238) I didn't feel as though I'd got a bairn, 'cos I mean t'only time you ever brought 'em out were when visiting-time (came) and they were... then you fed 'em; and then they were back in t'nursery for you to get a nap (239) - and it were great! In fact, I'm lookin' forward to goin' in this time (laughs) (240)

TERESA: You'll have to make the most of it (pause). When you were getting ready to leave the hospital, did you have arrangements at home to make things a bit easier for you when you got out - did you have some help?

CATHY: Well, B. offered to help (242); and, er, I'd got all t'stuff sorted out, and all it wanted was bringing downstairs and airing (243); and it was the first time he'd ever shown any interest in doing owt (anything) for me (244). And me Mam and Dad come down (245), and

me Mam's one of these that (say) "Oh, yer not doing that right" and "Yer not doing this right" and "She'll want that doing" (246) and he ended up swearing at her. Well, they had a big argument over it (247): so when we come out - well, I'm saying, it looked like a bomb had hit it (248). (whilst she was still in the hospital) everybody were coming and telling me how nice he'd kept t'house and (that) he'd got everything ready (249): and when I come out... (overcome by her memory of what occurred)... oh, it were bloody terrible, lass! - I sat down and roared (cried) (259). I were doing housework ten minutes after I'd got in t'house...

TERESA: Oh dear me (shocked)

CATHY: ...it were that bad (251). But, er, I think that's why I lost me milk, because I were at it (busy, distressed) (252). I'd have liked to have carried on breast-feeding (253), but I were just at it solid (continuously): it never, altered, you know. I were still doing housework and I weren't getting the rest. (254)

TERESA (sympathetically): Yeh

CATHY (somewhat defiantly): Min'st (mind) you though, I've learnt to cope with it now, so (255)

TERESA (agrees): Uhuh, uhuh - what about transport back from hospital - how did you get back?

CATHY: Er, one of his (husband's) mate's cars (256) - he, he brought me back by car 'cos...well, what it were, me Dad's car had gone off t'road (257A); and me husband had sellt our car while I were in hospital, because he knew I wouldn't part with it otherwise (257B) (takes out a cigarette). You see, we bought this little mini... (searches unsuccessfully for a match)

TERESA: Have you got a match, do you want...?

CATHY (accepts a light): I ain't got a light...we bought this little mini and, er, we couldn't...we sent off for t'log book for it and they couldn't...they'd got no, no note of it at t'motor place, like (257C); so we were beginning to think it were stolen, you know (257D) - so he got shot on it while I were in hospital (257E); and then he finds out that t'fellow he got shot on it to sent off and got t'log book as easy as pie! (257F)

TERESA: Really?

CATHY: ...and it were t'best car we'd ever had (257G); and it only cost us thirty pound and all - that were t'best thing about it (257G) (sighing wistfully).

TERESA: Oh dear... right, when you got home, how long was it before you were visited by the midwife?

CATHY: I can't...I think it were t'day after (258)

TERESA: Uhuh, and what was she like when she came?

CATHY: Well, she...they're all helpful; I mean they're...they try to

make you understand things (260). I mean, I have, I have got a bit of common sense like (261), but - I don't know, I think a babby causes more problems than owt - you know what I mean? It caused problems between me husband and me Mam and Dad, they were arguing (262). And they (i.e. professionals) look at it - well, let's say through rose-coloured glasses, let's say (263). They think it's all straightforward and easy (264); well, I suppose to them it <u>is</u> easy - but you've got to have money, same as I said (265)

TERESA (agreeing): That's right, yeh

CATHY: ...and I mean, I were fed up of them coming and causing arguments (266) ; and I were, I were in t'middle on it - I'd got to take sides between me husband and me Mam and Dad, and you can't do that, and then they come down (get angry) (267). And then I told her about it - t'midwife - (imitates midwife) "Oh, it'll be sorted out, once the baby's walkin' and talkin'" (268) - you know all the... but tht's it - it weren't getting sorted out, it were getting worse, in fact (269). I know, I know it's a callous thing to say, but I were beginning to wonder whether it were worth me having a bairn, you know what I mean? I were thinking to mese'n "Well, I wished she'd a-been born dead now" (270)

TERESA: Yeh, yeh, and you wouldn't have had half the trouble... (echoing C's sentiments)

CATHY: And...but I don't know - they, they expect you to cope, that's what it is... (271)

TERESA: Uhuh...expect you to get on with it. What, er how long was it before you were visited by your health visitor?

CATHY: Oh, er, about three or four days, summat like that (272)

TERESA: ...and what was she like when she came - like the midwife?

CATHY: No, she were okay (274). I mean, I've had, er, I've had marital problems since (275) and I've been able to go up and talk to her - she's been really good and understanding, and things that she's said to me has made complete sense to me (276)

TERESA (encouragingly): Mmm?

CATHY: ...but, me husband is one o'them that weren't (won't) listen to anybody, so, you see, it's not made us (our) problem any better (277) - but I can see it a lot clearer now (278)

TERESA (curious): Mmm...mm...what happened - what's been going on ?

cathy (seriously): Well, he used to, er, he used to beat me a lot (279)

TERESA (concern, dread): Oh dear....

CATHY (hastily): ...only after we were married - he never brayed (beat) me before we were married (280). And he brayed (beat) me when I were carrying' t'babby, and she's carried a mark on her stomach where he brayed me (281)

TERESA (sympathetic, concerned to find the reasons): What ...was it just arguments got out of control, or...?

CATHY: Well, he's...he's gypsy blood in him you see, and he's very quick-tempered and, you see, he flies off t'handle for t'least little... like, if he's had an argument at work he used to come home and take it out on me or owt like that, you know - 'cos I were t'only one (to take it out on) (283). And I used to try to talk to him, but he just couldn't...you couldn't get owt through to him (284). I ended up going to me own doctor in t'end, 'cos I were, I were bad with me nerves, and I thought "Well - twenty-one year old and a bag of nerves!" - and I were havin' to take sleeping tablets and this, that and the other (285) - and I thought "Well, it's no good, because I'm just gonna end up neglectin' me bairn" (286)

TERESA (encouragingly): Mmm?

CATHY: You see, it didn't make it too bad once I'd got her (indicating the baby) (287). (softly, almost to herself) 'Cos I know well, if I haven't got him, I've got part of him (288)

TERESA: Mmm?

CATHY: You know what I mean? So that made it a lot easier. Now, I mean, now they (these considerations) could make it a lot easier to say "I'm going" tomorrow (laughs). I wouldn't be bothered, I've got me bairn, you know what I mean? (289)

TERESA: Mmm - uhuh (Yes)

CATHY (indicates current pregnancy): I mean, this one were only 'cos he thought he were goin' down t'line (laughs) (290)

TERESA (curious): Why did he think he was going down t'line?

CATHY: 'Cos he's a bugger - it's t'lads that he mixes with - they're always trying to get him into pinching and that (291)

TERESA: Well, if you've got no bloody money, what are you supposed to do? (echoing first part of interview)

CATHY: Well, that's it - (confidentially) he's had, he's had to pinch coal and things like that - else we'd have been freezin' (293). We'd have been freezin' and all, up to her being about five month old. She were down here (in the living room) in t'cot; B. were sleepin' on t'floor and I were on t'sofa (294). And when I tell...when I telt them at t'Social Security (imitating the reply) "Oh, a lot of people are in your..." - well, I know they are...(exasperated) (295)

TERESA (pursuing her idea - righteously) ...but it doesn't make it right

CATHY: No, it doesn't. That's what I can't understand. I mean, fair enough, there's folk that's been on t'dole for years and years (297) - (snaps her fingers) they've only got to go like that and they get all they want (298). Me and my husband's always worked for a living, you know (299), and that's what I mean - I mean, I've had to sell me

telly; I've had to sell me bar; I've had to sell me rings, just to pay electric bill (300). And, I mean, I've worked for them - we've both worked! (301) (sadness here)

TERESA (supportive): I know

CATHY: ...and that's what makes me...it...you know, I think - I don't know... I wished he could get a job. I mean, he's been for hundreds, but there's no chance - and that's what makes it so...so bad, you know (303)

TERESA: Mmm...

CATHY: ...and it wouldn't be so bad, but now we've got a bairn to bring up as well (304)

TERESA: Mmm, I know, that's it - when you've got a baby it's worse, isn't it? So, where did he hit you - everywhere?

CATHY: Yeh, yeh, he used... I used to end up with black eyes and busted ribs and all sorts (305)

TERESA: Oh, you poor thing - it must have been awful.

CATHY: Well, it was...it was (pauses)

TERESA: Was it every night, or...?

CATHY: He doesn't ...no - but I could, I could guarantee that before t'week were out I'd got a good hidin' for summat or other (306)

TERESA: What - just anything?

CATHY: Well, I'll tell you what it were. He used to go out pinchin' (307), and up to (the time of) me havin' t'babby (308) he used to go out about eight o'clock at night and I wouldn't see him while (until) next day, and we didn't sleep together or owt like that (309). We couldn't sit down and have a talk like me and you are doing now (310)

TERESA: Mmm...

CATHY: ...and it were just all gettin' on top of me, and I found mese'n nagging at him (311). And then, when he started bringing these thieves in (312), and I were tryin' to tell him that they were just usin' him, see, he wouldn't listen to me (313). (ruefully) then, that's when he used to fly off t'handle - he thought I were talkin' a load of shit (314)

TERESA: Mmm... Does it still happen now, then, or...?

CATHY: No. He hasn't hit me for, it's about... he hasn't hit me since I've been carrying this one (i.e. about eight months) (315)

TERESA: Mmm... Could you defend yourself - did you hit him back or...?

CATHY (as if this is obvious): Oh, I used to hit him back, but I used...I used to get it twice as bad - (emphasises) - twice as bad. That's it, men are stronger. Yeh, I er, I mean, he changes, like into

t' (incredible) hulk when he's mad (angry); and he can throw me round this room like a toy (316)

TERESA: Mmm?

CATHY: You see, but... now we don't argue so much 'cos more often than not he's out of t'house (317)

TERESA: Mmm?

CATHY: I got him a load of fishing tackle, and that kept him out of trouble for a bit. You see, once he weren't in, we didn't argue (laughs) (318)

TERESA: Yeh...

CATHY:... and I thought, well, it's not fair on t'babby really...

TERESA: Yeh...

CATHY: ...bein' in the middle of arguments (319)

TERESA (recapitulating): Mmm... So it's mainly money that caused the arguments then, is it ?

CATHY: It is, yeh, that's, that's what it is - it's money that's done it (320). I mean, in a way he were right - if we had got money he wouldn't have to go out pinching (321). But he's never been caught (322), but he's always been split on (informed against). And it's always been his mates (with great irony) - you know what I mean, his good friends who would never split on him? (323) (using husbands naive phrases).

TERESA (knowingly): Oh, aye!

CATHY: ... and now, we're paying all t'fines off all t'time (324)

TERESA: Mind, he's got to watch folk, haven't you?

CATHY (agreeing): Mmmm...

TERESA (worldy-wise): If you're goin' to do any nickin' ...

CATHY (maternal, excusing): Well, you see, he's gullible, me husband (326)

TERESA (inviting her to continue): Mmm?

CATHY:...but I could see, right from t'beginning, that they were just using him (327). But I tried to tell him and, of course, I were wrong (328). But I... he's found out since that I were right. And, in fact, sometimes he's said to me "Eeeeh, Cathy, I wish I'd a-listened to yer" (329)

TERESA: Yeh, yeh...

CATHY: ...but it's too late now, 'cos I mean, now, I mean, we're payin' three pound a week on fines (330). (sadly) That three pound a

week could be gettin' me extra snap for me bairn, you know what I mean? (331) (with a faint hope) But he's probably learned his lesson now (332)

TERESA (warm and encouraging): Eeeh, I think you've done well to survive, I really do. I mean, how much must you be gettin' a week?

CATHY: Forty-seven pound

TERESA: For three people ?

CATHY: ... and then there's ten pound rent to come out of that

TERESA: So, you're living on thirty pound?

CATHY: Thirty-seven. There's ten pound bank loan a week (to be paid back); five pound (a week for the furniture) suite; three pound (a week) insurance. (calculates) We end up with about six pound a week for snap (food) and clothing and household stuff (333)

TERESA: Gosh, that's terrible (difficult)

CATHY: I know - and then I've got to get me coal out of that as well. I don't know, I don't know how we've...we've had to survive, I mean (333A), same as I pay two pound a week for a bag of 'tatties. We have chips, more often than not, which is all we can afford, and t'babby has Weetabix and chips. I ha'nt had, I ha'nt had a joint of meat for ...ooh, God knows, but it's over a year since I had a joint - we have to make do with sausage (laughs)

TERESA: Even sausage isn't cheap, though, is it? It's about sixty or seventy (pence) a pound now.

CATHY: No, it isn't no. I pay about fifty-eight (pence) a pound. I get a pound and a half, and it lasts us three or four good meals, you know (333B) (pulls strained expression).

TERESA: Yeh, yeh...eeeh, you poor thing, I just don't know how you manage.

CATHY: I just don't - I don't. I've got to - I've got to keep me will power up (334)

TERESA: Yes, you've just got to keep going (echoing)

CATHY: ...'cos if I don't, I know that t'next thing (is) I'll be having another nervous breakdown...

TERESA: Yeh...?

CATHY: ...and I couldn't, I couldn't go through all that again (335). I mean I were...I were pelletin' mese'n with, er, drugs and this, that and t'other, just to calm mese'n down (336). And I thought, "Well, Cathy, slowly but surely you're killin' yerse'n off" (337). And, luckily, I ain't had sleeping tablets or owt like that since I had her (338). But if things carry on t'way they are, I'm goin' to have to... I don't want to go... I don't want to start takin' drugs and that, but... (339) (looks hopeless)

TERESA: Well, they don't help anyway, do they really? I mean, what you need is money - you need some money to live on (echoes sentiments)

CATHY: That's it. But, I mean, we've trailed through to (neighbouring town), we've trailed through to (another neighbouring town), we've tried all over to get some money and you just can't - they're just not interested (341). I mean, I've got, I've got one pair of sheets and that's to do for three beds - so God knows how I'm goin' to do it (342). I've had to sell one of me beds and all (343). I ain't got no bed for our babby when t'other babby comes along. They've more or less told me that they've both got to share t'same cot (334)

TERESA: My goodness...

CATHY: ...and even that, that's broke, t'cot - it were second-hand when I got it (345)

TERESA: Mmm...Has the health visitor...does the health visitor know, 'cos she might be able to do something?

CATHY: I've been up to t'health visitor (346). She sent me t'Social Services at (a suburb of her home town) (347); and I went there, but they'd got nowt in (348). I mean...I mean I didn't like...I don't like begging...
TERESA: ...I know, but you've got to...

CATHY: ...that's...that's what I feel like I'm doing - begging (349). (doggedly) But I mean I've got a...I've got a bairn to think about now (350)

TERESA: I know - that's it, yeh...

CATHY: I mean, we've always worked for what we've wanted, - but there's no chance (351). I mean, that maternity allowance...I'd really built me hopes up 'cos they'd sent me a book on Friday (352); and I'd built me hopes up 'cos I'd seen a cheap tumble-drier (353), and I thought, "Right, with t'money I'm goin' to get that (354). On Saturday, they'd knocked it off his dole money (355) - they never said a word to us about it (356) - so we had to go through and see to it. "Oh well", they says, "we can't be giving you this and that as well" (356A). But I mean, I were goin' to get a bed and all sorts out of that money (357). I mean, this baby's due now in about a week to a fortnight, summat like that (358); and upstairs I've got a little pair of, like, plastics; a little blue vest; a little blue cardigan; a blue pair of mittens and a blue shawl and that's it - that's all I've got for this bairn (359), and I know it's goin' to be a lad this time 'cos I can tell, see (360) - if it had been a lass, I've got plenty of gear from her (indicates baby); but I've got nowt if it's a lad (361), and I'm just whittling mese'n to death now, 'cos I'm getting that near, you know, I, I can feel that I'm near t'end now (362)

TERESA (sympathetically): Oh dear me... Did you, em, did you know what sorts of things to get ready for your first baby ?

CATHY: No, I didn't (363)

TERESA: well, how did you find out?

CATHY: Well, I got one of them books from. from t'antental clinic; and it says, oh "Everything you Need for your Baby"; so I just followed that more or less (364) But I were getting stuff, I were getting stuff that I didn't need, like (365). Even when they packed me case up, they never said nowt that you didn't need to take t'baby's stuff through (366), so I packed this case full of t'babby's clothes and nappies and all sorts (367). Well, they supply nappies and vests (368) - and, well, I didn't know, - they never said nowt to me (369)

TERESA: You should have took a few of them... (laughs)

CATHY (laughs and replies in same tone): I did - I took a load, lass! (370)

TERESA (laughs) Good...!

CATHY: I'll tell yer, he (B.) come to pick me up, and he'd been late or summat - he were supposed to be comin' at one o'clock (371). Well, after five o'clock they wearn't let you go or summat (372), so it were getting on to four o'clock and they'd used my bed - (explaining) they'd got my bed made up for somebody else (373). So I thought, "Well, I can't go" (374) - and I were dressed all ready (to go) (375), and it were t'time for her feed and I were leaking (laughs) (376). So when he comes, I says "We'll have to go in here", I says; "We'll have to feed t'babby", I says, "because you're too late - 'cos her feed were (due) at three" (377). And this nurse says "Oh, get a few nappies while you're in there, love". Well, I'd got t'big case with all me stuff in, and I filled it - I packed it out. They lasted me about five week! (378)

TERESA: Yeh, you'll have to do the same thing next time, an' all! (laughs)

CATHY (decidedly): I'm going to do. I've told them - everybody that visits me's got to bring a little shopping bag (with them), and I'll put some in (379)

TERESA: You must try to get whatever you can, (laughs). Right - when you were coming home from the hospital with your baby, can you remember what you were worrying about - can you remember your immediate worries, what with being a first time mother and...

CATHY: Yeh, it were "How am I going to feed it?" (laughs) (380); you know, 'cos I were breast feeding like and I'd been told off (by) no end of folk that once you get out and get t'housework done, your milk goes (381); and I thought, with him not working, how am I going to get all t'proteins and that for t'babby...that a babby needs, y'know...'cos she were on solids, her, at four weeks old she were that fast - and I thought, well, I'm never, ever goin' to be able to feed her (382). And then (next) I thought, "Well, I wonder if t'house is goin' to be warm enough for her?"

TERESA: Yeh, yeh (go on)...

CATHY: ...'cos it's terrible cold in winter, this house; and I thought

"well, has he got enough coal for..." - you know, for t'fires to keep 'em in and that (383). And then I thought, "Well, I wonder what t'house is goin' to be like when I get back?" (384)

TERESA: Yeh...

CATHY (laughs): Well, I sat down and roared, lass!

TERESA (laughs with her): Did you feel confident?

CATHY: I felt clumsy, I didn't feel confident at all (385); in fact, it took me three or four days before I got to love her. I know it sounds funny, with it being me first bairn and me wanting her so much, but I...I hadn't got that bond with her. It took days for it to grow on me, you know what I mean? (386). I just felt clumsy because, before, I'd never dream of picking a bairn up that small; (seriously) and I were always frightened to death of dropping her - you know what I mean?

TERESA: Yeh (encouragingly)

CATHY: I felt so clumsy with her (387), until me mother said "Well, they're a lot stronger than they look, you know!" But oh, I did feel clumsy, I felt inadequate (388). T'only thing that I felt good and proud and confident about were, when I were walking down the street (with the baby), and people were saying, "ooh, let's have a look!"

TERESA: Yeh...

CATHY: You know, you know I felt really great then, when people were saying "Oh isn't she lovely?" (389) (wryly) And she weren't really - she were ugly when she were born - she were really terrible! (laughs)

TERESA: (laughs with her)

CATHY: I think it were with bein' overdue and all, 'cos she were all...all patchy and blotchy and dry... you know, all dry skin and that (390)

TERESA: Mmm... Were you glad to get home ?

CATHY: Yeh, I was. (Mind you) I wearn't be this time, but... (laughs) (391)

TERESA: Right...if anything happened during the early weeks, where did you go for help and advice ?

CATHY: I used to go up and see t'baby doctor - (checking her meaning) - you mean if owt happened t'babby ?

TERESA: Mmm (affirmative)... You know, if anything was worrying you or...

CATHY: I used to go up and see t'baby doctor (392); but I found that he were a load of bull (393). Well, I mean, his, my husband's, mother suffers with T.B.; and although me husband isn't chesty, she is, me daughter (indicating baby) - and me mother's chesty as well and I'm

that fear of the cot deaths going round - there was a little lad down here had died with it (395). But she were that chesty - I could always tell when she were asleep, you know I could really feel it, you know,on her chest, ruttlin' all t'time (396). And I went up to see t'baby doctor about it; and he said oh, it were t'cold in her nose - her nose were blocked (397). But she's ...she's gettin' worse and worse (398). She's had t'T.B. injection but she is very chesty and it does frighten me sometimes (399), because I know, sometimes when she's bad she wakens me up, she's that loud and that (400). (resuming her account) He reckoned it were her nose (scornfully) - and I wouldn't go to him now. If I've got any problems I'd go to me own doctor at (names group practice), 'cos he's ever so good, him (401).

TERESA: Uhuh...What sorts of things have worried you during this first year of being a mother - what things stand out as having been a big worry? (accounting for her last statement) There's <u>that</u> for a start...

CATHY: Well, dressing her has been... you know, providing clothes for her and that...because from being about six months old to being a year old, they seem to go through clothes like, like nowt... you know what I mean, they grow out... (402). One day you can put 'em on and they fit all right, and the next day - that's it, and you think "Well, that's a bloody waste of money, that" (402A). I mean, I got a hell of a lot of clothes for her when she were first born; and she seemed to grow out on 'em before I knew what were happening (402B)

TERESA (agrees and elaborates): Yeh, they do...they shoot up, don't they?

CATHY: But, er, t'main problem's been feeding her and dressing her, you know, with not having enough... (403). I mean, same as I said, me and me husband, we've starved so as that she could have summat (404). It's not...bothered us, like. I mean, I've always had me Mam - if we've been short of snap (food) I could always go up; but she's on t'dole as well, you see. You can't expect too much from them, but she's always made sure we've come away with a...with a meal inside us, you know (405). And when she got, when she got walking, that was t'worst problem, because you've got to have eyes up your arse to keep...you know (406). She keeps banging herse'n now; and I daren't take her up to t'clinic 'cos she...she's got a black eye now, where she fell against t'corner of t'bloody table...

TERESA: (reassuring): They're always doing it...

CATHY: ... and I daren't take her up to clinic, 'cos you've heard they...these things about women beating their bairns up and that - and I think, "Well, I wonder if they'll think I've done that?" (407)

TERESA (reassuring): Mmm... I know, it's a real worry, isn't it? But I think that's something they've all got at this age, 'cos a lot of mothers have said that one thing that's really worried them is the baby throwing itself around - they just...some of them just tearing across the room...

CATHY: Well, that's what I mean - since she got walking she's been on her arse more times... (408)

TERESA: I think it's 'cos they can't balance when they're that age.

CATHY (offering Teresa a cigarette): Do you want one of these?

TERESA: No thanks, they're too strong for (laughs) - I'll get the matches. (encouraging her to continue) Yeh?

CATHY: It's not that and all (not only that) - I got...I can't afford to get her proper shoes (lighting a cigarette). T'shoes that she has got, I got 'em from a jumble sale and they've got no tread on 'em - and she keeps sliding off that carpet there... (indicates carpet)

TERESA: Oh, yeh... (notes the spot)

CATHY: ... and going and flying (409). I mean, t'other day - I know it sounds callous - but she did t'splits. Now it hurt her poor little... but it were that, it were that comical I just couldn't, you know, I just couldn't help mese'n from laughing at her, you know - 'cos she went ...she were sort of getting' off that carpet and she...one foot went that way and one foot went that way and... (410). Mins'st you, though, I've always said this - if you make too much fuss over a bairn (after a 'spill') they roar (cry) all the more (411)

TERESA: Yeh, yeh...

CATHY: ...I mean, at one bit she'd only got to go like that and catch herse'n; and if she roared (cried) I used to... "Oh, me babby!" - (fly to her aid) you know all things like that (412). And folks say, "Oh no, you're makin' a rod for your back - just laugh at her!" So I laugh at her now if she does owt (413) If I know she's gone bad (fallen heavily), like when she hit her head I knew there was summat up then because she really screamed, and it come out more or less straight away - and then I did panic. But owt else (if any small accident occurs) I say, "Oh, get up, yer silly bugger!" and laugh at her. And then she's (all) right, you see - she has a laugh with us (414)

TERESA (laughs): Yeh...

CATHY: (still thinking of baby's behviour): It's amazing...kids - and she's very intelligent for her age (415) (thinking of an example) That's one thing I wouldn't like... - I got some new eye-shadow, and it were a screw-on top, and I thought "Well, a bairn her age'll not be able to take it off". So I give it her - walks in t'kitchen - comes back in - blue eye-shadow everywhere - she'd got it all over! (416) I'd only just got it from Avon, and I thought, "Well, I never thought that a bairn her age'd have t'intelligence to screw t'top off and take it all out". And...ooh, but they're a lot brainier, kids, than we think (417)

TERESA: Yeh, yeh, bright... (moving on) Right, the next bit's about, em, help and advice. Do you think you've ever suffered from lack of help and advice ?

CATHY: Yeh, I have. Yeh, when, when I were carrying her, I didn't know what I were lettin' mese'n in for or nowt. I mean, I found out - (wryly) - I found out by actually doin' it, d'you know what I mean?

TERESA: Yeh, that's what a lot say

CATHY: Like me mother and all these that's 'ad kids; they all used to say "It's the worst pain you can ever go through - but once you see t'baby, you forget all about t'pain" (419). Well, of course, nobody likes t'idea of havin' pain; so for t'last few week I were like this, you know (huddles in mock terror) - I were really shittin' mese'n. Well, (imitates) "T'worst pain you can ever have..." - you know (420). And then I thought to mese'n, "Well, you silly bugger - if it's t'worst pain you can ever have, how come they go in and have two and three kids", you know what I mean? "Well" I thought, "it can't be that bad or they wouldn't - they would only have one". And then there's me mother there with four, and she's saying it's t'worst pain you can ever have! (421) But to be honest, I think it's just like tryin' to have a good shit when you're constipated - that's t'only pain I can liken it to. Yeh, that's all it is, really (422). But now I'm gettin' to t'latter end with this one, I'm remembering t'pain from t'last one, you know what I mean ? (423)

TERESA (moving on): Right, the next bit's, em, do you think your husband's adapted to being a father quite well, or...

CATHY (decidedly): Do you want my honest opinion ? I don't think (that) bringing a bairn up changes (affects) a man at all - that's my opinion from B. I mean, he can still say "Oh, I'm going so-and-so" - "I'm goin' to do so-and-so today" (424) (contrasting her own lot) If I want to go anywhere, I've either got to take t'babby with me or find a babby-sitter now. I mean, I'm stuck in t'house from one day to the next (425). I mean, I've only been...it's only 'cos I've been really badly (ill) for t'past couple of days that me Mam's got (looked after) t'babby - otherwise I'd have been wi'her, you know what I mean? (426) And I sleep with her, and she waits (stays awake waiting) for me to go to the bed on a night, so I get no break from her...

TERESA: It's twenty-four hours a day, is it?

CATHY: Yeh, I have her through t'day and through t'night (427). He says "Oh, I'm goin' to so-and-so's for an hour" - I can't. You know I don't think it (parenthood) changes (affects) a man at all (428). T'only time it changes (affects) a man is if his wife pisses off and has to bring 'em up hisse'n - <u>then</u> they understand how we feel (429). But, apart from that, they can just say, "Oh, I've got a daughter - I've got a son" (and) that's it - that's t'end of it, for them (430). I mean, even if...he don't have to worry about "Is she gettin' enough snap (food)?" - you know, things like that. He don't like to let nowt worry him; and (whereas) I've got to think to mese'n, "Now, have I got enough clothes for her for winter?" - "Have I got enough this?" - "Have I got enough that?". I do all t'worrying (431). Plus, they're on about evicting us from this house and all, and... (432)

THERESA: Really?

CATHY: Yeh, there's been a mistake with t'rent. Now (recently) t'rent man comes when he feels like it (irregularly), so it got us about three week behind with us (our) rent. Well, at head office they've got us about six week behind, and they're on about evicting us - well

(quotes) "take possession of t'house" (432A). You see, with it being a pit house, they're not forced to find me another house, see? If it were t'Council, they'd have to, but with it bein' a pit house they're not forced to, you see (432B). So, I have all these worries, plus bringing a bairn up, and he...he don't...it don't bother him at all - he's not bothered (433)

TERESA: Mmm, dear me... (moving on) Has the baby been ill at all this year ?

CATHY: Well, apart from her being chesty - she's had a lot of colds and that, you know (434)...but that's only, that's only expected with t'house - I mean, you can feel it as soon as you walk up them stairs, cold and damp... (435)

THERESA: Yeh, yeh - but other than that she's been... ?

CATHY: She's been pretty fit (436). In fact, it's me what's been badly (ill) more, you know, since I had her, than she's been (437) But she's a good babby - well I'm saying, when she's good she's really good - but when she's bad I could kill her! (438) (laughs)

TERESA: Yeh, yeh - what about feeding? You said you breast-fed (her) at first?

CATHY: Yeh, I did, yeh (439)

TERESA: How did you find that?

CATHY: That were painful - very painful. I mean, it felt like they'd got a moughful of teeth (440). But I thought, "Well, if it's t'only way I'm goin' to get me figure back, I'm goin' to keep on" (441); and (eventually) I got enjoyment out of it. And I thought...well, you know I used to love to just watch her, and it used to...(too difficult to describe her pleasure)... I don't know (442). It were just t'same as when he were bringin' all of his mates in - I used to think to mese'n "Well, I'm not goin' upstairs to t'cold bedrooms to feed her!" So I just used to get it out and feed her - I didn't give a chuff who were in because...well I'm not lettin' me bairn starve (443)

TERESA: Yeh, just for other people...(echoes)

CATHY: ...and with her bein' overdue and all she were right hungry, 'cos t'cord or summat weren't feeding her - you know, it had started disintegrating. But with her being greedy it were painful at first (444). But after t'first couple of week, Oh it were lovely...a lovely sensation (445). I'd do it again but, er, I've got a bike and that, and I want to, I want to get me figure back, 'cos it's a bigger babby, this one (446)

TERESA: Yeh...and then at what stage did you start bottle-feeding?

CATHY: I started bottle-feeding her when she were about four week old, 'cos me milk had gone. But (later) she were off t'bottle for four month - she don't even know what t'bottle is! (447)

TERESA (following this up): And did you manage to get your milk and everything alright?

CATHY: Yeh, I got me milk okay (448)

TERESA: Em, who would you say has been most helpful in bolstering your self-confidence in looking after her?

CATHY (thinking): Well, I can't...nobody really. I've had to do it mese'n, you know what I mean? I've had to think, "Well, Cathy if you don't look after her, nobody else will!" And me mother's badly (ill) herse'n and me father does everything for me mother, so I couldn't really put it on them. And I've got nobody around here and his (husband's) family's too far away so I've had to do it mese'n, I've had to - you know what I mean? I've had to cope (by) mese'n (449), and I've thought - well t'same as that doctor (her own G.P.) said "If you start neglecting t'bairn with the way your husband's been treating yer and this, that and t'other - it's just no good". I mean, he could've given me the drugs and tablets for me nerves and that months since. "But", he says, "It's goin' to be no good", he says, "yer just goin' to neglect yer bairn". So I've done without and I've, er, I've overthrown it mese'n, you know what I mean? (450)

TERESA (affirmative): Uhuh (referring to schedule) Right, the next bit's about your first visit to the clinic with the baby. Were you apprehensive about going?

CATHY: Yeh, I were - I, I felt terrible (451). I didn't want to go because I felt all...well, t'women round here (in the neighbourhood), they're right bitchy, and I thought, "Well, they'll be on about me bairn and this, that and t'other" (452). 'Cos, I mean, I couldn't afford to buy brand new for her, and I used to - still do - go to Dr. Barnardo's and jumble sales t'first chance I get. And when I went up there (to the child health clinic), there were all these women with babbies with lovely pink outfits...and I <u>tried</u> to dress her nice, you know what I mean? (453) But I just couldn't compete with them and I did feel a bit funny (out of place) (454). And when I got back I says to B. I says, "I'm not going up there again", I says, "it's shown me up, you know!" (455)

TERESA: A lot of them use second hand stuff, you know, though...

CATHY: Oh I know - you ought to see 'em at t'jumble sales, lass, with big fur coats on 'em and that, going <u>scrounging</u> (456)

TERESA: Yeh, I got this from a jumble sale (laughs)

CATHY (indicating her own clothes): I've got <u>all</u> these from a jumble sale! (laughs)

TERESA: ...'cos I don't get much you know, with still studying...

CATHY: Yeh ? (feels coat)

TERESA: I mean, it was only two quid

CATHY: Yeh, you'll have your books and all that lot to pay for, wouldn't you, as well? (457)

TERESA: Yeh, but, you know what I mean, they can look as good, I

think, if you just...

CATHY: Of course they can, yeh... You ought to see t'young 'uns now, at t'jumble sales. I mean, at one time it were all these old fogies and that, you know; but now, you se t'young 'uns going up - and they come away with some beautiful stuff (458)

TERESA: Yeh, yeh

CATHY: Mind, you see, I don't like buying stuff, you see, when I'm pregnant, 'cos you never know what size you're goin' to go back to (459)

TERESA: Yeh...yeh, wait 'till you've had it and...

CATHY (returning to subject): but, er, I did feel a bit shown up at t'clinic (460)

TERESA: (probes): ...and, er, so did you go back ?

CATHY: I did; but I don't go, I don't go very often (461). I mean, like (names health visitor at child health clinic), she says, er, she says, "Oh", she says, "if you're ever short on clothes", she says, "We have a couple of boxes behind, behind t'counter where they serve tea and that" (462). So I went up about three month back and got her some clothes - some good, decent clothes and all (463). And I went up last week and I says to her, "Have you got any more clothes I can look at?"

She says, "Aye, love", she says, "go and help yerself". So I went, and this woman put two boxes out like; and they'd only got a bit of stuff (464). And I says to this woman, I says, er, "Have you got a carrier bag, love, for these clothes?", "Have you paid for 'em?" she says. "Paid for 'em?" I says, "Why, have you got to pay for 'em?", "Yes, you've got to pay for 'em; it all goes in the Christmas fund for the kid's party". Well, I didn't know; and she were right snotty about it (465). So I says, "Oh, I'll put 'em back then, love", I says, "I ain't no money to pay for 'em". She says, "Well, you know you've got to" (466). So I says, "Oh, I'll go and see (names health visitor), then about it", I says, "because she told me I could have them". "Oh, it doesn't matter - if (names health visitor) says it's all right, then it's all right" (467). I thought, "Yeh - she's either fiddling or being a bit...", 'cos I'd never seen here there before, you know.

TERESA: I don't know who it is...

CATHY: She were an old woman with grey hair and glasses

TERESA: I don't know...

CATHY: I've never seen her before (questioning) (468)

TERESA: Oh, take no notice of her, oh dear... Right, the next bit is, is it possible to have a private talk to staff at clinic if you need to?

CATHY: Yeh, it is (469)

TERESA: It is, okay, right. Do you like the system whereby you just pop in when you want to, or would you rather have appointments?

CATHY: Oh no, I like...I can never keep appointments, that's t'only thing (470). I...'cos I mean, like going to t'doctor's. If I want to go to t'doctor's, I've got to get up right early in t'morning (and) get t'babby dressed, washed, changed, fed before I can go anywhere, you see. And then by that time it's too late for t'doctor's. I find mese'n getting up right early, (but) I can never keep appointments (471), so...but, er, I just like to be able to pop in when I, when I want to (472)

TERESA: Uhuh...have you ever preferred not to go for any reason?

CATHY: Only when, like I say, when I first found out that she were chesty; and I went up and told t'doctor, and he said it were a cold in her nose. Well, I knew it weren't, and I thought, "Well, if these are what you call baby doctors, then I don't want to see 'em no more" - and I wouldn't go up and see him every time I had a problem, then (473)

TERESA: Did you ever think it was just a waste of time when you did go?

CATHY: Yes, sometimes I do, yeh, 'cos, I mean, they just pop 'em on t'scales and that's it. You're just sat callin' (talking) and having a cup of tea and that (474)

TERESA: Why do you think some people never go?

CATHY: I don't know, (475)...I think...well, I'm saying, in my, in my view, it's probably because they're t'same as me (476) - they don't like being shown up or owt like that (477) (pause) Or sometimes they just can't manage it (478)

TERESA: Yeh, yeh if they've got a heavy day.. Right - the checks that she's had done at the clinic by the health visitor and the doctor - has the doctor looked her over?

CATHY: Yeh, when she was... (uncertainly) I think it were when she were twelve week old (479)

TERESA: Has he only done it once, then?

CATHY: Yeh (480)

TERESA: And were you happy with that - the check, what was that like?

CATHY: Yeh, (486); but one thing I find with her being me first. They (staff) seem to think that a lass whose first bairn it is goes with every little problem - you know what I mean? (487) (describing the stereotype) They're very... I've forgotten t'word for it, but t'slightest little problem and they're at t'doctor's (488): and I found that t'same with t'doctors at (names health centre) (imitates doctors) "Oh, it's nowt to worry about" - and they...they think you're just being overactive about it, you know (489). But I mean, when it's your first bairn, you don't want owt up with them (anything wrong with them) - you want to find out that they're all right (490). I mean, at t'hospital they said that all t'first-time mothers, they're all like

TERESA: But so you should be, though, I mean, what do they expect? They'd be complaining if it was the other way! (echoing sentiment).

CATHY: Yeh

TERESA: What...er, how often did you go to clinic at first, would you say?

CATHY: I used to go every fortnight - every two week like (492)

TERESA: And when did you start tailing off?

CATHY (slightly confused): Well, when I could...when I were...I don't know, really (493). (recovering herself) When I found out mese'n that she were getting everything that she should, and gaining weight properly, and doing things that she should at her age, you know (494). And I thought, "Well, it's a waste of time havin' someody tellin' me what I already know", you know (495), so I... it just dropped off (496). I...I don't know, I think...I like to take her out more and that now, you know, instead of nipping up t'clinic (497); and usually on a Thursday, anyway, I'm up at me Mam's all day (498), so...

TERESA: Yeh, uhuh, right. The next bit's about immunisations. Has she had them done at the clinic?

CATHY: Yeh, she has, yeh (499)

TERESA: And they explained to you what the immunisations are for?

CATHY: No, no they ain't (laughs) (500). They just come or send a letter; and they'll say to me "Oh, she's due for a so-and-so" (501). But, t'same with that - what were it, now? - whoop cough (whooping cough immunisation). I didn't...didn't let her have that. I think it were because I didn't...I'd heard that much about it, you know what I mean?...So I...the bad side effects and this, that and t'other (502). But nobody ever explains what they do (503). I mean, she's been having jabs (injections) now, and half on (of) (em I don't... (504). Even when I were in hospital, they give her...they took some blood out of her groin. Well, I know they do t'Guthrie test on t'heel for jaundice and that; but I didn't know what this needle...'cos she were in right agony, t'babby (505). And I'd (had) to go and ask what they'd done it for, 'cos I were worried, you know (506). One of t'nurses said, "Well, I've never known 'em do that, love" - and it were because she'd got two sections of her cord instead of three (sic) (507), but it weren't nowt to worry about (508). But there again, it was because they hadn't told me (that she worried) (509)

TERESA: Right, yeh...if they'd told you, you wouldn't have worried? (echoes)

CATHY: Yeh (509)

TERESA: Have you had any problem with the immunisations?

CATHY: No, none...none at all (510)

yours done?

CATHY: Yeh, yeh - I think she did, yeh. I've had all t'necessary jabs and that (511)

TERESA: Right...do you still think the health visitor wants you to go to clinic now?

CATHY: I think...once they get over a year old I think...I don't know (512). I think...now, I only use t'clinic when I've problems or owt, you know what I mean? (513). Or when I want somebody to talk to, 'cos I can talk to (names health visitor) okay (514). Min'st you though, they all give yer the same advice, "Go out and enjoy yerse'n" and...you know. But (laughs), but I can't afford to go (out). I mean, we've only been out three times, I think, since last Christmas, and that's it - and one of them were me sister's wedding, we really had to go to that one (515). But sometimes I just...I get that used to being stuck in t'house (that) I'm scared to go out ...it sounds a bit stupid, yeh...(516)?

TERESA: Yeh, I know what you mean...

CATHY: (hesitantly: I, I feel as though people are laughing at me and talkin' about me when I go out; so nine times out of ten I end up stuck in t'house (517). That's...what...another reason why I don't like 'buses either, I'd rather walk it to me Mam's, (although) what with a pushchair and a bag and a babby and that, it's a bit much (laughs (518) miserably).

TERESA: Oh them - I don't know why you worry. Who are these people, anyway? I mean, does it matter what they think? It doesn't matter really, does it? (attempts to encourage her)

CATHY (struggling to express her feelings): It...you know what I mean...

TERESA: (recalling her own similar experience): I know how you feel - it's a horrible feeling. I got like that when I was ill.

CATHY: I know. But since I've had...since I've had her, I 'ave dropped off (taken less care of herself), you know what I mean? I have...I've spent more time seeing to her propertly (so) that I ain't had enough time to see to meself (520)

TERESA: Uhuh, uhuh.

CATHY: ...you know what I mean? I mean, when we were first married, you'd never catch me like this (indicating her dress) - I'd be always dressed up with make up on, and I'd look nice. (sadly) But I can tell that I've let meself go with (due to) looking after her (521)

TERESA: (empathic) You haven't got time, have you?

CATHY: That's it...I ain't got time and half of t'time I just can't be bothered to (522), 'cos I find mese'n spending that much time looking after her (that) I ain't got time to see to mese'n right (523)

TERESA: Yeh...

CATHY: ...and I feel that other people notice it as well (524), because me Mam's always saying to me, "Oooh, Cathy, you haven't half let yerse'n go" - you see? (525) and that gives me that guilt complex, then; so that I'm like this (indicating her present mood), looking at mese'n (526)

TERESA (attempting to cheer her): I was goin' to say, your hair looks really nice - it's a gorgeous colour

CATHY (deprecatingly): Oh, it isn't (she has just coloured it)

TERESA: It's in good condition, though - look at the shine on it

CATHY (playing with her hair): It gets on me nerves

TERESA (persists): ...but I mean, obviously your hair's really nice when you've done it - dead shiny

CATHY (agreeing): It is, but... I mean now...that I just don't see any reason to do it. I don't see any reason to put make-up on 'cos I never go anywhere (528)

TERESA: Yeh...

CATHY: You know what I mean? There's only sometimes that I...I'm sat in t'house, and I think, "Oh, Cathy, tha' does look a mess!"; and I get t'make-up out, and...you know...

TERESA: Yeh...

CATHY: ...doll meself (up)...pretend I'm going somewhere...and it makes me feel a lot better (529). But then, when he (her husband) walks in, he never notices anyway, so I mean...I could walk round t'house stark naked and he'd never notice (laughs)

TERESA: (laughs)

CATHY: ...in fact, I have done, once or twice! (530)

TERESA (laughs): ...in summer, I hope, when it wasn't too cold!

CATHY (thoughtfully): "I can imagine mese'n now", I says ..."I can imagine mese'n now", I says to him the other day, I says: "no wonder you don't fancy me any more". He says, "Why not, love?" I says, "Well, all t'blue veins that you get, and I've got stretch marks and all", I says. I just look like a piece of that cheese with blue veins in it, you know; and I thought, "Well, if I were thee, B. I wouldn't fancy me, either!" (531)

TERESA: And what did he say?

CATHY (continues her account): But he's...I'll tell yer, he seems to be ashamed of me when I'm like this, you know. He doesn't...he don't say nowt but it's the way he acts... Reluctant to take me out. And if he does take me out, he leaves me, you know, and stuff like that (532). But as soon as I get me figure back, that's it - he's back to

his jealous, possessive se n (self) again

TERESA: Uhuh

CATHY (bitterly): I can't understand men, me (533)

TERESA: ...nor me neither. Can you remember when you first had to go to clinic...did you feel you had to go, did you feel obliged to go?

CATHY: Well, same as I said, they never said nowt to me (534). I thought I were expected to go and I thought I had to go every week; 'cos t'first week (that) I missed, I half expected somebody coming down and saying, "Why haven't you been down this week?", you know. And I thought you were expected to go, because they never said nowt to yer (535)

TERESA: Mmm...Did you make any friends at clinic?

CATHY: Not really, no (536)I...there's a couple...well, I'm saying, there's one woman up there that I know to talk to; (thinking) and another one, because I've known her from before I come down here, you know what I mean? So I know her to talk to (537). But, apart from that, if them two didn't come in, I'm sat by mese'n usually, you know (538). So, that's another reason why I don't go up (539).

TERESA (agrees and elaborates): Yeh, it's horrible isn't it...I hate sitting where I don't know anybody...

CATHY: I tried to get along with everybody, though - but round here they just seem as though they're all zombies, you know. They keep their se'ns to their se'ns, and you just...(540).

TERESA:...Yeh, yeh... Right, em did you first meet your health visitor after you'd had your baby...was that when you first met her or did you meet her before your baby was born?

CATHY (thinking hard): Oh, now wait a minute...er, yeh, I did meet her before. I think it was one of t'times...(pauses)...it were about four or five week before I had t'babby (541). I can remember her coming to t'house and introducing herse'n and this, that and t'other (542); and, you know, she said that...like, they keep a check on t'babby, and as they grow up (543)

TERESA: Uhuh, does she visit you very often?

CATHY: No, not really (544). Er, she always asks me when I go up if (whether) I've any problems or owt (545): 'cos, same as I said, I'd had a good talk with her and told her all me problems and that (546). But I like somebody...somebody who'se neutral (uninvolved), like her

TERESA: Yeh...

CATHY: You know what I mean? If, like, say, I were talkin' to me mother, then me mother'd be all on my side; and if I spoke to his (her husband's) mother, (then) his mother'd be on my side, you know what I mean? I wanted somebody who'd got nowt to do with it, but could give me advice, like (547). That's why I started going to me doctor; but I found out after a bit that he were siding with me, because he were

saying to me "Now, if I come and see yer, will yer husband be in?" - you know what I mean? Or, er, like if I used to send for him, he used to say "Is your husband in?"; and I used to say, "No"; and he used to say, "Oh, I, I want to ask yer if ye're all right?"... you know (548). But I wanted somebody to talk it out with <u>both</u> on us... (549)

TERESA: Yeh...has (names health visitor) seen B. then?

CATHY:... which she did, yes, yes, she's seen B. (559). But all he says when she walked... he says he were listening to her; but, soon as she walked out of t'door, he just turned round and he says, "I don't want you going up there anymore (551A); I don't want anybody interfering with us" (551B)

TERESA: It's difficult, though...

CATHY (continuing her narrative): He says, er, "If we've got any problems, we'll sort 'em out ourse'ns" (552); but he's not willing to try. I mean, I've tried and tried (553). I mean, me Mam and Dad's asked me to go home more times than owt; and I've, I've always stuck by him, you know what I mean? I've turned round and said, "No, Ma, I'm not coming back"; and I've stopped with him (554). But it's just not...I don't know, he's very much like a child - it's like I'm bringing two on 'em up instead of one, you know what I mean? (555A). He hadn't had much education (555B); and, well, t'way he were brought up, I thought it were wrong, 'cos his parents neglected him (555C), and he ended up being brought up with his grandparents, who were really too old to care, you know what I mean? (555D). He could do what he wanted; go where he wanted; and no authority were used on him, you see (555E); and I think he's trying to do that now with us (me) (555F).

TERESA: Yeh, yeh...

CATHY: He's trying to show... I mean, their family - it were nowt for t'fellow to beat t'wife up; (with great irony) it were <u>good</u> that, you know what I mean? They all did it - so, of course, he did it to me 'cos he thought it were good; and he thought, well, it were proper to (appropriate for) him (555G). I mean, I were brought up proper; I weren't brought up spoilt or owt like that. I got, I got more or less everything I wanted; but not, not quite everything (555H). But 'cos they weren't bothered about him - his normal parents, I mean (555I) - <u>my</u> parents have tried to take over where <u>his</u> parents left off. They've treat(ed) him t'same as me (555J); but he's not grateful for it (555K). He, you know...he wants to be by hisse'n, and (able to go) off, and to say, "I'm t'boss" - and that's it. (555L)

TERESA: What...em, after you've had a fight, does he apologise or anything?

CATHY: Yeh, he...that's, that's what made it so bad. I mean, he used to say, "Oh, I'm sorry love; I'll never do it again" - and some times he'd cry; and if there's owt I hate to see, it's a man crying. And then I used to think, "Well, he really means it this time". But then after a bit I got to thinking - and it's just an act, this...you know, this crying and "Oh, I'm sorry, I'll never do it again" (556), when I know damn' well he's goin' to do it again (557)

TERESA: Yeh, it's funny isn't it...

CATHY: But, he'd only got to say a couple of words to me and I used to melt (558)

TERESA (empathic): Yeh, yeh...and it (his previous behaviour) doesn't matter...

CATHY: You know, sometimes...sometimes he could just say summat to me, and I could pick a knife up and I could just ram it through him. And then, two minutes after, he'd say summat else and I'd think, "Well, I don't know", you know, "I don't know how I could have picked that knife up"; and...(at a loss)...I don't know...(559)

TERESA (elaborating Cathy's previous statement): I think you're right - I think it's 'cos a lot of men just don't grow up...

CATHY (agreeing vehemently): They don't, they don't...

TERESA: ...they stay kids all their lives

CATHY: That's it (560). I mean, I thought that having t'responsibility of a child'd...you know, evrybody says, "Oh, he'll grow up once you get t'bairn". But he ain't - he ain't altered (561). (pensively) It's...it's funny, that...I don't know, <u>he</u> seems to be growing up now that <u>she's</u> growing up, you know what I mean? Now that she's talkin' and walkin' and that, he seems to be...I don't know, takin' more notice on her and that (562)

TERESA: Uhuh, uhuh...

CATHY: But before, he never let her change his life a bit (563)

TERESA: Eeeh, it's strange isn't it...

CATHY: I can't...I don't know...I'm never goin' to get to understand them, me. (very seriously) I'll tell you summat - I'd never get married again - never! (looks at Teresa and laughs, amused by her own vehemence)

TERESA: (laughs with her)

CATHY (emphatically): Never!

TERESA (returning to schedule): When, er...have you ever found...rang the health visitor up?

CATHY: No, I hadn't no. I've got her 'phone number, but I just...I don't know, I'd sooner see her when she's up at t'clinic - you know what I mean? - wait to see her then...

TERES: ...(rather) than ring her up?

CATHY: Yeh, because I...I don't think you can say t'same thing over a 'phone as you can...

TERESA: face-to-face...?

CATHY: Yeh. It's...it's...I think it has more impact when you talk face-to-face (565)

TERESA (agreeing): Yeh, yeh, I do (too). What...do you like her (the health visitor)?

CATHY: Yeh, she's okay (566)

TERESA: Do you think you know her quite well?

CATHY (pondering this): Not quite well - I mean, I know if I've got a problem...I know that she's there...let's put it that way.

TERESA: Uhuh - you know her well enough, you would say, for (that)?

CATHY: Yeh, yeh (567)

TERESA: Do you think she knows you quite well?

CATHY: Well, she would do, yeh (i.e.. 'I suppose so, yes') (568)

TERESA: Well enough. Right, em, how long have you had your doctor - all your life?

CATHY: No (569). Er, there's five to choose from at (names group practice), up like where I go (570). But since me husband started hitting me and that, I found that I stuck to this one doctor, you know what I mean? 'Cos I can really...I can really sit down and talk to him; and I can really...well, I'm saying, he's t'only one that gets through to me - let's put it that way (571). (returns to general question) But I've always had them doctors up there - but, I mean, they...they change. I mean, once one makes a bit of money, they go and retire and...you know what I mean? - buy a new car and that (572)

TERESA: Have you ever asked for a home visit from your doctor?

CATHY: Yeh, yeh I did (573)

TRERESA: Has he been all right (accommodating) about it - about coming out?

CATHY: Well, it's not so much t'doctors up there - it's t'receptionists (574). I mean, like I said, when I were badly...when I were carrying her...I'd found out I were pregnant and they wouldn't send a doctor out to see me - because that doctor had said it were wind, you see. So they wouldn't send anyone to see me (575). In fact, I ended up getting one of me mates to go and 'phone up to make an appointment, 'cos I were that badly (576). And they wouldn't send a doctor out - but that's t'receptionists - they think they own t'place (577). (illustrating her point) I mean, you can go up now and you can say, "I want to see a doctor". (imitates receptionist) "Why, what's up with you?" I mean, if you knew what were up with you, you wouldn't bother going to see t'doctor, would you? (578)

TERESA: (laughs) Er, no

CATHY: ...and then they...then they... (trying to remember) Oh aye, what were it now I went up for? (remembers) Oh, I tried for pain

killers - I'd got bad migraine or summit and...oh, it were me sinuses, they were all blocked, and it had given me toothache and earache and me eyes were going runny, the whole lot. And I 'phoned up to make an appointment (579). And she says, "Oh, come up and see us, love" (580). So I went up. I says, "Can I see a doctor" (581) (imitates receptionist) "Why, what's up with yer?" (582). I says, "I want to see the doctor". You know what I mean - it isn't her place to just prescribe. But they do - they think they own it up there (583). (pauses) Next question? (584)

TERESA: Right...looking back, where would you say you learned most about looking after your baby from? I think you said (from what Cathy has already said) that it's yourself, isn't it?

CATHY: From meself (585); and, with (due to) me mother being badly (ill), me and me sister brought up t'youngest two (of her own brothers and sisters). We did all t'nappy washing and changing and feeding and that, you know, with (due to me mother being badly - so I knew a lot through (as a result of) that. And housekeeping and that - I mean, me mother were always one of them sort as - when you tidied up - she used to go shhh like this (imitates mother testing surfaces for dust) and go round t'room with (her) fingers - you know what I mean - she were a bugger for that! And, with her being badly and all, we had to bring up t'youngest two by us se'ns (ourselves) (586)

TERESA: Uhuh...and what about baby books - what would you say about them?

CATHY: They're okay - but they give you all t'good side

TERESA (inviting her to continue): Yeh?

CATHY: I mean, it's like one of these bloody romantic films where you see 'em walking off in t'sunset together - you know what I mean? It's not like that - life isn't like that (587)! (pensive) I don't think they could put it down in words, what it's like - you know what I mean? (588) They try, (let's) put it this (way): they ease yer mind a lot, but they give yer t'good side, not t'bad (589)

TERESA: ...yeh and they should give you the bad (side) as well...?

CATHY: I mean, they're...(looking for examples)...like, now, t'symptoms you can get when you're pregnant: they just say, "Oh, you can get swelling of t'feet", so-and-so; but they never go on to say that t'swelling of t'feet could stop you from walking; that it were very painful; how often you might get it - you know what I mean? (590)

TERESA: Yeh...not all the details...

CATHY: That's it. Like morning sickness - they never tell you what it's like, having morning sickness - I mean, it's chuffing terrible, that! I wouldn't, I wouldn't like any lass to go through that - no chance! (591)

TERESA (laughs): Right, em...what does the baby's father think of the clinic, the health visitors and others you've had contact with in the care of your baby?

CATHY: He don't reckon much to 'em (593) - I mean, he thinks that you have a bairn and you bring it up and that's ...that's t'end on (of) it, as far as I can gather from him (594). He thinks that they're just a set of interfering people, you know, who like to stick their noses in your business (595). And he reckons that health visitors and this, that and t'other only come to see yer bairn if they think you've been braying (hitting) it and whatever, so... (596)

CATHY: Well, I know he has t'wrong...he's got t'wrong idea about life, you see... (597)

TERESA: Mind - they (husbands) take some convincing...

CATHY: They do, yeh

TERESA: ...if you try and you know...(pauses - changes the subject) Right, em, would you personally advise other new mothers to go to clinic?

CATHY: Well, er, I suppose it's up to them (598). I mean, I can't see as it's done me and t'babby any good, really (599). I mean all...t'only time it's done her good is when she's had to go up for her injections (600); but apart from that you're still not gaining anything (601)

TERESA: (encouraging her to continue): Uhuh...uhuh?

CATHY: It's just a place...as far as I can gather, it's just a place where women go...take the kids so t'kids can play together...so (that) they can have a cup of tea and a call (chat)...

TERESA: Yeh...

CATHY: It's just, like, a break from t'twenty-four-hour routine, you know what I mean? (602). I suppose it's...it's a good thing in a way, because, I mean, you can get...

TERESA: You need to get away...

CATHY: You do. You need that break. I mean, at least...if not once a day (then) once a week, you need that break from rout... (603) min'st yer though, if they're owt like my bairn, you've still got to keep yer eye on her once they're walking about, 'cos she's a bugger! (604) (thinking it through) But I would, I'd advise 'em to go, yeh - if they thought they could mix in with t'company and that, you know (605)

TERESA: Uhuh...looking back, have you enjoyed this year?

CATHY: (thoughtfully): Yeh...yeh, I have
TERESA: Overall...you could say (that) you have?

CATHY: Yeh (606)

THERESA: What have you enjoyed most about it?

CATHY (without hesitation): Being independent and knowing, now, that I'm grown up...I've got a bairn of me own - you know what I mean?

TERESA: Uhuh...right - if anything, what would you rather be doing with your life?

CATHY: I don't know (laughs). I've always fancied being a model (608) (dismissing this) - but, er, no, er, I'd got a good career. I wish I'd have stopped at t'first sewing factory (609), instead of movin' on and going and living with him (her husband) and that (609A), 'cos I were earning some good money, you see, and I'd have probably been a supervisor or summat now (609)

TERESA: Uhuh, uhuh...

CATHY: But I mean...I know lasses have dreams (610), but I always said, "Well, I'll never go in a factory!" - but, I mean, factory work is t'only work you can get...

TERESA: That's right, yeh...

CATHY: ...and sometimes it's higher paid than owt else, you know what I mean? (611) (realistically) But I...I'd have probably been where I am now, that's what...er, if I could go over it again I'd be where I am now (612). (adds decisively) But I don't think I'd be married this time...

TERESA: Yeh?

CATHY: I think I'd be single! (laughs) (613)

TERESA (laughs with her): Right - what have you personally missed most since having your baby?

CATHY: (promptly): Going out and socialising - er, being able to be one of t'lasses, you know what I mean? It's...you're tied down - I mean, you're tied down when you're married; but you're tied down even more when you've got a bairn around yer (614). I know...I know, fair enough, it's <u>your</u> fault in t'fist place that you've 'got (conceived) a bairn (615); but, you know, I miss going out and enjoying mese'n (616A); and I miss being able to work for a living (616B). Being stuck in t'house and all, t'only work I do is housework, which, you know, you don't get paid for anyway (616C). So..but that's what I miss most...I think it's with me being young and all. Now, if I were in me thirties it wouldn't bother me so much (617)

TERESA: Yeh, yeh...but at this age you want sort of...

CATHY: Mmm...

THERESA (returning to schedule): What, em...is there anyone you can rely on to look after the baby if you do want to get out - have you got anyone you can leave her with?

CATHY: Well, same as I said, I could leave her with me Mam and Dad (618) - but me Mam's badly (ill), and I don't like putting (imposing) on me Dad; so I think (that) before (I'd) put on them I'd sooner stop in (619). In fact, I find mese'n...I mean, I've had t'chance to go out, and I've found mese'n stopping in, because - same as I said -

I've...it's like what do they call it?

TERESA (referring to Cathy's previous account): Agrophobia?

CATHY: That's it...agrophobia. I feel as though everybody is looking at me and talkin' about me when I go out...

TERESA: Yeh...

CATHY: ...so I'm getting that scared to go out (620)...in fact I'm t'same when I go shopping (621). I enjoy shopping usually (621A); but - since we've both lost us (our) jobs, I mean (621B) - now it's, oh, go in t'shop - tin of beans from here - and you know...and I know exactly what I've got to get every week, 'cos I ain't got enough money to get owt different (621CD). So it's just like a...I can go in three shops, get a few things from each shop and that's it (621E) - that's me...that's like, me outing over and done with (621F). Whereas, he's out at all times, you see (621G)

THERESA (sympathetically): Oh, it's terrible...(pauses)...are there any changes you'd like to see in the services... I mean, you've mentioned a lot so far...is there anaything we've missed that you think is important?

CATHY: Well, I think they should tell you more about t'injections and that for your babbies (623). I think that that is definite - because, I mean, a lot of women...they wearn't (won't) let the bairns have injections simply because they don't know what they're going to do t'bairn (624)

THERESA: Yeh...

CATHY: You know what I mean? And...(pauses, thinking)...they shouldn't rely on yer to know everything (625). They should try and help you more to understand what yer goin' to go through (626). I think that's t'main...t'main things - instead of yer having to pick a book up and finding fairly tale stories on how to have a bairn (627). I think they should tell yer, you know, what you need to know (628); and not keep owt back from you. I think that's t'main thing (629)

THERESA: (pursuing her thought): ...'cos some mothers have said they wish that there'd ...there'd been mothers there who'd had a baby, who could say, "It's not all roses, it's like this..."- you know, yeh, like you could tell someone else now, couldn't you, what it's like...?

CATHY: Well, put it this way - when I get this bairn, it'll be like bringing twins up really: because I mean, she's still a babby herse'n (631). I'll have more idea, with this one, how to bring it up, than I did with her (632). Because, I mean, you tend to ask questions, like, off yer mother - you know what I mean? You tend to ask yer mother things more than owt (anybody else) (633): and yer mother or yer father, they always go with their way - (the way) they've brought you up - do you know what I mean? They expect you to stick to that rule - like there's many a time I can go up (to her mother's) now, and me mother'll say, "You know, you shouldn't be doing that with t'bairn"; and "You shouldn't be letting her do this" - you know what I mean? (634). And I think "Well, who'se bloody bairn is it - is it mine or is it me mother's?" - you know what I mean? - and I turn round and

tell her, "Look, it's my bairn - (and) I bring it up t'way I see fit to" (635). I mean, you've got to learn (636); but I don't think people should expect you to learn all by yerse'n (637). they should give yer advice, fair enough (638); but not (just) from their (own) experience (639); (but) from known fact, if you know what I mean... (640)

TERESA: ...sort of objective like...

CATHY: Like all this about "Oh, it's t'worst pain you can get" - like I were telling you - they shouldn't say that. They should say, "Well, fair enough, it's a pain - it's a bad pain (but) you get over it..." - you know what I mean? - "...when you see t'babby, you're all right": but not "Oh its's t'worst pain you'll ever get" - you know what I mean? It sounds as though...that you're ready to go on t'cross or summat like that (641)

TERESA (laughs)

CATHY: ...'cos they're going through (by) their experience, you see, instead of...I mean, every woman knows that parting with a bairn is goin' to be painful - which it is - but it's over and done with once t'bairn's there (642A). But I know they frightened me stiff when I come to having her. In fact, I were ready for...for shovin' a cork up me to hold it back a bit longer, 'cos I were that scared! (642)

TERESA: (laughs): What would you do differently next time round?

CATHY: I don't know. I think I'd end up doing same - exactly t'same (643). Because, I mean, she seems to be thriving on what I've done for her, so I'll...probably this one'll thrive just as much, with (by) using t'same method (644).

TERESA: Will you go up to clinic?

CATHY: I don't know. I doubt it. I don't...I think...same as I said, it's all right (for) the first time mothers and t'babby being up to about six month old. But after that it's just for a call (talk) and a (cup of tea)...

END OF INTERVIEW

4.4. STAGE 2. RESTATEMENT OF TEXT AND INITIAL LABELLING OF MAIN TOPIC AREAS

(corresponding to step 4 in the procedural outline).

The meaning units identified in stage 1 are restated in the third person, preserving the central meaning as intended by the interviewee. Some obvious irrelevancies can be identified and omitted at this point, which in concert with the more succint summary statements reduces the text for further analysis. As a preliminary stage in organising the text, the main topic of each section of text is noted in a purely identificatory heading, e.g. where an incident, or a complaint about a specific matter is told, the section is given a brief title. The meaning units identification numbers are included to show where the statements occurred in the interview.

PLANNING FOR A CHILD

Cathy and B did not plan to have a child at this particular time (3)

They had tried for two years previously to have one. (4)

Having suffered three miscarriages, Cathy thought herself unable to have a successful pregnancy. (5)

Resolved sadly to accept childlessness (6)

When Cathy stopped actively trying to have a child, she was successful. She now believes 'trying too hard' actually prevented conception; but whether due to mental or physical factors or to 'fate' is unclear (8)

It just happened (9)

Cathy believed one needed to take 'special' care when pregnant (10a)

For her, this was disproved to some extent by events... (11)

... when, despite not being 'careful', she carried the child well (12)

She expected to have problems in view of her previous miscarriages (13)

Now the opposite is the case - she is 'breeding like a rabbit' and 'can't stop'. She is proud and pleased to be fertile. However, she feels the process is outside her control... She laughs, but is mildly exasperated at the unpredictability of life (14)

In retrospect, Cathy did not want to wait to have a child (15)

She wanted a child whilst still young herself (16)

Cathy has formed definite views on 'older' parenting. She sees child-rearing as a long, hard slog requiring youth to succeed. Also the resulting 'age gap' is considered to be bad. Being young herself, the difficulty is reduced; and mother and child can 'grow up together' (17)

SEXUAL ASSAULT

At sixteen, Cathy suffered a miscarriage following a sexual assault which occurred shortly after she had left school. She had intended to abort the baby in any case (20)

Cathy dared not tell the police because she thought her attacker was likely to seek violent revenge. She ought to have reported it, and in retrospect this would have been the right course of action (possibly compliant with values ascribed to interviewer) (23,24,25)

Frightening aspects of the assualt led to a long delay in telling her parents, with feelings of personal guilt and implied fear of recrimination (29)

Shortly after telling her parents, she lost the child (30)

She feels this was due to the nature of her work. The event occurred at work and was painful (31)

The repercussions did not stop at the damage of the assault itself, but led to loss of her job, which was important to her. She resents this, feeling that her employers have written her off as worthless, and are punishing her for miscarriage and illness, both of which are outside her control. (33)

She feels she was unfairly treated, but has accepted her lot, whilst remaining resentful and sore in consequence. (33)

SEX EDUCATION AND THE REALITIES OF SEXUAL EXPERIENCE

Cathy found a used contraceptive at thirteen; and was informed almost incidentally about contraception by a school friend (35)

Her mother told her when she was a year older, and already knew (37)

Cathy feels she was ill-prepared for the realities of sex. She feels she was given a biased view; told simply that it was 'a good thing' (39)

Miscarriages and possibilities of pain and disapointment were not mentioned (40)

The simplistic picture given led to inadequate preparation for the often routine and mundane features of 'sex' (42)

Earlier in her relationship with B she had enjoyed sex far more because of its vaguely illicit quality. Now the reality is less appealing. She resents the information which she feels was witheld, feeling disappointed and in some way cheated. (44)

CONTRACEPTION

Cathy took oral contraceptives from age fifteen for approximately one year(47, 48, 49)

Her first miscarriage resulted from sexual assault only two days after stopping the 'pill'. The timing of events was unfortunate. (50, 50a)

Back on the 'pill' until age seventeen and a half... (51)

...she discontinued taking it when she met B (52)

Unable to use the 'pill' whilst breast-feeding baby (53)

...they resorted to a simple technique (54)

It was failure of the withdrawal technique which resulted in her second (ill-timed) pregnancy (55)

She would have preferred to wait before having a second child (57)

She feels she needed some time to 'get used' to her first child before

becoming pregnant again. (58)

REALISATION OF PREGNANCY - INITIAL ENCOUNTER WITH SERVICES

Weight gain in spite of her diet and morning sickness were seen by Cathy as clear, unambiguous indications of her pregnancy (60, 62)

The doctor dismissed her symptoms as 'wind'. Cathy felt rebuked and foolish - felt as if she were thought to be lying or soliciting undue attention (63)

Her pregnancy was denied in spite of informing the doctor that her pregnancy test was positive (64, 64a)

She persisted with the doctor by reference to her persistent symptoms; and to the instructions she received to acquaint her doctor with the results of the test. She was only following instructions. (64b)

Her husband was outraged at the doctor's 'unreasonable' behaviour... especially in view of her continued state of being unwell... (66)

... and her previous history of miscarriages (68)

Even on this further visit the doctor was unconvinced (70)

Only when irrefutable physical evidence became apparent did the doctor agree that her pregnancy was 'real' (71)

She is very aware of the serious consequences which could have resulted: and displays considerable antagonism to the doctor concerned. She feels that he treated her in an unreasonable, dismissive manner, making light of her very real concern. She feels the incongruity of official attitudes; for the behaviour which was 'proper' according to instructions on the pregnancy test kit was branded as 'improper' by the doctor. (75, 76)

With some satisfaction, Cathy recalls that the doctor had to change his mind. She won the 'battle', but still feels aggrieved about it. Her word alone is felt to be regarded as valueless by the official world of 'them'. She is very antagonistic and would have held the doctor culpable for the possible loss of the child. There is much use of 'they' and then' in these passages. (72)

Cathy sees doctors as 'they' - an abstract totality distanced from her. 'they' - the abriters of truth, the legitimisers - may make complete mistakes due to 'their' dismissive attitudes. She questions their authority as experts on the basis of her experience.

HUSBAND'S REACTION TO HER PREGNANCY

B. was with her when the result of her pregnancy test was given to her (77)

He was very calm about it, in contrast to Cathy, who was delighted (78)

ADVICE FROM DOCTORS REGARDING HER PREGNANCY

Cathy did not receive any advice from her doctor regarding pregnancy. However, she expected none; and finds the notion of a doctor offering advice amusing. For her the 'way of being' with a doctor does not include his giving her advice this is too egalitarian a concept. (78)

She thought feeling ill might be due to her pregnancy (83, 84)

She went back to her doctor for help and was rebuked for her ignorance (86).

She remembers the phrase used to send her away (87)

She was refused a sick note on these grounds. Rebuked for soliciting time off work regardless of how ill she felt in virtue of an authoritarian dictum reflecting the 'word' rather than the 'spirit' of the law. (88)

Still unwell, she continued to take time off work and nearly lost her job. She felt ill, pregnancy was experienced as an illness. The doctor's dismissal, added to pressure from work, made her feel as if she was accused of improper behaviour, as 'stupid' and 'wrong'. (89)

Doctors are not a source of advice (90)

Medical advice is not freely offered, but has to be extracted by dint of much effort and pleading. She is exasperated by 'their' attitude, an unwillingness or refusal to take her seriously, and her own powerlessness to help herself. 'They' can help. These things can be dealt with, as eventually they are. But it is a struggle to convince 'them' of your needs. 'They' seem to act on the assumption that her needs are not real or worthy; and are only convinced by unremitting persistence on her part. There is a blurring of the 'they' of the doctors with the 'they' of the social services - both are seen as unyielding, dismissive, powerful agencies. (91)

PROBLEMS AT WORK

Working in a sewing factory, Cathy was taken off machine work as soon as it became known that she was pregnant and given a standing-up job. Standing up gave her fainting, dizzy spells. (92)

She was treated in a punitive, unfair and cruel manner by her employers, who gave her inappropriate and unpleasant jobs, and refused her any help in her tasks (she wasn't allowed a chair or to wear slippers when her feet pained her as a result of eight hour's standing at work). Her own attempts at retaliation only made things worse; and when she took time off work she was threatened with the sack. Faced with the choice between this and unpleasant work, she decided not to let them upset her. Wanting to be shown some concern and care, she encountered only coldness, cruelty and entire lack of sympathy. Feeling under threat and 'hard done by' by those in authority and in control of her life chances. Now she vows that she would never return to work there. (98,99,100,101,103,105,106,102,107)

HELP AND ADVICE

Cathy had no idea where to go for help or advice regarding her pregnancy. (109)

She was totally unfamiliar with the procedure - although she expected that there would be one (110)

On her first contact with the midwife, she felt she was expected to know more than she in fact did. She felt ignorant and 'put down' (111)

There is arcane knowledge which those professionals inside the 'system' take it for granted that the public should know. (112)

Having been through the process once, she is now expected to know all about it. (113)

She has more 'idea' this time; but feels that 'their' expectations remain unrealistic. She is aware of the existance of the 'system' but not sure what it is. She feels belittled by the midwife, who expects her to 'know'. (116)

This illustrates her problem Not knowing what to do, she feels foolish, confused and anxious about being belittled. But there is no escape - she must have contact in this case. She is ambivalent towards the helping agency. She knows that the exemption certificate exists and that she was entitled to, and received one during her previous pregnancy. This time she is not sure if she qualifies; and since no-one has mentioned it, she dare not mention it herself. Her need struggles with fear of recriminiation and labelling as a 'scrounger' if she asks for something to which she is not entitled. (117)

She feels that she is in some way outside the 'system'. In her case, she is obliged to ask or beg for help which is normally freely given to others. She is perpetually over-looked or ignored. The 'system' is unfair to her, since the onus is on her to initiate help all the time. She cannot understand why help is not offered to her in an acceptable fashion. (117G)

EXPERIENCES OF ANTENATAL CARE

During her first pregnancy, Cathy was able to attend clinic at her local health centre, under the care of her own doctor. This was a convenient journey for her. However, during her current pregnancy. She must continue to attend the (more distant) hospital clinic. This is a long and tedious journey, exacerbated by her very early appointments, which cause her to set off at an unreasonably early hour. She finds this very exasperating indeed, regarding it as an enforced and (probably malicious) change of venue. Again, no-one has explained to her why it is better for her to attend at the hospital clinic. (120,121,122,123,124,125)

Cathy is anxious to be accepted and approved of, but uncertain how to achieve this (128)

Her initial impressions are of an interminable first visit, during

which she is subjected to a barrage of relatively impersonal questioning, followed by a physical (internal) examination. (129,130,131)

Cathy is disappointed when she cannot see her own doctor for antenatal care (132)

...especially since she felt he was personally interested in her, and she could talk to him. (136)

The woman doctor she saw (in common with other women doctors) was less sympathetic towards, and rougher with, other women. (137)

She thinks maybe women are less sympathetic towards other women than a man is towards women in this situation.
(137a)

She feels that she is passed on like an inanimate object to another doctor in a totally impersonal fashion. An uncaring, impersonal ethos prevails. (137b)

CONTINUANCE OF HOSPITAL ANTENATAL CARE

She is in the ludicrous situation of being compelled to dash from hospital to health centre to attend two antenatal appointments on the same day(138, 139)

Even when the situation was pointed out repeatedly, the unnecessary duplication was ignored... (140)

...though staff behaviour showed that they recognised the superfluity of the second visit (142)

The superfluous second visit involved loss of time at work and caused her problems with her employers. This is another example of her not being taken seriously; as a result of which the inconvenient arrangement persisted in spite of her protests. In retrospect she is amused at the 'silliness' displayed and its persistence - but it was a very uncomfortable experience at the time. (143)

NATURE OF HOSPITAL ANTENATAL

In strong animal imagery she recalls her impression of being one of a lage, regimented, de-humanised group. 'Slaughter' evokes the fear and threat which existed in the situation. (145)

She recalls prolonged periods of waiting, which served to increase the anxiety and tension which she experienced. (146, 147)

Her impression was of a largely uncaring attitude on the part of the medical staff, leading to a feeling of worthlessness, being treated like an object. (148)

Doctors in that situation are largely uncaring, and treat mothers-to-be like insignificant, worthless objects devoid of human dignity. Her humiliation was complete when, having finished with her, she was compelled to walk naked across the room before she could cover herself - no-one brought her gown across. (149)

She now tries to cope with such situations by telling herself that she is no more than an object to a doctor; and that normal human relationships and feelings like shame and embarassment are out of place in this context. (153)

ASKING QUESTIONS AT THE HOSPITAL

Cathy sees asking questions at the hospital clinic as covertly impermissable. Seeking for increased confidence and control and aware of her inadequate procedural knowledge, she would ask questions, but these were treated in dismissive mannner. She was no better informed. (163)

Cathy felt 'put down' - she was in some way expected to know without being told; and not to know was in some way culpable. Either the staff had somewhat unrealistic expectations of her; or the reverse and she was simply not expected to want to collaborate actively (164)

Even when she stresses the distress and difficulty which the rash is causing her, no-one cares, and her request is insensitively brushed aside as inappropriate - she must see her own doctor. At the same time, what constitutes an appropriate request at the antenatal clinic is not clearly defined. Her insensitive dismissal leads Cathy to feel that 'they' think she is behaving improperly, making too much of it. (164 -179)

ANTENATAL CLASSES

Cathy went to one such class and never went back (180)

She reasons (retrospectively) that this was her intention; she only wanted guidance on breathing in childbirth. (181)

She did not go to take part fully. She rationalises the rest as a 'waste of time' with ludicrous excercises on offer. (182)

The class seemed 'okay' but for her it was experienced as largely irrelevant, inappropriate and not applying to her own situation. (188-192)

Her visit to the antenatal class made her feel more than ever 'different', isolated and not a 'mainstream' mother-to be. She knows what her baby should be getting but is unable to provide it. She can never afford to do things 'their' way - she is base, poor, different. The total irrelevance of this generalised approach and advice to her own condition and needs distresses her when she considers the child's needs. (193-197)

HUSBAND'S ATTITUDE TO HER PREGNANCY

Cathy's joy and pleasure in her pregnancy can be contrasted with her husband's incredible calmness and uninvolvement. Desperately wanting to share her pleasure with B, she is hurt and saddened by his lack of interest. She is isolated and alone, cheated of the emotional and practical help which she feels she should be getting from him. (199-207)

CHILDBIRTH - HER EXPERIENCES IN HOSPITAL

In hospital Cathy was the subject of an emergency induction procedure, during which the only message conveyed to her by the staff was that of alarm - 'something' unspecific was wrong, obviously - but what it was she had no idea. During this very alarming sequence, every procedure was done to her, or took place around her. There was no direct communication with her, explaining what was to happen - or indeed what was already happening. She was 'out of control', passive - an object rather than an active agent. (209-233)

The exceptional circumstances surrounding Cathy's delivery singled her out as 'different' from the other, 'normal' mothers, who went home after their deliveries much more quickly than she did. (235,236)

In retrospect, Cathy enjoyed the rest in hsoptial, in comparison with her stressful, demanding life back home. The full weight of responsibility did not 'hit' her until her return home. (239)

CATHY'S RETURN HOME WITH THE BABY

Right from the start, the new child is seen to be Cathy's sole responsibility. Even B's supposed preparation of the baby's things in readiness for Cathy's homecoming is described as '...doin' things for me...' (244)

Despite her husband's supposed preparations and her own careful planning, her homecoming was a 'disaster' due to the chaotic state of the house and her family's bitter arguments. A passive victim of these events. Her plans disrupted, she broke down and cried. (242-251)

These events were instrumental in producing a further disappointment - that of losing her milk and being unable to breast-feed her child. (252)

Her expectations dashed, her life has not altered as she has anticipated - for the better. She simply returned to the accustomed 'grind'... (254)

... and learned to cope. Cathy and her husband are the sports of a malign fate which favours others - not them (256-257)

ENCOUNTERS WITH THE MIDWIFE

'They' appear to 'mean well' - they present themselves in a helpful manner... (260)

... whilst underrating Cathy's capacity for common sense (she is treated as if she had none) (261)

The experience of motherhood has caused more problems than joy, with family feuding. (262)

'They' have no conception of the gravity of the problems Cathy is facing, assuming that life is as straightforward for her as for others. From 'their' standpoint it may be easy; but it is not so from

hers. (263)

The main problem is money or the lack of it. 'They' are different and apart from Cathy. 'They' have money; and because of this they cannot understand that Cathy is different and cannot 'fit in'. The advice offered belongs to a different world entirely to the one she inhabits. (264)

The midwife made light of her predicament at the centre of the family feud, by offering the pat solution that 'time will heal'. (268)

The reality was very different from the midwife's glossy solution. (269)

The midwife expected her to cope better than she was doing. The midwife's unrealistic expectations made her feel once more a failure: she could not live up to the midwife's implicit assumptions concerning the nature of motherhood, with which she felt herself to be constantly compared. This idealised view placed her, outside the mainstream of advice which the midwife could offer. (271)

The weight of events led her to extreme reflections. (270)

ENCOUNTERS WITH THE HEALTH VISITOR

The health visitor got closer to 'reality' than did the midwife; Cathy felt able to discuss her 'marital problems' with her. The health visitor is valued because she accepts her. (276)

The health visitor's help and advice was to no avail due to her husband's intransigent attitude... (277)

... but she has benefitted by being less confused about it all (278)

CONNECTION BETWEEN THEFT AND FAMILY VIOLENCE

B's excursions for theft and persistent lack of communication led to arguments followed by his beating her violently, resulting in actual bodily harm. She sees the theft and violence as closely related. When she tried to warn him, he would lose control, accusing her of lying. This occurred regularly even during her first pregnancy, though he has not 'touched' her since her current pregnancy started. Things got especially bad when he brought his 'thieving' companions home and she tried to warn him that he was just being 'used'. Trying to fight back simply led to more violence. (305-309)

Cathy feels ineffectual and 'toylike' in these encounters - she is unable to defend herself in any real sense. (316)

More recently, Cathy has hit on a strategy for 'containing' the arguments. Buying B some fishing gear has limited arguments by taking him out of the house. She hopes it will also keep him out of trouble. However inadequate this strategy, it deals with the problem and reduces tension for the sake of her child. (317, 318)

MOTIVATION FOR THEFT

The root of the problem lies in the lack of money (320)

B. is forced to steal because of their lack of money; and by implication poverty is responsible for his violence also. (321)

Betrayal by friends leaves her bitter at B's being 'split on' by his supposed good friends. This emphasises how right she was to warn him against them (323)

The result of B's gullible behaviour has been a series of fines, which they can ill afford to pay since the money is badly needed for food and clothes for the baby. She emphasises how she knew all along that B. was being 'used' by his 'friends' but he would not heed her. Since being convicted B. now agrees that Cathy was right and has even said as much - but this realisation though well and good, has happened too late in the day. She hopes (but not with much conviction) that B. has now learned his lesson. (324-331)

Now she vaguely hopes that he will heed her future warnings. She resignedly accepts what has occurred and what may possibly occur again. (332)

THE FAMILY'S FINANCES

Every penny is exactly accounted for. It is very hard; but they have no choice. (333)

Their diet is very poor, with meat a rare occurrence. Cathy sometimes wonders how she's managed - but she has no choice; she mustkeep going and 'keep her willpower up'. The only alternative is a nervous collapse which she could not face again. (333-335)

At one time she was taking an excessive and punishing amount of drugs to stay calm. Since the birth of her child she has fortunately been able to manage without these but a recurring fear is that she may be driven back to that frightening state by the pressure of events if no improvement occurs in her lot. She has had to struggle to survive; and the fear of personal collapse is an ever present strain. (336-339)

ENCOUNTERS WITH THE SOCIAL SERVICES

Her present resources for meeting the needs of the new baby are alarmingly inadequate. She has been forced to dispose even of a much needed bed by poverty. She has met with indifference on the part of the social services in all the contexts tried. 'They' don't care; 'they' expect the two children to share one cot; 'they' have nothing that is useful to Cathy and no money to offer her. She hates having to request resources from the social services, which she regards as 'begging'. But she has no choice, she must do what she can for her child. She is forced to demean herself by begging from the uncaring for the sake of her child. (341-350)

The injustice of a system which enforces 'begging' from those who have worked and would work again if there were any hope of gaining

employment galls her. (351)

The futility of trying to struggle against a malign fate. Her plans for disposal of the maternity allowance to improve her family's lot are thwarted by an uncaring system, which claws back with one hand what it gives with the other. She questions this, only to be rebuked for expecting too much. Once more her hopes are dashed by a punitive and uncaring system. (352-357)

PERCEPTION OF HER PRESENT NEEDS

The birth of Cathy's second child is imminent (358)

So far, she has only managed to get together a few inconsequential items for the baby (359)

... which fatalistically she is convinced will be the worse economic alternative - a boy. If it had been another girl she could have coped better from existing resources used for her first baby. (360)

Cathy feels powerless to complete her preparations, a prisoner of circumstance. Very ill-prepared, she feels close to despair of ever coping in time. (361)

PREPARATION FOR HER FIRST CHILD

Not knowing what she needed for her first child, Cathy had sought authorative guidance from a book available at the antenatal clinic... (364)

... but this she felt turned out to give faulty guidance, irrelevant to her own situation and causing her to buy items which, with hindsight she didn't really need (365)

This was compounded by the total lack of guidance about what to take in when she went to hospital for her confinement. Again wrongfooted and unaware of what to bring, she felt foolishly uninformed and in a sense betrayed by the hospital, quick to reprimand but not to inform. (366-369)

Once, circumstances worked in her favour, in the shape of her husband's late arrival, resulting in the need to feed her baby and an opportunity to obtain some free nappies and vests from the linen room. The nurse's casual sanction gave her a rare opportunity to help herself - something she is now planning ahead to do again when the chance arises. (371-379)

IMMEDIATE WORRIES AND CONCERNS

Her immediate worries were fundamental concerns regarding the baby's basic needs to be properly fed and warm and to be returned to a reasonably looked-after home. She feared she would 'lose her milk' due to necessary overwork on her return home. She feared lack of money with which to obtain coal and other necessities, due to B's unemployment. She feared returning to a chaotic house - a fear which was all too well justified. With all this went a sense of crushing responsibility, and also a guilty sense that she should have known how to cope (380, 382, 383, 384)

Cathy felt herself to be an inadequate, clumsy mother... (385)

... with surprisingly inappropriate, feelings towards a previously much wanted baby (386)

The whole experience was new and extremely frightening (387)

Some much needed reassurance came from her mother. The only time Cathy felt 'good and proud and confident' was when her baby was being admired during trips out in the pram. She deeply appreciated the effects on herself of this approval and acceptance. (389-390)

MEDICAL HELP AND ADVICE

She was grossly dissatisfied with the advice received from the doctor at clinic. She was well aware of the potential importance of family predisposition to certain illnesses, e.g. 'chest trouble' and frightened by the phenomenon of 'cot death' and anxious to protect her new baby from this risk. Her baby's symptoms were severe and alarming, but the 'baby doctor' dismissed her worries by pronouncing the child's persistent chest infection as due to a 'stuffed nose'. Cathy was disturbed by his dismissal of her real concern, and in doing so lost all credibility for her. She would now refuse to see him. (392-400)

Cathy would now consult her own GP who she feels she can talk to and who knows his job. (401)

WORRIES DURING THE CHILD'S FIRST YEAR

Basic necessities are the ever present problem, there is chronic lack of money to dress the baby, coupled with the frustratingly short life of baby clothes, since Cathy cannot control the rate of the baby's growth but must struggle to keep up with it. It is equally a struggle to feed her adequately, both parents 'go without' for her sake, and have been forced to seek help from Cathy's mother who, though also out of work, sees that they never go home unfed. She feels out of control, being unable to ensure adequate provision, and a reluctant dependance on her mother. (402-404)

When the baby started to walk, she began to bump herself, and Cathy worried firstly, in case she should hurt herself, and secondly, lest she should be thought by 'the clinic' to be beating her child, especially as she has told the health visitor about family violence. She does not trust 'the clinic' and expects to be suspected there, it's policing function is more in evidence than its caring function. (406-407)

Feeling guilty in case the child's inadequate footwear causes her an accident, she fears the worst yet cannot do anything about it. She has to watch the child taking unnecessary risks with worn out soles on second hand shoes. (409)

MOTHERING AND THE 'LOCAL WISDOM'

She gained more confidence in dealing with her child's mishaps by heeding other mothers' wisdom. This taught her that learning to care

for a child involves control of her spontaneous reactions, and discriminating 'serious' fron 'non-serious' occurrences. (410-414)

She is thrilled and gratified by her child's behaviour which illustrates how intelligent she is (i.e. by contriving to unscrew a bottle, with consequent mess). She has been fascinated by her child's development, learning and re-examining her own beliefs regarding children's abilities. (415-417)

LACK OF ADVICE AND ALARMIST TALES

Cathy feels she has suffered from a chronic lack of help and advice. When she became pregnant, she had no idea what a trial motherhood would be. The harsh reality only became known to her through experience. (418)

Her own mother's account of childbirth was misleading and frightening (419-421)
Her own experience was very different from that of their accounts. She has not forgotten the pain and discomfort from the previous birth as she approaches this second one. (422)

HER HUSBAND'S RESPONSE TO FATHERHOOD

Men are unaffected by fatherhood, B. still runs his life as usual with freedom to do as he pleases (424)

She contrasts this ruefully with her own lot, she is mostly restricted to the house (425)

Only in very exceptional circumstances is it possible for her to have a break. (426)

The need for care is continuous and unremitting, both day and night (427)

Her husband can leave to visit friends or otherwise do as he pleases (428)

Only if deserted would a man understand the total responsibility felt by a mother (429)

For a man, fatherhood amounts to no more than a bland formal statement (430)

B. doesn't even take the child's provision into account. He prefers to avoid all worry and concern, leaving it all to Cathy. (431)

Cathy deeply resents B's non-involvement in any aspect of child care, or indeed in any other problematic issue with which she has to contend.

At present there is an unjustified threat of eviction, which B. ignores. B. will not take responsibility for anything; typical of 'men' in general. She is alone, troubled and unfairly beset with every worry. There is no sharing of concerns equally, as there should be. (432-433)

BABY ILLNESS

Baby has had a number of colds. (434)

This is to be expected dur to their cold and damp living conditions. She is not unduly alarmed by the child's persistent colds, as she can see a clear reason for them, albeit beyond her control. She accepts this stoically. (435)

Overall the child has been reasonably fit (surprisingly, she herself has had more illnesses since the birth of her child.) (436-438)

FEEDING PROBLEMS

Breast feeding proved to be painful. (440)
... but she was prepared to suffer to get her figure back (441)

... finding to her surprise that she got a lot of pleasure out of it. (442)

This pleasure was marred to some extent by B. inconsiderately having his 'mates' around. Since there was no where warm for Cathy to go for privacy, she resolved to overcome her personal embarassment, reasoning that the priority was to feed her baby. (443)

Her overdue child was exceptionally 'greedy' because of the disintegration of the 'cord', making feeding painful. (444)

Later, breast feeding became a treasured experience (445)

Cathy would like to breast feed her new baby and has worked out a strategy to help retain her figure. (446)

She was compelled to give up breast feeding. (447)

HELP IN GAINING/MAINTAINING SELF-CONFIDENCE

Nobody has been in a position to offer sustained help. She is forced by circumstances to cope alone. (449)

She fears her GP's warning that she may start neglecting her child. (His analysis:- it is either drugs and child neglect on the one hand; or individual perseverance on the other), seems to sum up her situation so she has pulled all her strength together to survive. (450)

FIRST VISIT TO CHILD HEALTH CLINIC

She was very apprehensive about going to clinic (451)

She did not want to go, fearing that others would disparage her child and herself, fearing their hostility and 'not fitting in'. (452) Cathy felt ashamed of her child's second-hand clothing. She tried; but couldn't compete with the 'lovely pink outfits'; and felt put down. (453)

Clinic visits were experiences of acute shame, her appearance and that of her baby provoke 'nasty' comments. Others treat her as of no account because she is poor and unable to 'look nice'. She desperately wishes she could fit in but must remain an 'outsider'. (455)

Cathy is forced to participate unwholesome 'scrounging' which is demeaning even though changing trends make it less reproachable/more fashionable to attend jumble sales. Attending clinic poorly turned out accentuates her worthlessness in others' eyes. (456-460)

She attended clinic infrequently, not
least because she was publicly disgraced and rebuked by clinic staff for 'improper' conduct. Even when despite her own reservations she went along with her health visitors suggestion, she was made to suffer the indignity of public degradation. (462-468)

CLINIC SYSTEMS

Keeping appointments is a stress she prefers to avoid, self directed visits are to be preferred. (470-472)

LACK OF RELEVANCE

Cathy discovered the lack of 'expertise of the doctor and refused to see him again. (473)

Often visits were a waste of time. Weighing and a talk with other mothers were insufficient justification for a visit. The socialising opportunity was not one she could take up. (474)

REASONS FOR NON-ATTENDANCE

Others may have valid reasons for not attending, they may feel as she does, wishing to avoid degrading situations, or they may simply be too busy. (475-478)

MEDICAL EXAMINATION OF CHILD

The paediatrician's superficial knowledge was shown by his omissions. Now he is held in very low esteem. (480-484)

There are calm areas of her life e.g. her child is doing well in development. Nurses and doctors set themselves up as arbiters of a child's progress, with mothers as 'clients' needing access to their arcane skills and knowledge. (A) to ensure there is nothing obscurely wrong with their child; (B) to 'legitimise' their own child care ('Am I doing alright?'). There must be some need for legitimation and approval of mothers but they make unjustifiable assumptions about mothers, belittling their genuine concerns. There is a paradoxical situation in which on the one hand, mothers must learn when (and when not) to involve health professionals, which inevitably makes for mistakes, e.g. consulting doctors for 'petty' reasons and getting labelled/stereotyped disparagingly as a 'fussy hen'. On the other hand there is the fact that the clinic is there to detect what she supposedly cannot. Having and caring for a child is thus simultaneously construed as 'easy' and 'natural' on the one hand; and

as fraught with pitfalls and sources of potential error on the other. A 'good' mother must show concern - yet doing so can make her 'wrong' too! she can't win. (485-491)

Initially she attended clinic fortnightly... (492)

... tailing off when the clinic lost its original function of confirmation regarding elements of baby care; weight gain; and the achievement of 'milestones'. (494)

Now there is no point in going. (495)

She has better things to do. (498)

Cathy has taken her child to the clinic for immunisations. (499)

It is unheard of for 'them' to offer explanations for what they do or why they do it. They merely send a formal note stating that the child is due for something. She remains unsure concerning her refusal of pertussis immunisation for her baby, as she made the decision on unsure grounds. Ignorance encourages anxiety. There is a desire for more control over decision making, which could result from better information. On the one hand, the mother is expected to know and considered ignorant if she doesn't. On the other hand, if she inquires she is considered 'too nosey' - it is tacitly 'beyond' her and not her concern. An 'act of faith' in the staff is required. (500-509)

There have been no adverse effects from the baby's immunisations. (510)

CLINIC ADVICE

Cathy is not sure if the health visitor still wishes her to go regularly to clinic. (512-513)

She sees the clinic as occasionally useful: e.g. for advice on 'problems', and for a talk with someone. (514)

Advice given (to go out and enjoy herself) trivialises her deeply-felt sense of isolation and fear. Afraid of the contempt and ridicule of the wider social world, she can't take part, she is singled out as shameful and 'unworthy'. (515-516)

There is no understanding of her predicament by others which makes her feel even more of a freak. Understanding and acceptance by others is not a feature of her life. (517)

SELF IMAGE

There is a reason for people's rejection of her, since her standards of self-care have deteriorated since early marriage. Now she seems to have neither time nor motivation to 'look after' herself, whilst feeling guilty and alarmed at her appearance. She has been forced to reconsider her own personal attractiveness: and to conclude that she has 'failed'. Even B. and her mother - have scorned her; and there

seems to be no source of approval left. When she looks at herself with a cold critical eye it seems all insults are justified; she is not worth caring about, to be scorned and ignored is appropriate for her. Pregnancy is an ugly condition which calls for abuse. Sad, isolated and frightened, yet anxious to take part in life, she has to resort to make-believe - the only safe way of 'being attractive' without fear of a rebuff. (529, 530, 531, 532)

B. 'abandons' Cathy whilst she is pregnant. She is bewildered by his attitude, which she regards as typical of men generally, resuming interest in her when her figure is back to normal. (533)

CLINIC ATTENDANCE: MORAL IMPERATIVE

In the absence of guidance, Cathy at first assumed that attendance was obligatory and enforced. She thought the unspoken assumption of the 'authorities' was that it was there - therefore it had to be used. She did what she felt to be 'expected' of her out of fear of a reprimand. (534, 535)

ISOLATION IN THE CLINIC

Cathy's social contacts at the clinic are very limited. (537)

... and their non-arrival would leave her feeling extremely isolated... (538)

... the discomfort of which discourages her attendance (539)

Cathy feels isolated/rebuffed/turned away by the other mothers. She would like to fit in, but they will not allow her to do so. (540)

RELATIONSHIP WITH HEALTH VISITOR

The health visitor is there to keep a check on the baby's welfare. (543)

The health visitor is available when Cathy takes the initiative and goes to seek her. Cathy appreciates her as an uninvolved yet sympathetic advisor. (545-547)

Her approach can be contrasted with that of her doctor who tried to become her ally against B. She wanted both B. and herself to work out a solution not to be supported in rejecting him. (548-549)

The health visitor did see B. for a discussion: to no avail as this angered him, since he does not himself acknowledge any problem; and ended in his forbidding her to go to clinic. For him, the family and its affairs are not a valid concern for 'outsiders'. (550-552)

Though she tries, repeatedly resisting her parents' advice to leave B. he himself will not 'try'. She has no-one else; her efforts to improve things all come to nothing, it's hopeless. (553-554)

REASONS FOR B's BEHAVIOUR

When one contrasts B's undisciplined childhood with her own, she sees in it the roots of his present irresponsibility. He continually wants

to be 'the boss' yet untrammelled and able to be 'away' on his own. She feels as if she has two children (one an adult) to look after. (555)

EMOTIONAL TURMOIL

Cath's emotions towards B. include a bewildering mixture of love, hate, protectiveness and compassion. Their problems are deep and complex: she sees no easy solutions - they must be lived with. (556-558)

Although she has thought long and hard about this, there are no solutions, it is to be lived with. Her optimistic expectations of marriage and motherhood have been dashed. (559-564)

RELATIONSHIPS WITH/ATTITUDES TO HEALTH CARE STAFF

Cathy prefers face-to-face contact with her health visitor, it being difficult to express oneself on the phone. (565)

The health visitor accepts Cathy as a worthwhile person to be listened to, and she can be relied on to be there, and to be interested. (567)

Cathy prefers to 'stick with' the one doctor who she feels has shown understanding of her problems; and with whom she feels she can communicate. She puts little faith in the genuine reciprocity of such relationships, since doctors 'move on' - they are 'in it for the money'. She cynically accepts its impermanence. (570-572)

She resents what she sees as the improper barriers put between doctor and patient by over-zealous receptionists, who also diagnose and prescribe. (574-578)

True help is hard to secure; there are many barriers; and even when these are negotiated, the doctor's 'caring' is as a patient rather than as a person. He will suffer involvement as a means to make money. (579-583)

ROLE OF EARLY EXPERIENCE

As her own mother was ill, Cathy and her sister were involved in bringing up two young siblings, keeping house and conforming to exacting standards. This experience taught her a great deal. (586)

BABY BOOKS

The idealised picture conveyed by much baby literature, gives in her opinion a totally false picture of life. (587)

It would be difficult to 'put down in words' the total reality. (589)

She gives two examples of the gloss on harsh reality provided by literature. Her world is nothing like the cosy world of the baby books. (590-591)

B's OPINION OF THE CLINIC

B. is suspicious of 'do-gooders', whom he perceives as nosey, interfering, policing and punitive. He cannot conceive that they may genuinely wish to help. He sees the family as totally responsible for child-rearing; and is suspicious of the authorities who try to get involved. (593, 595-596)

Cathy understands his harsh view of life. B. is not subject to the sme conflicts as she is: to him, the dichotomy of 'us' and 'them' is a clear reality. 'They' must be after something.

ADVICE TO NEW MOTHERS CONCERNING CLINIC

Whilst acknowledging that it is 'up to them', Cathy feels tht the only practical benefit to her child from the clinic has been immunisation. Otherwise it has not made any appreciable difference. (599-601)

She recognises its value as a socialising 'break' for some mothers though not for herself. Although it may suit 'main-stream' mothers, it is not for her - she does not 'fit in'. (602-605)

EXPERIENCE OF MOTHERHOOD

Cathy has enjoyed having her own child with its symbolic implication of her own maturity and independence.

AMBITIONS AND REGRETS

She had hopes of a glamorous life. Though not fond of factory work, it offered a realistic option, and with part of herself she regrets not having stayed on rather than taking up with B. (608-609)

Dreams are irrelevant - real life is hard, and dreams are never realised. She regrets some decisions but recognises that there are limited choices in life which constrained her. It might have been better had she remained single. (610-613)

One major regret is her loss of freedom; though she accepts moral responsibility for her predicament, she would love to have a life outside the house once more. She realises that her youth makes her feel 'cheated' in this repsect. She also greatly misses both the intrinsic interest of having a job outside the house, and the economic independence which such a job brings. (614-617)

Although Cathy knows that she could leave the baby with her parents, conscience compels her to stay in rather than impose on her already overburdened father. (618-619)

Even when the chance to go out is there, the opportunity is not taken up due to her agrophobic condition; a product of her 'incarceration'. Limited, repetitive shopping expeditions emphasise the mechanical nature of her 'survival routine'. For her the world has become a prison - her freedom is limited not only by lack of money, but also by cumulative fear and self-isolation. Even shopping is no longer enjoyable; a mere mechanical operation rather than an expressive and exciting event, since she is not able to exercise any genuine choice of items. (620, 621)

SUGGESTED IMPROVEMENTS IN THE SERVICES

There is a need for mothers to be better informed if they are to take part in genuine decisions regarding take up of services. Lack of such information definitely leads to non-takeup, or rejection of, critical services such as immunisation in some cases. (623, 624)

Health care staff should not entertain unrealistic expectations regarding what mothers know about the services. (625)

More realistic preparation for childbirth, should be provided. (626)

... instead of the glamourised and unrealistic glosses on reality which are the focus of much 'baby' literature. (627)

Mothers-to-be should not be cheated by withholding information. (628-629)

It would be very useful if first-time mothers-to-be could have the benefit of realistic accounts and advice from experienced mothers at the clinic. (630)

The experienced mother becomes more self-determined, less dependent on the accounts of others. (631-632)

For many girls, their mother acts as the principle source of information and advice... (633)

... but mothers tend to expect daughters to rigidly adhere to their 'rules'. This leads to resentment, re-assertion by the daughter of her right to bring up her own child as she thinks fit. (634-635)

New mothers need to learn, but not alone. (636-637)

Others (both professionals and experienced mothers) should offer more factual advice, not idealised or idiosynchratic ones. (638-640)

Her plea is for 'known fact' unflavoured by either romanticism or drama reflecting the idiosyncracies of individual women. She was herself terrified by lurid tales of childbirth. There is certainly pain - which goes once the child is born. New young mothers-to-be should be protected from this type of alarmism. (641-642)

FUTURE PERSONAL CARE OF CHILD(REN)

Cathy has gained more confidence with which to approach the care of her second child ... (643)

... since her daughter seems to be doing quite well on her present regime. (644)

The clinic has a very limited usefulness as far as the welfare of the child is concerned. She does not think she will use it again... since apart from its limited practical use, she sees its functions as mainly social ones from which she feels herself to be substantially excluded. (645)

4.5. STAGE 3: Identification of the Central Themes of Relevance to the Research Interest

(corresponding to steps 5, 6 and 7 in the procedural outline).

The text is interrogated for it's relevance to an understanding of the interviewees experience, and organised around a summary central theme, which is regarded as of relevance to an understanding of her relations with health care provision, or becoming a mother. These themes, so identified, are regarded as the end product (the results) of the analysis for this interviewee.

First of all the larger area of the research interest to which the themes relate is noted; this is either to do with becoming a mother, or views of service provision. A main theme identified in the transcripts of relevance to this area of interest is then offered, supported by its constituent dimensions which show the ways in which the main theme was arrived at in the analysis, e.g;

In this case study, when talking about becoming a mother, one main theme discovered in the text, was the respondents descriptions of the CRUSHING RESPONSIBILITY she had felt. The constituent dimensions of this these were the SOLE RESPONSIBILITY for the childs welfare she felt forced to take on, the WORRYFUL nature of this task and the IMPACT OF THE REALISATION that she was expected to cope with it all. The constituents are then labelled with meaning unit identification numbers, to indicate their location in the text.

These are laid out in the following way:-

The larger area of the research interest to which the themes relate e.g. MOTHERHOOD.

A main theme identified as of relevance to becoming a mother e.g. CRUSHING RESPONSIBILITY.

All constituent dimensions of this main theme are then presented e.g. SOLE RESPONSIBILITY, WORRYFUL, IMPACT OF REALISATION, which represent each time in the interview the interviewee talked of the heavy responsibilities she felt she had undertaken. The constitutive dimensions of the main theme are the ways in which this theme was identified as of central relevance to the interviewee. They serve as evidence for the identified theme, which for some main themes were many and in others few.

MOTHERHOOD is characterised by:-

CRUSHING RESPONSIBILITY

IMPACT FELT

The stressful, demanding job of mothering is easily ignored in hospital.

When one comes home one really feels it then. (238)

SOLE RESPONSIBILITY

From the start, the child is regarded as A's responsibility solely.

The preparation for homecoming is described as a favour for A. (244-249)

B. (husband) seemed unconcerned (200-206)

She felt like a one parent family

WORRYFULL

All the worry about providing for the child is her responsibility. (631)

A LONG HARD SLOG

DEMANDING

Aged parents can't manage it.
The age gap is a bad thing. (13-17)

One can never keep appointments.
There is so much to organise and prepare.
Better just to pop in to clinic when ready (670-672)

NEVER ENDING DEMANDS

24 hour a day job, no break possible.
Even night time is not sacred. (624-629)

INJURIOUS TO THE SELF

FEAR OF THE SOCIAL WORLD

Confinement leads to a fear of going out (713-719)

SELF SACRIFICE IS REQUIRED

There is no time to see to oneself adequately, so ugliness is unavoidable (719-726)

DISFIGUREMENT

One ends up looking just like a lump of cheese (728-733)

A TIME OF HARDSHIP

CONFINED TO THE HOME

One is restricted to the house, only exceptional circumstances allow for a break from the 24 hour routine, day and night, with no respite. (624-629)

All the worry is her responsibility (631)

CUT OFF FROM THE WORLD

She is so used to being stuck in the house, that now she is afraid to go out (713-719)

Anxious to take part in life, she has to resort to make believe, as the only safe way (728-733)

"Fair enough" though it's her own fault in the first place, she must take responsibility (815)

THERE IS A SENSE OF LOSS

MISSED CHANCES AT WORK

If she'd stayed working, she could have been a supervisor by now, earning good money (809)

LOST FREEDOM TO TAKE PART IN LIFE

She is no longer able to be "one of the lasses" and misses going out and socialising (814)

LOSS OF SOCIAL CONTACT

She is stuck in the house, and sees no-one (816)

LOSS OF EARNINGS

She is no longer able to work for a living (816)

LOSS OF EXPRESSIVE CHOICES

She used to enjoy e.g. shopping, but now its just a boring routine, she can't exercise choice becuase she has no spare money and so is restricted to very limited options (821ff)

NEW AND FRIGHTENING EXPERIENCE

LACK IN CONFIDENCE

She felt inadequate, clumsy and had no confidence, experienced unexpected emotions (589-590)

APPROVAL WAS IMPORTANT

The only time she felt proud and confident was when passers by admired her achievement, treated her as a success (589-590)

INEXPERTISE

She was rebuked for her ignorance (87), Doctors and others dismissed her real concerns as petty, foolish, worrying; they typified her concerns as that of a 'mother hen'. She feels though, that a first-time mother needs to "find out that they're alright" (babies) (679-691)

A TIME FOR ALTROUISM

CHILD MUST COME FIRST

Apparently ludicrous arrangements were made to keep her husband out of trouble, but this must be endured for the sake of the child (318-319)

DEGRADE AND DENY SELF

Hated activities like begging become unavoidable when the childs welfare is at stake (350)
All major worries revolve around the childs welfare, and the ability to provide for the child sharpens the normal day to day worry about survival (580-585)
Doctors reinforce this view, as when he warned her to improve herself, overthrow her problems or neglect the child. Problems must not be dwelled upon, one can't feel self pity as the childs welfare is most important (649-650)

EXPERIENCE ITSELF IS THE REAL SITE OF LEARNING

NEW INSIGHT

When the child hurt herself, A. laughed which seems callous, but was not, as fussing a child leads to more crying. At one time she would fuss over the slightest event, and had heard others warning her about spoiling the child. She heeded this and found it works, the child laughs the hurt away. (610-614)

A FASCINATING/PLEASUREABLE TIME

SURPRISING CAPACITIES OF CHILD

Children are surprisingly bright, e.g. hers was able to remove the caps of an eyeshadow box which led her to re-examine her beliefs about a childs abilities. "They're a lot brainier than we think" (615-617)

UNEXPECTED PLEASURE
Surprisingly, A. enjoyed breast feeding, she "loved to just watch her" (639)
which became a lovely experience (645)

PLEASURE OF ACHIEVEMENT

She has enjoyed having this child, being independent, and knowing she now has a bairn of her own (806-807)
The child has been pretty fit, a good child, who can be endearingly naughty (634-638)

LIFE IS UNFAIR AND DETRIMENTAL

HARD DONE BY

She was raped when younger, which resulted in a miscarriage, and was unable to see justice done. She was reluctant to tell her parents, feared recriminations from her attacker, and afraid to go to the police (18-33)

She was punished by her employers, for what was outside of her control, and did not warrant that sort of treatment. (98, 101)

HARSH TREATMENT COMES HER WAY

There was a total lack of sympathy shown at her work place, when she was pregnant, (98), she was unfairly treated, given unsuitable tasks and even punitive ones like cleaning the toilets out. (92-107)

UNREASONABLE TREATMENT

Social Security officers treated her as an unworthy person but she has worked hard. (295-303)

SHE IS PRONE TO BAD LUCK

UNFORTUNATE

The futile attempts she made to control her own fertility, came to nothing, as she was raped only 2 days after stopping the pill. (47-51)

Her housing position does not assure rehousing (632)

PLANS FLOUTED

Events are largely outside her control, the 2nd pregnancy was ill timed, due to failure of the withdrawal method. (51-58)

UNLUCKY

The only car they had ever had, they believed to be stolen, but later found the new owner had no problem getting hold of legal documentation, a loss she regrets. (257)

Due to her rent collectors sloppiness, they appear to be behind with the rent, and are threatened with eviction, unluckily this type of housing does not assure rehousing. (632)

INADEQUATE PREPARATION FOR THE HARSH REALITIES OF LIFE (CHEATED)

CHEATED

She feels cheated by those who 'know' things, information is deliberately withheld, e.g., "sex is not just a 'good thing', that's too simple a view, which overlooks the pain and disappointment of miscarriages. It becomes boring in any case. (34-44)

Antenatal literature gives false information, requiring one to buy unecessary stuff. (563-569)

MISINFORMED

She was totally unprepared for the trials of motherhood, and only found out when it was too late. (618)

Advice in general is not very useful or true e.g. with giving birth, the pain was not as bad as she had been led to believe. Her own experience was much less harrowing. (619-623)

Baby books only tell the good side, which is not like real life, which would be difficult to put into words. It seems they try to ease one's mind by glossing over problems. (787-791)

UNACKNOWLEDGED NEEDS

People should not expect one to be well informed, they should try to help one understand what is to come, instead of "fairy stories". They should not withhold information. (826-832)

One needs to learn, but not alone, advice should be given, not from personal experience, but known fact, as otherwise it's too dramatic or falsely idealistic and leads to uneccessary worry. (836-842)

EXCLUDED FROM THE MAINSTREAM OF LIFE

VICTIMISED

Normally, certificates of need are given freely to all who need them, but she was not, no-one even mentioned it to her. She was **overlooked**, the onus being on her to initiate help, putting her in the awkward position of having to persist to get her entitlements, with the ever present fear of recrimination. (117ff)

EXCEPTIONAL PROBLEMS

Her jaundiced child, necessitated an extra long stay in hospital, which was unusual, so she was singled out as abnormal. (235)

SHE IS UNCARED FOR AND ABANDONED

TREATED FLIPPANTLY

On realisation of her pregnancy, she feared losing the child, and was unable to keep up with work demands. Despite her pleas for care, doctors flippantly change their minds. (60-75)

COLDLY DISMISSED

Doctors refuse to see her problems as real, saw her as trying to cheat, so that the resultant threat to her job security was their doing. (89)

The hardships caused by an uneccessary duplication of visits to antenatal care were ignored (142), and no concern was shown for the spreading rash she developed. (170)

Social service staff don't care about her forthcoming childs needs. (340-350)

She was given cold and cruel treatment at work when her pregnancy was confirmed and threatened with the sack. (101-103)

NO-ONE CARES

Cynical doctors change frequently, once they've made a bit of money, regardless of her wishes, they have no commitment to care. (770-772)

Now that she is ugly and misshapen, her husband doesn't fancy her anymore, for which she does not blame him. (728-733)

COMPLETELY ALONE

Her husband is not interested in child care, or family life. (200-206), (623-633) Now she anticipates the total loss of her husband; which before the advent of her child would have been unthinkable. (287-289)

DISSAPOINTMENT WITH LIFE

LET DOWN

Her husband was unmoved by the news of her pregnancy, which she found unbelievable as she was 'over the moon'. (77-78, (200).

Even when she liked a doctor, he moved on; and she never saw him again. (132)

The total lack of involvement on her husbands part; his refusal to make it his concern, spoilt her dreams, as she wanted to share it all with him. (624-633)

On coming home, despite preparations it was a disaster, all her **plans were destroyed**, she just sat down and cried. (250)

She was enjoying breast feeding, but lost her milk almost immediately. (253)

Her life did not alter in any way, as within minutes of arriving home, she was back to the old grind. (254)

Her maternity allowance held out hope for the betterment of her conditions, but all hopes were dashed, when the money was deducted from the dole. (351-356)

All her efforts to resolve her marital problems, which even involved the health visitor were to no avail (749-755) leaving her hopeless.

Her painful dreams are now **all spoiled**, she fancied becoming a model at one time, but girls all dream such things, and she once vowed she'd never do factory work, but one has to, to survive. (806-813)

UNDER THREAT OF COLLAPSE

FEAR OF PERSONAL COLLAPSE

The unreasoned violence of her husband, made her nerves so bad, she was driven to see the doctor, she was terrified at the bizarre situation she had found herself in; only 21 years old and dependent on tranquilisers. (279-286)

The responsibility of a child makes everything much more threatening. (304)

It has been very hard to manage with little money, but she must keep her willpower going, otherwise she may collapse again and recovery seems unlikely. The excessive and punishing use of drugs to keep calm is terrifying. (333-339)

She is troubled by the worry of threatened eviction (632-633), and fears hostile disparagement from others, e.g. 'bitchy' women at clinic who may laugh at her childs poor clothes, which makes her ashamed. (651-655)

This makes her scared to venture out, so she avoids public transport. (713-719)

HOPELESSNESS

All of her hard earned possessions have already had to go, and her husband has tried for hundreds of jobs to no avail. (295-303)

She fears he may be imprisoned for pinching, he is so irresponsible and easily led, but on the other hand, has had to steal coal. (290-293)

She feels helpless to change things, e.g. when she tried to stop him pinching by nagging, this led to severe beatings, he becomes uncontrollable and she is unable to defend herself. (305-319)

With hopeless resignation she accepts her lot (326-330)

Her impossible circumstances revolve around lack of money, (340-350) despite all her efforts to secure more.

Now her 2nd child is on its way and her panic increases as the delivery date looms closer. (358-362)

It's a losing battle trying to provide for her child, the frustratingly short life of clothes, and expense of food. (602-605)

Her husband won't even try to resolve their marriage problem

(740-755), as his problems stem from a poor childhood, which leaves her with a confused turmoil of emotions towards him, so that she now regrets marrying him. (755-764)

LACK OF PRESENTABLENESS

REJECTED

Others have good reason to reject her as she has allowed herself to go downhill, she feels guilty when others notice her failure. (719-732)

SELF DISGUST

When first married she would never be seen so ugly, she has allowed herself to go downhill (719-733), which others notice and make her feel ashamed (720), and it's not surprising that her husband no longer finds her attractive, as her disfigurement is all too obvious. (720-732)

DESPISED

She is forced to take part in despised activities like scrounging in jumble sales; even though today it may be almost fashionable to do so. (656-660)

Her shameful appearance provokes nasty treatment, and the disapproval and ridicule are unbearable. (651-655)

She was publicly disgraced at clinic (661-668) and now anticipates ridicule should she go out (713-719), as others despise and avoid contact with her. (737-740)

SERVICE PROVISION was seen as:-

DISTANT ABSTRACT TOTALITY

STAFF HAVE AUTHORITY AND POWER

Those in authority share the same attitudes (71); they can condemn one and withhold help e.g. by declaring that 'pregnancy is not an illness' (86)

Advice is not freely offered, it has to be extracted through persistence and pleading. One must convince them of ones needs before they will yield (90-91) (117ff)

They have access to priveledged information. (109)

As judges of ones behaviour, they can hand out or withhold approval, without any consideration of how a mother may need to 'find out' that all is going well (686-691)

It is unheard of for them to offer explanations for what they do, she was kept in ignorance of hospital procedures and immunisations and so was worried (700-711)

They can demand certain conduct, e.g. the first time she missed

clinic, she anticipated swift retribution; thinking attendance was enforceable. (734-736)

Her husband thinks little of them; that they are merely nosy and out to get you for child beating (793-797)

STAFF ACT IN SOCIALLY/MORALLY SUPERIOR WAY

Doctors don't give advice; this is an amusing idea, they merely order one around (80).

She was anxious to gain their approval; to do the right thing in their eyes (112)

Her doctor was right to moralise; and she invests in his view that she could neglect her child if she does not persevere. (649-650)

They laugh at ones concerns, thinking mothers make too much of it all; like "silly hens". (686-691)

THEY HAVE HIDDEN/INSIDE INFORMATION

They possess inside information, which she suffered for the lack of, e.g. the start of her pregnancy she knew there must be a procedure, she was just not sure what it might be (110); but the midwife expected her to know and treated her as foolishly uninformed. (111)

The implicit rules are all too obvious when the unenlightened transgress them e.g. questions were not allowed at hospital (163-165), where one was often put down as ignorant.

This was the same at clinic, when she was belittled by her lack of know how, e.g. when a problem which seemed pertinent to her (skin rash) was dismissed as not appropriate there. (170-178)

The ignorance of such matters, leads to one being wrongfooted e.g. on admission to hospital she did not know what to bring, she had no idea of what was expected (563-569), but was anxious to do the right thing. (112)

<u>SHE FELT ILL DEMEANED IN THE EYES OF "SUPERIORS", APART AND BASE</u>

SHE WAS BASE AND DIFFERENT

She did not expect to fit in antenatally and chose selective and limited contact (180-198), as she had nothing in common with 'their way' as revealed in the film shown on child rearing which was totally innappropriate to her lfe circumstances. (190-196)

Her unbearable predicament with family in-fighting was glossed over with off pat solutions like "time will heal", which was a nonsense and implied she should be coping. She felt a failure in their eyes, as they seemed to be looking through "rose coloured glasses" and could never appreciate her perspective. (260-269)

She is ashamed of the obvious differences between her and them; would like to do it their way, but cannot hope for this. (198)

She feels guilty and anxious about her poverty, especially the meagre diet she is able to offer her child, which seems alarmingly poor, and reflects on her as a mother. (196-200)

The advice offered simply cannot apply to her (263) "to go out and enjoy yourself" is a ridiculous notion, as she can't afford to go out and moreover is now afraid to try, being ashamed of her appearance. (713-719)

Baby books only give the good side, but life isn't like that for her. (787-791)

SHE WAS IGNORED AND DESPISED

She feels base and poor in comparison to others (196-200), having to act in shameful and degrading ways e.g. she detests begging social services for help but has no choice. (348-350)

As judged from their world, her problems do not seem so serious, so she is seen to be failing in their eyes; these expectations are unfair, and based on an idealised view of the world. (271).

Conact with clinic was a shameful experience; she feared disparagement by others and was ashamed to be seen in second-hand clothing as all the others were very respectable. She could not compete, felt put down and vowed she could never endure it again. (651-655)

Socialising there is impossible for her, she could not join in, (673-674) she felt ignored and despised, usually had to sit alone and even though she tried to get along with the others she was ignored and avoided. (737-740)

As the clinic is used mainly for such socialising (which is a good thing as mothers need a break), it is not the place for her to frequent, only for those who can mix. (798-805)

SHE SUFFERED MORAL CONDEMNATION

SHE FELT REBUKED AND BELITTLED

The doctor treated her concern about being pregnant as foolishly soliciting undue attention; which made her feel she was acting improperly, even though she was sure she was doing the right thing, as the instructions on her testing kit had said. (66-75)

She was rebuked for soliciting time off work; something the doctor would not condone, as if she was lying and couldn't be ill. (80-89)

Her skin rash was brushed aside as a ridiculous request, which was none of their concern. (170-178)

Social Security staff reprimanded her for soliciting help, as only one of many in need, even though she has worked (is respectable) and feels entitled to some help. (295-303)

She was publicly disgraced at clinic, as she was not aware that one had to pay for second hand clothing there, rebuked for not offering payment, she was forced to admit to having no money to pay and return

the clothes. (661-668)

They also think mothers make too much of their concers, and accuse one of hen-like pestering (686-691) which is shameful.

SHE FEARS BAD PRESS

She was anxious to be seen as an informed 'proper' person (109-115), fearing their judgements on her. Apprehension about her first visit to clinic was because she was unsure what was expected of her and did not want to be made to look a fool. (28-29)

When her child damaged her head, she anticipated them thinking badly of her, but she could do nothing about it as it was her poor footwear which caused the slip (606-609). There is no help available to her, as requests are transformed into threats e.g. the doctor frightened her into self improvement. (649-650)

All those who don't use the clinic, like her, are afraid of disparagement, and avoid the threat by staying away. (675-678)

DEHUMANISING CONTACT WITH STAFF

TREATED AS OF NO CONSEQUENCE

Impersonal interrogations are the order of the day (129) whereby one is regimented through the service as one of many (145), passed on from one doctor to another, "like a bag of flour" (129)

Staff treated her as if she was not worth caring about; the doctor, "didn't give a chuff" (148) and acted as if she was a little box in the corner of the room. (149)

Just like an object, she was subject to emergency and highly technical treatment in hospital, with no explanations or direct communication to her even though she was confused agitated and alarmed. (209-231)

RIDICULED AND HUMILIATED

She was treated as an exhibit; where there was no need for human emotions; as with doctors in general such matters are not applicable e.g. when she was forced to walk naked across a room full of medical students; who did not care how she felt. (149-153)

FELT WORTHLESS IN THE EYES OF STAFF

PROTESTS ARE IGNORED

She was outraged at the unwarranted dismissal by her doctor of her symptoms (60-75), and in general has to struggle to be heard; problems are not taken seriously, and one has to plead to get anywhere. This forces one to act in an undignified way. (90-91)

Social security dismiss intolerable living conditions as one of many, even though she has worked. (197)

Her elaborate description of her childs 'chestiness' symptoms were dismissed as 'cold in her nose', which is too simple to be true. (598)

Ridiculous clinic arrangements which caused her hardship; were never changed even though she kept telling them what was happening (140).

She was never listened to respectfully (170-178) and often treated as not having any sense. (260-2262).

Grave problems were made light of (263ff) which leads to incorrect diagnoses (679-684) and inadequate care.

CRITICAL ANTAGONISM TOWARDS STAFF

CULPABLE NEGLIGENCE/INEXPERTISE OF STAFF

On occasions, they have been forced to agree with her, they were wrong all along, and could be held responsible for the possible death of her child. (75)

They acted improperly and are not always correct. They make the wrong diagnoses (592-561) and so she refused to see this doctor again. The doctor at clinic proved himself to be no good when he mistakenly dismissed a bad chest as 'cold in her nose', (673) and often they do not conduct a very thorough examination e.g. they do not get the stethoscope out and check internally. (679-682)

They only tell one what is already known (693-698) in any case, and cause worry, making problems worse by withholding information. (700-711)

They are unreliable (770-772) and act improperly e.g. when receptionists refuse to send a doctor out when one is ill, and even prescribe medication. (773-784)

Contact with them brings no appreciable benefit, it's all just for socialising really (798-805) e.g. clinic visits make no real difference.

RIDICULOUS AND IRRELEVANT SERVICES

They are not always correct in their assessments (71-75), and can place ridiculous demands on mothers, e.g. when the changed venue of the clinic necessitated 2 bus rides (20-25). Even when the problems are pointed out to them, they persist in their idiocy. (138-142)

The activities at the antenatal classes were ludicrous "stretching yer ankles and this lot" and seemed a complete waste of time (182), whilst the clinic "only weighs 'em". (675)

The services are difficult to make use of because they make the wrong assumptions about mothers e.g. that their concerns are merely overactive mothering. (686-691)

APPRECIATION OF CARE

APPRECIATION OF CARE

FELT ACCEPTANCE

The health visitors concern about her marital problems was much appreciated, especially so, since she was allowed to talk. Even though, the problems are not resolved, she ended up feeling less confused about it all. (274-278)

REASSURANCE

The developmental checks, have been reassuring, as they mean she has one less thing to worry about. (685)

As someone to talk to, the health visitor proved accessible, even though the advice was irrelevant. (714)

ACTIVE INVOLVEMENT

The health visitor tried to intervene in her problems, was prepared to get involved, but ended up seeing the problem in a one sided way. (752-755)

REMAINING DATA (meaning units not already included in the thematic summary)

A. reluctantly depended on her mother for food (605)

She justifies her behaviour at each stage (639ff) e.g. breast feeding. Some questions elicited well told stories e.g. A's analysis of her husbands problems (279-319)

The stoical acceptance of the hard facts of life; e.g. the child will never be very healthy in such a damp house (634-638), as a mother she must cope alone (649), and this predicament is seen as all her own fault. (815)

Her conception and pregnancy were seen as perilous and precarious (1-13), as was her lack of control over, life events (13), information (823) and the future.

N.B. All category systems are inadequate to the task of covering every aspect of the topic they refer to c.f. "etcetera" H. Garfinkel 1967, Studies in Ethnomethodology. New Jersey: Prentice-Hall.

APPENDIX 5

SELECTION OF STUDY CASELOADS

Referred to in text 4.1.

Contents

Profile of HV caseloads (N=39) 1980

0 - 1 years caseloads

range = 50-168 for full-time staff
44-106 for part-time staff

Cases No	HV fr
40-160	6
60-80	7
80-100	10
100-120	12
120-140	1
140-160	2
160-180	1
	39

1-5 years caseloads

range = 110-532

Cases No	HV fr
110-150	2
150-200	0
200-250	6
250-300	8
300-350	7
350-400	9
400-450	3
450-500	1
500-550	3
	39

Schools caseloads

range 0 - 11

Cases No	HV fr
0	2
1	5
2	10
3	8
4	4
5	1
6	3
7	3
8	2
9	1
	39

Non-accidental injury caseloads

Cases No	HV fr	range = 0-13
0	7	
1	4	
2	5	
3	6	
4	4	
5	5	
6	3	
7	1	
8	1	
8	1	
10	0	
11	0	
12	0	
13	1	
	39	

Elderly persons caseloads 60-75 years

Cases No	HV fr	range = 0-29
0-5	21	
5-10	6	
10-15	4	
15-20	1	
20-25	3	
25-30	3	
	39,	

Elderly persons caseloads 75+ years

Cases No	HV fr	range = 0-50
0-10	26	
10-20	5	
20-30	3	
30-40	2	
40-50	2	
	39	

Number of child health clinics per month

No of clinics	HV fr	range = 0-14
0-2	3	
2-4	1	
4-6	16	
6-8	3	
8-10	9	
10-12	1	
12-14	5	
	39	

Developmental assessment sessions per month

No of sessions	HV fr	range = 0-4
0	7	
1	6	
2	11	
3	1	
4	10	
'as required'	1	
	39	

Health education sessions in schools per month

No of sessions	HV fr	range = 0-60
0-10	24	
10-20	4	
20-30	2	
30-40	4	
40-50	1	
50-60	1	
	39	

Number of 'problem families' caseloads

No of cases	HV fr	range = 0-30
0-5	15	
6-10	8	
11-15	8	
16-20	6	
21-25	1	
26-30	1	
	39	

The tabulated summaries above allow for a comparison of the Health Visitor caseloads and give an overall impression of the locality in which the study was to take place. On each of the indicators outlined above, the HV chosen for inclusion in the study fell within the modal or higher than modal caseload bracket. Of the 39 HV's working in the study area there were 12 who had higher or modal caseloads, e.g. over 100 charges in the 0-1 year old section and over 300 in the 1-5 year old section. Three of these HV's were excluded owing to the considerations outlined in the text (4.1) and the remaining 9 caseloads comprised the study population. Comparative data outlined in the table below indicate that they were not untypical of the study area.

5.2. Comparison of Health Visitor Caseloads (1980 summary)

HV	0-1 yrs	1-5 yrs	Not reg	Problem families	Elderly	CHC per month	HT per month	DA per month	GP's attached
1	114	366	1	6	36	8	1	2	3
2	103	368	4	9	40	9	1	2	3
3	87	291	1	9	13	4	1	1	3
4	62	269	8	20	8	4	2	1	3
5	113	425	6	16	39	4	0	0	4
6	101	400	13	14	2	8	1	0	3
7	88	287	2	0	0	12	2	2	4
8	106	362	0	0	17	12	1	1	3
9	78	304	9	0	0	4	1	1	3
Modal frequency									
	100-120	300-350	3-4	0-5	0-10	4-6	2	2	3
Range N=39									
	50-168	110-532	0-13	0-30	0-50	0-14	0-4	0-4	3-4

*HV are referred to by number only to preserve anonymity

There were 4 major care settings covered by the 9 HVs which again were not untypical in any way from the rest.

5.3. Table of Comparison of Chosen Care Settings

	1	2	3	4	5	6	7	8	9	10	11	12	13
A	2	100-120	300-350	5-10	20-30	1	1	8-10	2	GP	6	AHA (C)	15
B	3	100-120	250-300	0-5	0-10	7	8	4-6	1	CMO	10	AHA (C)	60
C	2	160-170	300-350	25-30	40-50	3	4	4-6	4	CMO	7	AHA (HC)	5
D	2	100-200	300-350	5-10	10-20	3	1	12-14	N/S	CMO	6	AHA (C)	8
Modal freq		100-120	350-400	0-5	0-10	2	3	4-6	2				
Range N=39		40-180	110-550	0-29	0-50	0-11	0-13	0-14	0-4				

Key

Column 1 Number of health visitors based in specific settings

Column 2 Caseload of health visitors (children under 1 year of age) expressed as an average range for the care setting

Column 3 Caseload of health visitors (children aged 1-5 years) expressed as an average range for the care setting

Column 4 Caseload of health visitors (elderly persons aged 60-75 years) expressed as an average range for the care setting

Column 5 Caseload of health visitors (elderly persons aged over 75 years) expressed as an average range for the care setting

Column 6 Number of schools served by health visitors and school nurses within care setting

Column 7 Number of children appearing on the register for non-accidental injury

Column 8 Number of child health clinics held during one month (usually advisory sessions dealing mainly with infants)

Column 9 Number of developmental assessment clinics held during one month (usually specifically for developmental surveillance by doctor and HV) NB: Setting does not use specific sessions for this purpose and number is included with general child health clinics in column 8

Column 10 clinic attended either by a GP from the care setting or by an AHA Clinic Medical Officer

Column 11 Number of GPs in the appropriate general medical practice for the setting

Column 12 Type of premises available for clinic sessions

Column 13 Age of premises (in years) used for clinic sessions

Modal frequency: Modal frequency of each characteristic feature amongst total available sample (N=39)

APPENDIX 6

TABULATED SUMMARIES OF SOCIO ECONOMIC DATA

Referred to in text 4.3.

Contents

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS - KEY TO CATEGORY CODES:

CATEGORY:	CODE:
1 *Maternal age at birth:*	*Refers to mother's age at the birth of her first child, to nearest year*
2 *Type of schooling:*	*1 secondary modern 2 comprehensive 3 secondary grammar*
3 *Age left school:*	*Refers to the age at which the mother herself left school, in years/decimals of a year*
4 *Qualifications:*	*0 none 1 CSE only 2 'O' level(s) or CSE and 'O' level(s) 3 'A' level(s) or 'O' level(s) and 'A' level(s) 4 professional examination(s)*
5 *Health education:*	*Refers to health education topics covered at the mother's school: 0 none 1 Human biolo 2 Human biology and domestic science 3 Huma biology, domestic science and sex education 4 Human biology, domestic science, sex education and baby care*
6 *Previous occupation:*	*Refers to the mother's occupation before the birth of her child:* *0 no occupation* *1 student* *2 primary industry (e.g. farming)* *3 factory work (e.g. seamer, line feeder, tracer, machine operator, machinist)* *4 service occupations (e.g. receptionist, market seller, hairdresser, shop assistant, supermarket worker, barmaid, waitress etc)* *5 professional or quasi-professional (e.g. social worker, nurse, teacher, child care worker, dispenser's assistant, lab technician)*
7 *Present occupation:*	*Refers to the mother's occupation since having her child. Categories as for item 6 (HW= housewife; PT = part-time)*
8 *Partner's occupation:*	*Refers to present occupation of partner:* *0 unemployed or no occupation* *1 student* *3 skilled industrial worker (e.g. miner, electrician, welder, fireman)* *2 unskilled or semi-skilled industrial worker (e.g. storeman, dustbin man, labourer)*

CATEGORY:	CODE:
8 *Partner's occupation (contd):*	4 *non-manual worker (e.g. security officer, policeman, accounts clerk)* 5 *professional worker (e.g. teacher, optician, metallurgist)*
9 *Length of time in present accommodation:*	*Refers to the length of time during which the family has occupied current accommodation, expressed in years/decimals of a year)*
10 *Residences since a child:*	*This refers to the number of residences in which the mother has lived altogether since childhood*
11 *Regular contacts in neighbourhood:*	*Refers to the mother's current regular contacts in the neighbourhood:* 0 *none at all* 1 *family only* 2 *family and friends* 3 *family, friends, and neighbours with children*
12 *Type of property lived in now:*	*Refers to the type of property currently occupied by the family:* 1 *private flat* 2 *private house* 3 *council flat* 4 *council house* 5 *tied housing (e.g. NCB house)*
13 *Bedrooms:*	*Refers to the number of bedrooms in present accommodation*
14 *Number of people living there:*	*Refers to the number of persons living in present accommodation (i.e. the first three would be mother, father and child)*
15 *Condition of property (own assessment):*	*Refers to mother's own assessment of current living accommodation:* 0 *'poor'; 'disgusting'; 'terrible disrepair'; 'terrible'; 'rubbish' etc* 1 *specific complaints (e.g. 'subsidence'; 'top flat'; 'chronic damp', etc)* 2 *'moderate'; 'not bad'; 'quite good'; 'okay' 'fair' etc* 3 *'good'; 'very good' etc*
16 *Domestic facilities:*	*Refers to current facilities possessed by mother:* 0 *no hot water* 1 *hotwater only* 2 *hot water and fixed bat* 3 *hot water, fixed bath, inside toilet* 4 *hot water, fixed bath, inside toilet, cooke*

CATEGORY:	CODE:
16 Domestic facilities (contd):	*5 hot water, fixed bath, inside toilet, cooker, washing machine* *6 hot water, fixed bath, inside toilet, cooker, washing machine, telephone* *7 hot water, fixed bath, inside toilet, cooker, washing machine, telephone, car*
17 Journey to clinic:	*Refers to the approximate time which it takes the mother to get to the child health clinic, in minutes suffixed by mode of travel (W = walking; B = by bus; C = by car)*
18 Journey to GP:	*Refers to the approximate time which it takes the mother to get to her GP's surgery, in minutes suffixed by mode of travel (W = walking; B = by bus; C = by car)*
19 Marital status:	*Refers to current marital status of the mother:* *0 single parent* *1 separated or divorced* *2 common law wife* *3 married*
20 Years known partner:	*Refers to the length of time for which the mother has known her present partner, in years/decimals of a year*
21 Years with partner:	*Refers to the length of the period during which the mother and her present partner have been living together, in years/decimals of a year*
22 Together before child:	*Refers to the length of time during which the mother and her partner were together before the child's arrival, in years/decimals of a year*
23 Position in own family:	*Refers to position of the mother in her own family (e.g. '2:3' means that she was the second child of three)*
24 Pregnancy planned?:	*0 no 1 yes*
25 Information type:	*Refers to the mode in which information was obtained from the mother:* *TI taped interview obtained*

CATEGORY:	CODE:
25 *Information type (contd):*	*I* an interview was obtained but not taped *R* refused to be interviewed, either directly or by not keeping repeated arrangements *NI* never in - i.e. the mother was never found at the premises in spite of repeated visits after notes and letters warning of the visit had been delivered *L* 'lost' - i.e. premises found to be empty on arrival *O* omitted from the sample due to removal from the area of study

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	FIRST DECILE (N= 15):									
	28	31	32	50	58	59	62	66	75	86
1 Maternal age at birth:		34	22			22				
2 Type of schooling:			3			2				
3 Age left school:			16			15				
4 Qualifications:			2			2				
5 Health education:			3			2				
6 Previous occupation:			5			3				
7 Present occupation:			HW			HW				
8 Partner's occupation:	0	3	5	0		0			2	4
9 Length of time in present accommodation:			1			1.5				
10 Residences since a child:			8			4				
11 Regular contacts in neighbourhood:			2			2				
12 Type of property lived in now:			4	3	2	4		4	2	
13 Bedrooms:	2	2	3	3	3	2		3	3	
14 Number of people living there:			3	3		3		8	3	
15 Condition of property (own assessment):			2			1				
16 Domestic facilities:			6			0				
17 Journey to clinic:			30W			5B				
18 Journey to GP:			15B			5B				
19 Marital status:	0	1	3			3		0		
20 Years known partner:			7			6				
21 Years with partner:			5			2				
22 Together before child:			3.5			0.5				
23 Position in own family:			3:3			1:1				
24 Pregnancy planned?:			1			0				
25 Information type:	NI	R	T	L	NI	T	O	NI	NI	R

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(First Decile ctd)						SECOND DECILE (N=14):			
	103	105	110	112	117		21	29	55	65
1 Maternal age at birth:	23		23	17			30	22		25
2 Type of schooling:	2		1	2			1	1		2
3 Age left school:	16		16	15			15	16		15
4 Qualifications:	1		0	0			0	0		0
5 Health education:	0		3	1			1	3		2
6 Previous occupation:	4		4	0			4	4		4
7 Present occupation:	HW		HW	HW			HW	HW		HW
8 Partner's occupation:	2		3	2			3	3	3	2
9 Length of time in present accommodation:	1.3		3	1.4			0.5	2		1.3
10 Residences since a child:	4		2	2			7	2		3
11 Regular contacts in neighbourhood:	3		3	3			2	2		2
12 Type of property lived in now:	4		2	4			4	5	2	4
13 Bedrooms:	2	3	2	3			3	3	3	2
14 Number of people living there:	3		3	3			3	3	3	3
15 Condition of property (own assessment):	1		3	0			3	2		2
16 Domestic facilities:	2		7	0			7	5		7
17 Journey to clinic:	5W		10W	10W			20W	10W		5W
18 Journey to GP:	15B		10W	15B			15B	10W		10B
19 Marital status:	0	0	3	3			3	3		2
20 Years known partner:			7	2			14	3		4
21 Years with partner:			3	1.4			10	2		2.5
22 Together before child:	0.5		2	0			8	0.5		1
23 Position in own family:	1:2		1:7	3:3			3:4	1:4		3:4
24 Pregnancy planned?:	0		1	0			0	1		1
25 Information type:	I	NI	I	T	NI		T	T	NI	T

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Second Decile contd)									
	72	82	83	85	88	95	111	116	140	145
1 Maternal age at birth:	20					22	25		24	21
2 Type of schooling:	1					2	2		3	1
3 Age left school:	16					17	15		15	16.5
4 Qualifications:	0					2	0		0	2
5 Health education:	3					3	1		1	1
6 Previous occupation:	4					4	3		5	3
7 Present occupation:	HW					HW	HW		5	HW
8 Partner's occupation:	0	4	0	3	5	3	2		3	0
9 Length of time in present accommodation:	1.5					2.5	1		2	3.5
10 Residences since a child:	2					3	3		2	3
11 Regular contacts in neighbourhood:	3					3	3		2	1
12 Type of property lived in now:	4	3	4		2	2	2		2	5
13 Bedrooms:	3	2	3		3	2	2		2	2
14 Number of people living there:	10	3	3		3	3	3		3	3
15 Condition of property (own assessment):	0					3	3		3	0
16 Domestic facilities:	0					6	6		7	0
17 Journey to clinic:	20W					30W	20W		30W	5W
18 Journey to GP:	45B					B	10W		30W	20B
19 Marital status:	2					3	3		3	3
20 Years known partner:	6					13	2.5		4	4
21 Years with partner:	1.5					2.5	2		0.2	4
22 Together before child:	0					1	0.8		0	2
23 Position in own family:	1:6					7:7	3:4		1:3	1:4
24 Pregnancy planned?:	0					1	0			1
25 Information type:	T	NI	NI	L	L	I	T	R	T	T

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	THIRD DECILE (N=15):									
	12	16	33	39	44	45	60	79	80	84
1 Maternal age at birth:	18	22		23	23					
2 Type of schooling:	2	3		2	1					
3 Age left school:	15.5	15		16	16					
4 Qualifications:	2	2		2	0					
5 Health education:	1	3		3	2					
6 Previous occupation:	0	3		1	4					
7 Present occupation:	HW	HW		HW	HW					
8 Partner's occupation:	2	3	4	2	3	2	2	3	2	
9 Length of time in present accommodation:	2	2		3	1.6					
10 Residences since a child:	2	3		3	2					
11 Regular contacts in neighbourhood:	2	0		2	1					
12 Type of property lived in now:	4	5	2	2	4	4	4	4	3	
13 Bedrooms:	2	3	3	3	3	2	3	3	4	
14 Number of people living there:	3	3		3	3	3		8		
15 Condition of property (own assessment):	2	0		2	3					
16 Domestic facilities:	4	4		6	7					
17 Journey to clinic:	10W	20W		10W	10W					
18 Journey to GP:	10W	20W		10B	10B					
19 Marital status:	3	3		3	3			1	0	
20 Years known partner:	6	8		6	4					
21 Years with partner:	2	2		3	2					
22 Together before child:	0.2	1		1.5	0.3					
23 Position in own family:	4:6	1:4		2:4	4:4					
24 Pregnancy planned?:		0		1						
25 Information type:	T	T	NI	T	T	NI	NI	R	NI	NI

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Third Decile ctd)						FOURTH DECILE (N=18):			
	92	96	98	100	130		20	27	34	35
1 Maternal age at birth:		26			20					
2 Type of schooling:		2			2					
3 Age left school:		16								
4 Qualifications:		2								
5 Health education:		2								
6 Previous occupation:		5								
7 Present occupation:		HW								
8 Partner's occupation:		3	2	2	2				3	4
9 Length of time in present accommodation:										
10 Residences since a child:										
11 Regular contacts in neighbourhood:					1					
12 Type of property lived in now:									2	2
13 Bedrooms:	3				2		3	2	3	3
14 Number of people living there:							3			
15 Condition of property (own assessment):										
16 Domestic facilities:										
17 Journey to clinic:					2W					
18 Journey to GP:					2W					
19 Marital status:										
20 Years known partner:										
21 Years with partner:										
22 Together before child:										
23 Position in own family:										
24 Pregnancy planned?:										
25 Information type:	NI	T	NI	R	I		NI	NI	NI	NI

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Fourth Decile contd)									
	40	41	49	73	76	93	99	109	113	125
1 Maternal age at birth:	22	29		19	23	26		30	27	33
2 Type of schooling:	2	3		2	1	2		1	1	1
3 Age left school:	16	16		16	16	15		15	16	15
4 Qualifications:	0	2		2	1	0		0	1	0
5 Health education:	1	2		1	1	2		2	2	1
6 Previous occupation:	4	5		5	4	4		4	4	3
7 Present occupation:	HW	HW		HW	HW	HW		HW	HW	HW
8 Partner's occupation:	3	4	2	3	3	3		4	5	2
9 Length of time in present accommodation:	1.5	5		1.4	4	2		2	4	2
10 Residences since a child:	3	3		3	5	2		4	6	5
11 Regular contacts in neighbourhood:	2	0		2	3	3		3	1	1
12 Type of property lived in now:	4	2	4	4	2	3		2	2	2
13 Bedrooms:	3	3	3	3	2	2	2	2	2	3
14 Number of people living there:	3	3	3	3	3	3		3	3	3
15 Condition of property (own assessment):	0	3		0	3	3		2	2	3
16 Domestic facilities:	0	7		5	7	6		5	6	6
17 Journey to clinic:	3W	20W		15W	30W	10W		10W	10W	5W
18 Journey to GP:	20B	10C		B	B	5B		15W	15B	5W
19 Marital status:	3	3		3	3	3	0	3	3	3
20 Years known partner:	10	8		4.5	7	8		6.5	10	14
21 Years with partner:	2	5		1.5	4	2		5	4	12
22 Together before child:	0.2	3		0	3	0.2		3	3	11
23 Position in own family:	2:4	1:1		2:2	1:1	1:1		2:3	1:2	2:2
24 Pregnancy planned?:	0	1		0	1	0		1	1	
25 Information type:	T	I	NI	I	I	I	R	T	T	T

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Fourth Dec ctd)					FIFTH DECILE (N= 20):				
	126	129	131	156		9	14	23	26	37
1 Maternal age at birth:	25	21	22	22					29	23
2 Type of schooling:	2	3	3	3					1	3
3 Age left school:	18	16	16	16					16	17
4 Qualifications:	2	2	2	2					0	2
5 Health education:	3	1	0	1					3	2
6 Previous occupation:	5	4	3	4					4	4
7 Present occupation:	HW	HW	HW	HW					HW	HW
8 Partner's occupation:	3	3	3	4			4		4	4
9 Length of time in present accommodation:	3	1.1	2	1					5	4
10 Residences since a child:	2	3	2	3					2	2
11 Regular contacts in neighbourhood:	1	3	1	2					2	3
12 Type of property lived in now:	2	4	2	3		2	2		2	2
13 Bedrooms:	3	3	2	3		3	3		3	3
14 Number of people living there:	3	3	3	3		3	3		3	3
15 Condition of property (own assessment):	3	3	2	2					3	3
16 Domestic facilities:	7	7	7	5					6	6
17 Journey to clinic:	10W	10W	15W	15W					10W	5W
18 Journey to GP:	10B	10W	15W	15C					10W	B
19 Marital status:	3	3	3	3					3	3
20 Years known partner:	11	6	7	15					10	8
21 Years with partner:	3	3	2	4					5	5
22 Together before child:	2	2	0.2	2					4	3.5
23 Position in own family:	1:2	1:2	3:3	1:3						1:2
24 Pregnancy planned?:				1					1	1
25 Information type:	T	T	T	I		NI	NI	NI	T	I

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Fifth Decile cont'd)									
	46	51	63	67	69	74	87	90	115	123
1 Maternal age at birth:	34	30		23	21	33	23		21	23
2 Type of schooling:	1	1		2	1	2	2			1
3 Age left school:	15	15		16	16	17	16		15	16
4 Qualifications:	0	0		2	1	2	0		2	1
5 Health education:	2	1		2	3	2	1		1	2
6 Previous occupation:	5	2		3	4	5	4		5	4
7 Present occupation:	HW	HW		HW	HW	HW	HW		HW	HW
8 Partner's occupation:	4	3	3		3	5	5	2	2	3
9 Length of time in present accommodation:	2	6		0.2	2	1	3.5		2	1.5
10 Residences since a child:	10	2		5	5	3	2		7	4
11 Regular contacts in neighbourhood:	3	3		2	2	3	3		1	3
12 Type of property lived in now:	2	2	2	4	2	2	2		4	4
13 Bedrooms:	3	3	3	2	3	3	3		2	3
14 Number of people living there:	3	3		5	3	3	3		3	3
15 Condition of property (own assessment):	3	3		2	2	3	3		0	3
16 Domestic facilities:	7	7		6	6	7	6		5	6
17 Journey to clinic:	15W	15C		5W	15W	5W	2W		10W	10W
18 Journey to GP:	15B	15C		10W	30B	B	2W		90B	10W
19 Marital status:	3	3		0	3	3	3		3	3
20 Years known partner:	12	15		3	4.5	16	8		3	6
21 Years with partner:	2	9			2	10	3.5		2	4
22 Together before child:	0.7	8			0.7	9	2		1	2
23 Position in own family:	7:8	1:1		2:2	2:4	1:3	3:4		3:5	3:7
24 Pregnancy planned?:	1			0	0	0	0		1	
25 Information type:	I	T	R	T	I	T	I	NI	T	T

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Fifth Decile cont'd)						SIXTH DECILE (N= 11):			
	124	128	132	135	136		10	11	15	22
1 Maternal age at birth:	21	26		21	18					
2 Type of schooling:	1	2		2	2					
3 Age left school:	16	16		18	16					
4 Qualifications:	2	0		3	1					
5 Health education:	2	2		0	2					
6 Previous occupation:	5	4		1	3					
7 Present occupation:	HW	HW		HW	HW					
8 Partner's occupation:	4	3	2	1	0			3	3	
9 Length of time in present accommodation:	2.5	5		1.1	1.1					
10 Residences since a child:	4	2		6	3					
11 Regular contacts in neighbourhood:	1	0		2	1					
12 Type of property lived in now:	2	2		4	4		4		2	
13 Bedrooms:	2	3	2	3	2		3	3	3	3
14 Number of people living there:	3	3		3	3		7	3	3	3
15 Condition of property (own assessment):	3	3		2	1					
16 Domestic facilities:	6	7		6	4					
17 Journey to clinic:	30B	10W		10W	15W					
18 Journey to GP:	30B	10W		15B	15B					
19 Marital status:	3	3		0	3					
20 Years known partner:	2.5	6		4	3					
21 Years with partner:	2	3			1.3					
22 Together before child:	0.5	2			0.1					
23 Position in own family:	1:3	1:2		3:4	9:10					
24 Pregnancy planned?:										
25 Information type:	T	T	L	T	T		NI	L	R	R

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Sixth Decile contd)								SEVENTH DECILE	
	25	52	70	102	106	118	151		3	6
1 Maternal age at birth:		35	29	28	23	27			24	
2 Type of schooling:		3	1	3	1	1			1	
3 Age left school:		18	18	17	16	14			16	
4 Qualifications:		3	3	3	1	1			0	
5 Health education:		2	3	1	1	3			3	
6 Previous occupation:		5	5	5	4	4			4	
7 Present occupation:		5	HW	HW	HW	HW			HW	
8 Partner's occupation:		2	5	3	2	2			4	4
9 Length of time in present accommodation:		3.5	7	3	3	4.5			4	
10 Residences since a child:		6	2	2	4	2			2	
11 Regular contacts in neighbourhood:		2	3	2	3	3			3	
12 Type of property lived in now:		2	2	2	2	2			2	4
13 Bedrooms:	3	3	2	2	2	2			3	3
14 Number of people living there:	3	3	3	3	3	3			3	3
15 Condition of property (own assessment):		3	3	3	3	3			3	
16 Domestic facilities:		7	7	5	6	6			7	
17 Journey to clinic:		20W	10W	20W	3W	20W			15B	
18 Journey to GP:		7W	30W	20B	5B	10W			15B	
19 Marital status:		3	3	3	3	3			3	
20 Years known partner:		5	10	6	7	5			7	
21 Years with partner:		4	7	3	3	4			4	
22 Together before child:		2.5	5	1.5	2	3			3.5	
23 Position in own family:		1:1	1:4	1:1	4:4	3:4			1:2	
24 Pregnancy planned?:		1	1	0		1			0	
25 Information type:	R	I	T	T	T	T	L		T	R

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Seventh Decile contd) 24	38	43	64	78	91	141	146	154	157
1 Maternal age at birth:		28	25		22	35	24		23	32
2 Type of schooling:		3	1		2	1	2		3	3
3 Age left school:		18	15		16	15	16		16	18
4 Qualifications:		2	0		0	0	1		3	3
5 Health education:		1	1		1	3	2		3	1
6 Previous occupation:		5	3		4	4	4		5	5
7 Present occupation:		5	HW		HW	HW	HW		5	5
8 Partner's occupation:		4	3	5	3	4	3	2	3	5
9 Length of time in present accommodation:		3.5	2		0.6	7	1.5		1.5	4
10 Residences since a child:		10	5		2	2	3		3	7
11 Regular contacts in neighbourhood:		0	3		2	3	2		3	0
12 Type of property lived in now:		2	2	2	4	2	4		2	2
13 Bedrooms:	2	3	3	3	3	3	3		3	3
14 Number of people living there:	3	3	4		5	3	3		3	3
15 Condition of property (own assessment):		2	3		3	3	3		3	3
16 Domestic facilities:		6	6		6	7	7		7	7
17 Journey to clinic:		10W	1W		2W	15W	2W		2W	20W
18 Journey to GP:		10W	1W		B	5W	2W		2W	20W
19 Marital status:		3	3		1	3	3		3	3
20 Years known partner:		11	5		3	17	4		9	10
21 Years with partner:		9	4		1.5	7	3		1.5	3
22 Together before child:		8	2		0.5	6	2		0.4	2
23 Position in own family:		2:5	2:5		2:4	1:1	1:1		1:2	3:3
24 Pregnancy planned?:		0	1			1			0	1
25 Information type:	NI	T	I	NI	T	I	T	R	T	I

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
			EIGHTH DECILE (N= 15):							
	158		2	7	8	17	30	36	47	48
1 Maternal age at birth:	21		28						18	36
2 Type of schooling:	3		3						1	3
3 Age left school:	16		18						16	16
4 Qualifications:	0		4						1	2
5 Health education:	1		2						2	2
6 Previous occupation:	4		5						4	5
7 Present occupation:	HW		HW						HW	5
8 Partner's occupation:	2		5	4	3	3		5	3	4
9 Length of time in present accommodation:	1.2		3						0.1	1.5
10 Residences since a child:	3		3						3	3
11 Regular contacts in neighbourhood:	3		3						3	3
12 Type of property lived in now:	2		2		2	2		2	4	2
13 Bedrooms:	3		3	3	3	2	3	3	3	4
14 Number of people living there:	3		3	3	3	3			3	3
15 Condition of property (own assessment):	3		3						0	3
16 Domestic facilities:	7		7						4	7
17 Journey to clinic:	2W		20B						5W	10W
18 Journey to GP:	2W		20B						10B	4C
19 Marital status:	3		3						3	3
20 Years known partner:			7						5	22
21 Years with partner:	3		6						2	17
22 Together before child:	2		4						0.4	16
23 Position in own family:	3:3								1:2	1:1
24 Pregnancy planned?:	0		1							0
25 Information type:	I		T	R	NI	NI	R	NI	T	T

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Eighth Decile contd)								NINTH DECILE:	
	56	94	97	127	134	138	144		1	5
1 Maternal age at birth:		29	27	23	25		24		30	24
2 Type of schooling:		2	1	3	1		3		1	1
3 Age left school:		16	15	17	18		16		15	16
4 Qualifications:		2	0	2	2		0		1	1
5 Health education:		2	2	2	2		1		3	3
6 Previous occupation:		4	4	4	4		4		4	4
7 Present occupation:		4	HW	HW	HW		HW		HW	HW
8 Partner's occupation:	3	3	3	0	4		3		3	4
9 Length of time in present accommodation:		4	3	1	5		0.5		1	1
10 Residences since a child:		4	2	3	8		2		4	2
11 Regular contacts in neighbourhood:		3	2	2	3		3		2	3
12 Type of property lived in now:	2	2	2	4	2		4		2	2
13 Bedrooms:	3	3	2	2	2		3		3	
14 Number of people living there:		3	3	3	3		3		3	3
15 Condition of property (own assessment):		3	3	3	2		2		2	2
16 Domestic facilities:		6	6	7	7		6		6	7
17 Journey to clinic:		10W	5W	10W	5W				20W	10W
18 Journey to GP:		10B	30B	10W	5W				10W	10W
19 Marital status:		3	3	3	3	0	3		3	3
20 Years known partner:		10.5	4		11					4
21 Years with partner:		8	3		5		3			
22 Together before child:		7	1		4		2			1
23 Position in own family:		1:2	1:1	3:4	3:3		3:5			1:
24 Pregnancy planned?:		1	1	1			1		0	
25 Information type:	NI	I	T	I	T	R	T		T	T

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Ninth Decile contd) 71	81	101	104	114	137	142	147	152	153
1 Maternal age at birth:	19	20	27		23		24			20
2 Type of schooling:	1	2	1		1		1			2
3 Age left school:	16	16	16		16		15			16
4 Qualifications:	2	0	0		2		0			1
5 Health education:	3	0	3		2		1			2
6 Previous occupation:	4	3	4		5		3			4
7 Present occupation:	HW	HW	HW		HW		HW			HW
8 Partner's occupation:	2	0	3		3	0	0	2		3
9 Length of time in present accommodation:	1.5	1.5	9		4		5.5			0.6
10 Residences since a child:	2	2	3		2		2			5
11 Regular contacts in neighbourhood:	0	3	0		1		3			2
12 Type of property lived in now:	4	3	2		4		3			2
13 Bedrooms:	3	1	3		3		2			2
14 Number of people living there:	3	3	6		3		3			3
15 Condition of property (own assessment):	1	3	3		3		3			
16 Domestic facilities:	6	5	6		6		7			6
17 Journey to clinic:	60W	10W	10W		10W		2W			10W
18 Journey to GP:	60B	10B	10W		20B		10B			10W
19 Marital status:	3	3	3		3		3			3
20 Years known partner:	9	5	3		5		9			2.5
21 Years with partner:	2	2	2		2		5.5			2
22 Together before child:	0.5	1	0.3		1		4			0.4
23 Position in own family:	4:5	1:1	1:1		1:3		6:6			2:3
24 Pregnancy planned?:		1	0		1					0
25 Information type:	T	I	T	R	T	NI	T	NI	R	T

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
				TENTH DECILE (N= 14):						
	155	159			4	13	18	19	61	68
1 Maternal age at birth:	20	20					30	21		23
2 Type of schooling:	3	2					3	2		2
3 Age left school:	16	16					18	16		15
4 Qualifications:	3	0					4	0		0
5 Health education:	2	2					3	3		1
6 Previous occupation:	3	4					5	3		4
7 Present occupation:	HW	HW					HW	HW		HW
8 Partner's occupation:	2	0				2	5	3	3	3
9 Length of time in present accommodation:	0.2	1					2	1.3		1
10 Residences since a child:	3	2					3	3		4
11 Regular contacts in neighbourhood:	1	2					3	2		3
12 Type of property lived in now:	4	4				3	2	2	1	3
13 Bedrooms:	3	3				2	3	3	2	2
14 Number of people living there:	3	3				3	3	3		5
15 Condition of property (own assessment):	3					1	3	3		3
16 Domestic facilities:	7	1					7	7		6
17 Journey to clinic:	10W	5W					10W	10W		15W
18 Journey to GP:	10W	10B					10W	10W		30W
19 Marital status:	0	3					3	3		2
20 Years known partner:	3	3					12	3.5		4
21 Years with partner:	1.5	1.2					4	2		3
22 Together before child:	1.3	0.1					2	0.3		2
23 Position in own family:	1:2	4:7					4:4	1:6		3:4
24 Pregnancy planned?:							1	0		0
25 Information type:	T	T			NI	NI	T	T	NI	T

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Tenth Decile contd)									
	77	89	108	133	139	143	149	150		
1 Maternal age at birth:	20		21	32	30	21	31	23		
2 Type of schooling:	1		1	3	1	3	1	1		
3 Age left school:	15		16	16	15	16	15	16		
4 Qualifications:	0		0	2	0	2	0	0		
5 Health education:	3		2	1	1	1	2	2		
6 Previous occupation:	3		3	1	3	4	3	3		
7 Present occupation:	HW		HW	HW	HW	HW	HW	HW		
8 Partner's occupation:	3	2	2	5	2	3	3	3		
9 Length of time in present accommodation:	4		1	5	6	2	8.5	1.5		
10 Residences since a child:	2		7	4	3	2	2	3		
11 Regular contacts in neighbourhood:	0		3	2	1	3	3	2		
12 Type of property lived in now:	2	1	4	2	2	2	2	4		
13 Bedrooms:	2		3	3	2	3	2	3		
14 Number of people living there:	4		3	3	3	3	3	3		
15 Condition of property (own assessment):	2		0	3	2	3	3	3		
16 Domestic facilities:	3		4	7	5	7	6	7		
17 Journey to clinic:	10B		5W	20B	10W	20W	10W	5W		
18 Journey to GP:	15B		5W	20B	10W	20W	10W	10B		
19 Marital status:	3		3	3	3	3	3	3		
20 Years known partner:	2		13	7	7.5	3.5	12	4		
21 Years with partner:	2		3	5	6	2	8	2		
22 Together before child:	0.7		1	3	5	1	7	0.2		
23 Position in own family:	3:6		1:2	1:3	2:3	1:1	3:6	1:2		
24 Pregnancy planned?:	0		1		1		1			
25 Information type:	I	O	I	T	T	T	T	T		

6.3. PROFILE OF MATERNAL SAMPLE ACCORDING TO SOCIODEMOGRAPHIC FEATURES

Table 1

Age of mother at birth of child

Age Group	FR	% of sub sample
17 - 21	23	26
22 - 26	38	43
27 - 31	18	20
32 - 36	9	10
	* 88	100

* Missing data N = 61
Mean age = 24.5 Range 17 - 36

Table 2

Type of school mother attended

School Type	FR	% of sub sample
Secondary	36	41%
Comprehensive	28	32%
Grammar	22	25%
	* 86	100

* Missing data N = 63

Table 3

Age mother left school

Age	FR	% of sub sample
16+	14	15
before 16	72	82
	* 86	100

* Missing data N = 63

Table 4

Mother's qualifications

Type of qualification	FR	% of sub sample
Professional	2	2
Some exams.	51	58
No qualifications	33	38
	* 86	100

* Missing data N = 63

Table 5

Health education topics studied by mother

Topic studied	FR	% of sub sample
None	4	4
Biology only	28	32
Biology, Domestic Science only	32	37
Biology, Domestic Science, Sex Education only	22	25
Biology, Domestic Science, Sex Education, Baby Care	0	0
	* 86	100

* Missing data N = 63

Table 6

Previous occupation of mother

Occupation Type	FR	% of sub sample
None	2	2
Student	3	3
Farming	1	1
Factory work	18	20
Service Industry	42	48
Professional/semi	20	23
	* 86	100

* Missing data N = 63

Table 7

Current occupation of mother

Occupation Type	FR	% of sub sample
Housewife	78	90
Professional	6	6
Service work	2	2
	* 86	100

* Missing data N = 63

Table 8

Partner/Father's Occupation

Occupation type	FR	% of sub sample
Unemployed	12	9
Unskilled/semi	30	24
Skilled manual	50	40
Non Manual	20	16
Student	1	-
Professional	12	9
	* 125	100

* Missing data N = 24

Table 9

Years spent in present accommodation

Years	FR	% of sub sample
Less than 2	37	43
Between 2 - 4	27	31
Between 4 - 6	15	17
Between 6 - 8	4	6
Between 8 - 10	2	2
	* 85	100

* Missing data N = 64

Table 10

Number of house moves since leaving parental home (mother)

Number of moves	FR	% of sub sample
Less than 3	58	67
4/5	16	18
6/7	7	7
8-10	4	4
	* 85	100

* Missing data N = 64

Table 11

Number of regular contacts mother has in her neighbourhood

Number of Contacts	FR	% of sub sample
0	8	9
1	13	15
2	27	31
3	38	44
	* 86	100

* Missing data N = 63

Table 12

Current property type occupied

Property Type	FR	% of sub sample
Private flat	2	1
Private house	65	56
Council flat	9	7.5
Council house	36	31
NCB house	3	2.5
	* 115	100

* Missing data N = 34

Table 13

Bedrooms available and number of residents

Number of bedrooms	FR	Number of residents						
		3	4	5	6	7	8	10
2	44	35	1x	2x				
3	82	63	1	1x	1x	1x	2x	1x
4		2						
	* 128	100	2	3	1	1	2	1

* Missing data N = 21
x overcrowded accommodation (i.e. more persons than bedrooms)

Table 14

Mothers assessment of property condition

Assessment	FR	% of sub sample
Poor	9	10
Major complaint	5	5
OK	19	22.5
Good	51	60
	* 84	100

* Missing data N = 65

Table 15

Domestic facilities available to mother

Facility	FR	% of sub sample
No HW	5	5
HW only	1	1
HW, FB	1	1
HW, FB, IT,	1	1
HW, FB, IT, C,	5	5
HW, FB, IT, C, WM,	8	9
HW, FB, IT, C, WM, T,	30	35
HW, FB, IT, C, WM, T, Car	34	40
	* 85	100

* Missing data N = 64

HW = Hot Water
FB = Fixed Bath
IT = Indoor Toilet
C = Cooker
WN = Washing Machine
T = Telephone
Car = Car

Table 16

Time taken to visit clinic

Mode of transport	Time taken in minutes: Less than 10	11-30	60+	Total	% of sub sample
Walk	54	23	1	78	91
Bus	2	4		6	7
Car	0	1		1	1
	56 (65%)	28 (32%)	1 (1%)	* 85	100

* Missing data N = 64

Table 17

Time taken to visit G.P.

Mode of transport	Time taken in minutes: Less than 10	15-20	25-30	45-90	Total	% of sub sample
Walk	32	5	3	0	40	50
Bus	13	16	3	3	35	44
Car	2	2	0	0	4	4
	47 (59%)	23 (29%)	6 (7%)	3 (3%)	79	100

* Missing data N = 70

Table 18

Marital status of mother

Status	FR	% of sub sample
Single	10	10
Separated/divorced	3	3
Married	80	85
	* 93	100

* Missing data N = 56

APPENDIX 7

ANALYSIS OF REVISED USER SCALE DATA

Referred to in text 4.4.

Contents

SCORES ON USER SCALE:

KEY TO NOTATION:

S = subject number

X1, X2, X3...X11 = the various items in the scale - i.e.:

X1 = Health Visitor assessments: X2 = takeup of immunisation

X3 = Hearing test X4 = Clinic attendance

X5 = 'Gap score' X6 = Age of baby at start of clinic attendance

X7 = Age of baby at end of clinic attendance X8 = Duration of attendance

X9 = First medical examination X10 = Non-routine contacts with HV

X11 = Non-routine contacts with medical officer in clinic

Y = Total score of combined items on the user scale

S:	X1:	X2:	X3:	X4:	X5:	X6:	X7:	X8:	X9:	X10:	X11:	Y:
1	6	4	0	4	13	15	14	14	4	17	0	91
2	8	4	4	2	12	15	15	15	4	2	1	82
3	8	4	4	1	10	15	13	13	4	5	0	77
4	6	4	4	3	12	15	15	15	4	14	0	92
5	8	4	4	3	12	14	15	14	4	9	0	87
6	4	4	4	3	10	13	15	13	4	7	0	77
7	4	4	0	3	10	13	15	13	4	19	0	85
8	8	4	4	3	9	15	15	15	4	8	0	85
9	8	4	4	2	9	12	15	12	4	3	0	73
10	8	4	0	1	10	15	15	15	4	2	0	74
11	8	4	4	2	9	14	15	14	4	1	1	76
12	6	4	0	1	6	12	15	12	4	1	0	61
13	8	4	4	5	12	14	15	14	4	18	0	98
14	6	4	0	1	8	14	15	14	4	7	0	73
15	8	4	4	2	10	14	15	14	4	0	1	76
16	0	4	0	1	6	14	15	14	4	4	0	62
17	8	4	4	3	9	14	15	14	4	9	0	84
18	6	4	4	4	12	14	15	14	4	16	0	93
19	6	4	4	5	13	14	15	14	4	22	0	101
20	4	2	4	2	8	14	12	11	4	7	0	68

S:	X1:	X2:	X3:	X4:	X5:	X6:	X7:	X8:	X9:	X10:	X11:	Y:
21	6	0	0	1	4	14	14	13	0	3	0	55
22	8	4	4	2	10	14	15	14	0	5	0	76
23	8	4	4	1	6	14	15	14	0	5	0	71
24	8	4	4	2	9	13	15	13	0	10	0	78
25	8	4	4	2	10	14	15	14	0	5	0	76
26	8	4	4	2	9	14	15	14	0	3	0	73
27	8	4	4	1	7	13	15	13	0	4	0	69
28	4	4	0	0	2	11	6	2	4	0	0	33
29	2	4	4	0	2	13	15	13	4	0	0	57
30	8	4	4	3	10	14	15	14	0	11	0	83
31	0	4	0	0	0	0	0	0	0	0	0	4
32	0	4	0	0	1	12	4	1	4	1	0	27
33	4	4	4	1	6	14	15	12	0	3	0	63
34	2	4	0	2	7	14	15	14	0	9	0	67
35	4	4	4	1	7	14	13	12	4	6	0	69
36	8	4	4	2	13	14	15	14	0	10	0	84
37	4	4	4	1	7	14	15	14	4	6	0	73
38	2	4	4	1	8	14	15	14	4	9	3	78
39	0	4	4	1	4	13	13	11	4	5	2	61
40	0	4	4	1	5	14	14	13	4	6	0	65
41	4	4	0	1	6	14	15	14	4	5	0	67
42	(omitted from sample)											
43	2	4	4	2	11	14	13	12	4	15	0	81
44	0	4	4	1	6	12	15	12	4	3	0	61
45	2	4	0	0	4	14	15	14	4	3	0	60
46	4	4	4	1	7	14	15	14	4	6	0	73
47	4	4	4	2	9	14	15	14	4	12	0	82
48	6	4	4	2	10	14	14	14	4	11	0	83
49	6	2	4	1	5	14	15	14	0	4	0	65
50	2	4	0	0	0	0	0	0	0	0	0	6
51	8	4	4	1	7	13	15	13	4	2	2	73
52	8	4	4	2	6	14	15	14	4	3	2	76
53	(omitted from sample)											
54	(omitted from sample)											
55	2	4	4	0	3	14	5	4	4	1	0	41
56	4	4	4	3	12	14	15	14	4	10	0	84
57	(omitted from sample)											

S:	X1:	X2:	X3:	X4:	X5:	X6:	X7:	X8:	X9:	X10:	X11:	Y:
58	0	4	0	0	2	7	11	3	4	2	0	33
59	0	2	0	0	2	13	4	2	4	2	0	29
60	0	4	4	1	6	14	10	9	4	7	0	59
61	8	4	4	6	13	14	15	14	4	28	1	111
62	6	4	4	0	1	4	12	0	0	0	0	31
63	0	4	4	4	10	14	13	12	4	8	0	73
64	0	4	4	3	10	14	12	11	4	17	0	79
65	0	4	4	0	4	13	11	9	4	3	0	52
66	0	4	0	0	0	0	0	0	4	0	0	8
67	0	2	4	2	10	15	13	15	4	6	0	71
68	8	2	4	3	12	15	15	15	4	15	0	93
69	0	4	4	2	11	14	15	14	4	4	0	72
70	2	4	4	4	9	13	13	11	4	11	0	75
71	8	4	4	3	12	13	15	13	4	13	0	89
72	0	4	0	1	3	12	15	12	4	3	0	54
73	2	4	4	3	8	11	15	11	4	5	0	67
74	4	4	4	3	8	14	15	14	4	2	0	72
75	0	0	0	0	1	13	3	13	0	2	0	32
76	0	4	4	3	8	14	15	14	4	4	0	70
77	6	4	4	7	14	15	15	15	4	41	0	125
78	0	4	4	3	7	15	15	15	4	10	0	77
79	0	4	4	0	4	13	15	13	4	3	0	60
80	2	2	4	0	4	15	15	15	4	3	0	64
81	0	4	4	4	13	14	15	14	4	19	0	91
82	0	4	4	1	3	11	15	11	4	2	0	55
83	2	2	4	0	4	14	10	9	4	0	0	49
84	2	4	4	0	4	14	15	14	4	3	0	64
85	2	4	4	0	3	14	4	3	0	2	0	36
86	0	4	4	0	1	14	2	1	0	1	0	27
87	0	4	4	1	9	14	15	14	4	8	0	73
88	0	4	4	0	3	12	15	12	0	2	0	52
89	2	4	4	4	12	14	15	14	4	22	0	95
90	0	4	4	2	9	14	15	14	4	7	0	73
91	0	4	4	3	12	14	15	14	4	10	0	80
92	0	4	4	1	9	13	15	13	0	4	0	63
93	2	4	4	1	6	13	15	13	4	7	0	69
94	0	4	4	3	12	14	15	14	4	15	0	85

S:	X1:	X2:	X3:	X4:	X5:	X6:	X7:	X8:	X9:	X10:	X11:	Y:
95	0	0	4	1	6	14	11	14	0	6	0	56
96	0	4	4	1	5	14	15	14	0	2	0	59
97	2	4	4	3	10	14	15	14	4	15	0	85
98	0	4	4	0	4	12	15	12	4	3	0	58
99	0	4	0	1	8	14	15	14	4	7	0	67
100	4	4	4	1	7	14	8	7	4	6	0	59
101	0	4	4	6	11	15	15	15	4	15	0	89
102	0	4	4	3	10	13	15	13	0	14	0	76
103	0	4	0	0	3	10	8	3	0	4	0	32
104	0	4	4	3	12	13	15	13	4	18	3	89
105	0	2	4	0	0	0	0	0	0	0	0	6
106	0	4	4	1	9	14	15	14	4	9	1	75
107	(omitted from sample)											
108	0	4	4	3	11	14	15	14	4	22	4	95
109	4	0	4	1	7	14	15	14	0	5	0	64
110	6	0	4	0	1	13	3	1	4	0	0	32
111	0	4	4	0	4	13	12	10	4	3	1	55
112	0	4	0	0	0	0	0	0	0	0	0	4
113	0	4	4	3	9	15	13	13	4	4	1	70
114	0	4	0	5	10	13	12	10	4	27	4	89
115	0	4	4	2	10	13	15	13	4	7	1	73
116	0	4	0	0	4	13	11	9	4	0	0	45
117	0	0	0	0	1	13	3	1	4	0	0	22
118	0	4	4	0	8	14	14	13	4	13	0	74
119	(omitted from sample)											
120	(omitted from sample)											
121	(omitted from sample)											
122	(omitted from sample)											
123	0	4	4	5	13	13	15	13	4	2	0	73
124	0	4	4	2	9	14	15	14	4	6	0	72
125	0	4	4	3	11	14	13	12	4	4	0	69
126	0	4	4	2	7	14	15	14	4	3	0	67
127	0	4	4	8	14	15	15	15	4	6	0	85
128	0	4	4	3	12	15	14	14	4	3	0	73
129	0	4	4	3	12	14	14	13	4	2	0	70

S:	X1:	X2:	X3:	X4:	X5:	X6:	X7:	X8:	X9:	X10:	X11:	Y:
130	0	4	4	1	8	14	15	14	4	0	0	64
131	0	4	4	2	10	15	15	15	4	1	0	70
132	0	4	4	3	11	15	15	15	4	2	0	73
133	8	4	4	7	13	15	15	15	4	20	0	105
134	8	4	4	2	9	14	15	14	4	7	1	82
135	8	4	4	1	6	14	15	14	4	3	0	73
136	8	4	4	1	9	13	15	13	4	2	0	73
137	8	4	4	3	10	15	15	15	4	9	0	87
138	6	2	4	3	11	15	15	15	4	10	0	85
139	8	4	4	9	14	8	15	15	4	22	0	103
140	6	2	4	0	2	8	13	6	4	1	0	46
141	8	4	4	2	8	14	15	14	4	7	0	80
142	8	4	4	3	12	14	15	14	4	8	0	86
143	8	4	4	6	14	15	15	15	4	12	0	97
144	8	4	4	3	10	15	15	15	4	5	0	83
145	4	4	4	0	3	13	12	10	4	3	0	57
146	8	4	4	2	8	15	15	15	4	5	0	80
147	8	4	4	4	13	15	15	15	4	9	0	91
148	(omitted from sample)											
149	8	4	4	4	13	14	15	14	4	11	1	92
150	8	4	4	6	13	14	15	14	4	16	1	99
151	6	4	4	2	10	15	13	13	4	3	0	74
152	8	4	4	3	12	15	15	15	4	8	2	90
153	8	4	4	2	11	15	15	15	4	10	2	90
154	8	4	4	2	9	14	15	14	4	7	0	81
155	8	4	4	3	13	14	15	14	4	7	1	87
156	6	4	4	0	6	14	13	12	4	2	0	65
157	8	4	4	0	10	14	15	14	4	8	0	81
158	8	4	4	0	8	15	15	15	4	5	0	78
159	8	4	4	0	13	15	15	15	4	8	0	86

7.2. Analysis of revised user scale in study proper

1. The minimum possible score = 0
   The maximum possible score = 134

   i.e. item 1 max score 8
   2 4
   3 4
   4 9
   5 15
   6 15
   7 15
   8 15
   9 4
   10 41
   11 4

(For items 10 & 11 there was no upper limit to HV or CMO contact; in practice the range went up to 41 for item 10, and 4 for item 11 and these have been used to define the upper limit as found in the sample).

2. For the sample studied, the scores range was 4 - 125

3. When the scores on each item were correlated with those for all other items minus that one, significant associations were found indicating that each item was measuring a similar related trend to each other item.

Health Visitor Assessments

In order to discriminate between those who had attended for health visitor assessments at clinic and those who had to be followed up, the health visitor notes at clinic and her own records were scrutinised. Where a mother had not attended, and was followed up at home, this was not counted as an instance of usage, even though the assessment had

been done. For those mothers attending hospital as out patients to have their child monitored, each visit to hospital was counted as an instance of usage, the same as for clinic attendance. Some health visitors routinely preferred to carry out their assessments at the clients home, in which case only where there had been problems in doing this was non uptake counted. Health visitors in the study also pointed out that whenever they visited a client, they would informally check the childs developmental status. For the purposes of the study however, only specific records of assessments formally carried out and recorded as having been done were counted as uptake. These considerations cast some doubt on the validity of the scoring obtained, in that it remains possible that some mothers did have their child assessed for which there is no record, however, if they did so it was not an instance of voluntary uptake in the usual sense in which we are interested in this study.

Table 1, gives a summary of the uptake of health visitor assessments, which when compared with voluntary take up reveals a substantial degree of follow-up by health visitors.

The notion of voluntariness in uptake is very difficult to operationalise for the purpose of the study, but it was considered necessary to attempt to make this kind of distinction in order to separate client initiated from professional initiated uptake. Only when the researcher was satisfied that there had been a problem in uptake (either recorded non-attendance, issued reminders, refusals recorded etc.) was an instance of non-voluntary uptake decided on, in each case. This is not to imply that instances of voluntary uptake are to be regarded as those in which undue pressure or coercion was in

evidence, but simply that the initiative was a professional one rather than from the clients themselves.

From table 1, it can be seen that the majority 78.5% of the sample had 3 or 4 assessments carried out during the first 18 months post natally. Of these, 39% could be considered client initiated i.e. where the mother had been invited to attend and had done so, without any particular intervention on the health visitors part.

Table 1. Health visitor assessments

mothers could score 0, 2, 4, 6 or 8, corresponding to the number of assessments voluntarily taken up 0, 1, 2, 3 or 4 respectively.

Score on scale	No. of assessments	FR.	% of sample	no.voluntarily taken up	% of sample
8	4	83	55.7	44	29
6	3	34	22.8	16	10
4	2	19	12.7	15	10
2	1	7	4.5	16	10
0	0	6	3.9	58	38
		149		149	

The table requires further elaboration to clarify the differences in uptake, between those who voluntarily had assessments carried out, and those who required follow up.

Table 2. Comparison of voluntary and encouraged take up of HV assessments

No. of assessments done	Voluntary take up	% of sample	Encouraged take up	% of sample	T
4	44	29	39	26	83
3	8	5	26	17	34
2	3	2	16	10	19
1	3	2	4	2.6	7
	58	38	85	57	143
			0		
		6			
					149

85 members of the sample required follow up in order to reach the scores they did on uptake

The falling numbers who had assessments done, and the corresponding falling number of voluntary take up reveals that having had one or two assessments done is no guarantee of future take up.

Table 3. Fall in voluntary take up over time

	voluntary	encouraged
of the 143 who had 1 assessment done	91	52
of the 136 who had 2 assessment done	75	61
of the 117 who had 3 assesent done	60	57
of the 83 who had 4 assessment done	44	39

Only 44 members of the sample voluntarily had all 4 assessments done and could be considered ideal users of this service. The remainder all requiring encouragement to a greater or lesser degree, i.e. 29% VS 71%.

Item 2. Immunisation uptake

Immunisation uptake was scored similarly to health visitor assessments, according to voluntary uptake or not. Subjects were scored whether the injection took place or not if they attended for the purpose.

0 = no voluntary uptake
2 = 1 voluntary visit (and or injection)
4 = more than one visit for immunisation

Table 4 Uptake of Immunisations

score on scale	N	%
4	133	89%
2	10	7%
0	6	3%
	149	100

This table again requires a finer breakdown of the total sample N = 149

129 had all immunisations done
14 had some done i.e. 2 or less
6 had none done

Those who had some done, had not finished the course and would be considered unsatisfactory. Of the 6 who had none done, only one child was considered unsuitable for immunisation due to health reasons, the remainder had no recorded immunisations or refused. The majority who attended for some or all sessions, N = 143 did so at clinic. (115 clinic and 28 general practitioner)

The avoidance of whooping cough vaccine

49 persons did not have the whooping cough vaccine.
42 had the rest but not whooping cough. (28% of sample)
6 had none done 4%
1 had attended for some .7%

The majority of the sample voluntarily attended clinic or their general practitioner to have their children satisfactorily immunised. However, a significant number refused the whooping cough vaccine, a feature which is further explored in the qualitative section of the study.

Item 3. Hearing test

Only two scores were possible here, 4 if the test had been carried out either at clinic or at home where the client had voluntarily complied or 0 where follow up was necessary.

Table 5 Uptake of hearing test

Hearing test done	146	voluntarily done	125	83%
hearing test not done	3	requiring encouragement	24	16%
	149			

A small percentage required encouragement in having the hearing test carried out i.e. 16% which is still significant in that it is higher than those requiring immunisation follow up, and priority is placed by health visitors on ensuring this is done, making it a major part of the service. In only 3 cases was it not carried out.

Item 4 Clinic attendance

This was scored according to the percentage of possible attendances for the clinic in question.

Table 6 Attendance at clinic

Score	% of possible attendances	FR	% of sample
9	90-100	1	.4%
8	80-89	1	.4%
7	70-79	2	1.3%
6	60-69	4	2.6%
5	50-59	4	2.6%
4	40-49	8	5.3%
3	30-39	32	21.4%
2	20-29	28	18.7%
1	10-19	34	22.8%
0	0-9	35	23.4%
		149	100%

From the table it can be seen that very few made maximum use of the clinic, by attending each time they could go, or a session was held. In fact only approximately 8% attended for 50% or more of possible visits. The majority 92.6% went less than 50% of possible visits. There is a concentration of persons at the lower end of the scale

i.e. 46% of the sample attended for 19% or less of possible visits. For those attending a clinic where more sessions are offered this means a maximum of 11 visits possible, and for those attending those with fewer sessions this means a maximum of 5 visits possible.

Almost half the sample then attended clinic less than 5 or 11 times in 18 months, indicating that few visits are the norm. It was very unusual for mothers to attend more than 23 times in 18 months, and exceptionally rare for them to attend frequently i.e. attend over 75% of the sessions. It is far from clear what ideal attendance from the professionals view would be like, but this data gives a clear picture of what attendance actually took place in this locality.

Further more detailed information on clinic attendance was collected in order to clarify what patterns were like. The total number of attendances in table 6, gives an overall measure of usage and is a useful indicator of voluntary uptake by the sample. It does not show when the visits took place over the 18 months, or which periods of the childs development were covered by uptake. The following tables go some way towards a more detailed analysis of clinic usage over the 18 months.

Item 5. The 'Gap Score'

This reflects the number of months out of 15 during which the mother did not go to clinic or contact her health visitor. A high score e.g. 15 indicates monthly attendance, there were no months during which service was not used, and a non user would score 0.

Table 7 Continuity of contact with clinic/health visitor

Gap score	No.of missing months	FR	% of sample
15	0	0	0
14	1	4	2.6
13	2	12	8.5
12	3	16	10.7
11	4	8	5.3
		40	27.1
10	5	21	14.0
9	6	17	11.4
8	7	12	8.5
7	8	10	6.7
6	9	12	8.5
		72	49.1
5	10	3	1.9
4	11	11	7.1
3	12	7	4.5
2	13	5	3.2
1	14	6	3.9
0	15	5	3.2
		37	23.8
		149	100

Percentages have been combined to facilitate a clearer perception of the trends. Most members of the sample, approximately 73% had 4 or more months during which they did not make use of the clinic or health visitor. The major grouping (nearly half of the sample) missed between 5 and 9 months, making it less usual to have few (less than 4) or many (less than 9) missing months. For those at the bottom of the table, it can be seen that 23% of the sample did not make use of this service during 10 or more months of the first 15 months of the childs life. For the majority of the time then, the clinic was not attended in any consistent way. Those at the top of the table tended to visit clinic almost every month, and/or see their health visitor in a fairly regular consistent pattern.

Items 6, 7 and 8 Duration of attendance, document the ages at which clinic attendance starts and finishes and the duration of attendance. This means that a mother who attended clinic early and finished late in terms of her childs age at the time, would score more highly than one who came late and finished early.

Table 8 Duration of Attendance

Score	Item 6 age start attending months	FR	% of sample
15	1	29	19.4
14	2	74	49.6
13	3	26	17.4
12	4	7	4.6
11	5	3	2.0
10	6	1	.6
9	7	0	0
8	8	2	1.3
7	9	1	.6
6	10	0	0
5	11	0	0
4	12	1	.6
3	13	0	0
2	14	0	0
1	15	0	0
0	did not go	5	3.3
		149	100

Table 9 Duration of Attendance

Score	Item 7 age end attending months	FR	% of sample
15	15	103	69
14	14	7	4.6
13	13	11	7.3
12	12	6	4.0
11	11	4	2.6
10	10	2	1.3
9	9	0	0
8	8	2	1.3
7	7	0	0
6	6	1	.65
5	5	1	.65
4	4	3	1.9
3	3	3	1.9
2	2	1	.65
1	1	0	0

Table 10 Duration of Attendance

Score	Item 8 months in total	FR	% of sample
15	15	25	16.7
14	14	58	38.9
13	13	23	15.4
12	12	12	7.8
11	11	6	3.9
10	10	3	1.9
9	9	4	2.6
8	8	0	0
7	7	1	.6
6	6	1	.6
5	5	0	0
4	4	1	.6
3	3	3	1.9
2	2	2	1.3
1	1	4	2.6
0	0	6	3.9
		149	100

From the tables it can be seen that most people 86.4% (N = 129) brought their child to clinic for the first time in the first 3 months of its life. Only 5 never went at all and it was unusual to start coming later on, i.e. only 15 people came when their child was over 3 months old.

The majority were still attending when their child was 15 months old, i.e. 69% (103) were still attending whilst 45 had ceased to come. Again only 5 scored zero having never been. Those who preferred not to attend stopped at various points, the earliest was at 2 months and from then on small numbers of people dropped out until the age of 13 months when a more significant number cease attending. When this data is looked at in relation to the duration of attendance (i.e. how many months of the last 16 spanned attendance) the picture is fairly similar. Most people continue to attend for 12 or more months of

their childs life i.e. 78.8% (N = 118). Only 20% attended for less than 11 months duration. 15 people attended for part of the time between 6 and 11 months of their childs life, whilst 16 went for 4 months or less.

It was unusual then, not to make an appearance at clinic, at all, or to attend over only a short period of time. Taken together with table 7 and 6, it seems that it is common for women to attend clinic infrequently over a long period of time, there being long periods of time (between 5 months and 9 months) out of 15 during which they do not attend or see the health visitor. They do not attend every week, or month necessarily but call in every now and then up to the end of the first year, and beyond.

When we look closer at attendance in relation to the age of the child, there are some observable patterns.

Table 11 Pattern of attendance according to age of child

age of child in months

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
no.who attended one or more times at each age	32	95	112	124	104	101	90	86	76	64	67	88	75	46	40
no.who did not attend at each age	116	53	36	24	44	47	58	62	72	84	81	60	73	102	108

X2 = 270.100
df = 14
p< = .001

The distribution is not random, whereby at the beginning (apart from the first month when some may still be in hospital) the number who attend always exceeds those who did not attend up until about the age of 9 months when there are about equal numbers attending and not attending. After this point the figures are reversed, more do not attend than attend except for the 12th month where noticeably more attend. This would coincide with the 12 month assessments and developmental medical for which all would be asked to attend.

A breakdown of the numbers attending each at each month age again reveals a pattern.

Table 12. Frequency of attendance at each age/month

Age in months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
no. who attended once in each age /month	16	24	38	48	49	50	52	54	48	38	47	55	55	34	31
no. who did not attend in each age/month	116	53	36	24	44	47	58	62	72	84	81	60	73	102	108
no. who attended more than once in each age/month	16	71	74	76	55	51	38	32	28	26	20	33	20	12	9

Mothers then (from table 11) were more likely to attend up to their child becoming 9 months old, than thereafter when numbers begin to fall dramatically. When a breakdown of the type of attendance is made in terms of whether mothers attend once per age/month or more than once, an interesting pattern emerges.

In the first few months of the childs life, at ages 2, 3, 4 and 5 months, mothers are much more likely to attend clinic more than once in each age/month. At no other time does the figure for those attending more than once each age/month exceed those who attended only once. The differences in numbers are not great, but reveal a trend in attendance which favours those age/months. Mothers are very unlikely to continue visiting clinic often (i.e. more than one time in each age/month) after their child is 5 months old. The number who did not attend at all in each age month grows as the child gets older, particularly after the 4th month and the 12th month. Those who do attend in each age month are on the whole more likely to go only once. This would be consistent with the attendance figures shown in table 6. i.e. only 34% of the sample went to over 25% of possible visits. The majority 65% went to clinic less than 25% of the times they were on offer. Again table 7 confirms this pattern as it was unusual for a mother to go every month, i.e. only 27% of the sample missed going for 4 or less months, the majority 73% missed more than 4 months in attending. As most mothers continue attending over a period of 12 months, and their rate of visits is low (see table 8, 9, 10) i.e. 78% spread their visits over 12 months of their childs life, it appears that regular (i.e. monthly) attendance is not usual for this group. Rather attendance is concentrated in the early months of the childs life, when mothers are more likely to go more than once in each month and then tails off, there being relatively long periods of time between visits (5-9 months). The total number of visits made by those who attended in each age/month shows a similar pattern.

Table 13 Patterns of Attendance/Age of Child

Age of child/months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
total number of visits in each month by all mothers	54	221	244	258	198	178	143	131	111	101	94	137	104	67	54

More visits were made at ages 2 months, 3 month, 4 month and 5 month and 12 month, as more people attended at these ages, and they visited clinic more than once at these ages, rather than at other ages.

When we look at the age at which attendance began and ended, it is possible to determine more precisely which sorts of patterns are preferred; for example it would be possible for those who come early to clinic (to score well on table 8) to ceease attending early (score badly on table 9). An arbitrary cut off point of 12 was taken on each score for tables 8 and 9, to see how many persons scored 12 or more on both tables, i.e. how many persons were early starters and late finishers. The trend was clear, (table 14). 121 people scored highly on both tables 8 and 9, showing that those who come early to clinic (i.e. at or before child is 4 months old) tend to carry on attending late (i.e. up to 12 months old). This was the most common pattern accounting for 81% of the sample. 16 people came early, but stopped attending early also. It was very unusual for a mother to start attendance after the child was 4 months old if she had not been before that date i.e. only 7 persons did in this study. However, having come to clinic late, 4 continued to attend at least up until

the child was 12 months old. To summarise then early starters tend to be late finishers, but the reverse is not true i.e. late starters are not early finishers.

Table 14 Patterns of Attendance

	Early Start Early Finish	Late Start Early Finish	Late Start Late Finish	Early Start Late Finish	T
FR	16	3	4	121	143
% of Sample	10	2	2.6	81	

Table 10 shows the duration of attendance for the sample as a whole. 118 people (79%) attended for a period in excess of 12 months. Only 10% attended for less than 4 months overall which includes those who never went. Attendance then is spread over a year for most members of the sample.

Item 9. First medical examination

It did not matter for the purposes of this study, when the examination took place, so that if it could be found anywhere in each clients records a score of 4 was given, otherwise (as this is not offered at home) a 0 was entered.

Table 15 Take up of Medicals

score	medical	FR	% of sample
4	recorded	122	81.8%
0	not "	27	18.1%

The majority had the medical examination at some point in their childs first year. Only 27 people had no record of this being carried out.

Item 10. Non-routine contacts with the health visitor

The total number of contacts with care recorded for each person was noted and all routine contacts omitted. These routine contacts did not constitute significant voluntary usage by the mother, or had already been accounted for in the index and they included; weigh only entries at clinic, assessment visits at home, the hearing test entry. Non-routine contacts would be those which could be considered active uptake on the clients part e.g. specific visits to clinic for advice noted on the record card, any routine contact which was accompanied by a consultation with the health visitor or phoning the health visitor with a problem.

Table 16 Non routine contacts with health visitor

No.of non routine contacts	FR	% of sample	
41	1	.6	
28	1	.6	
27	1	.6	
22	3	1.9	
20	1	.6	
19	2	1.3	
18	2	1.3	
17	2	1.3	
16	2	1.3	
15	5	3.2	
14	2	1.3	
13	1	.6	
12	2	1.3	
11	4	2.6	
10	7	4.5	
9	7	4.5	27.5% N=43
8	7	4.5	
7	12	7.8	
6	9	5.8	
5	11	7.1	52.7% N=82
4	9	5.8	
3	19	12.3	
2	16	10.4	
1	8	5.2	86.4% N=134
0	14	9.3	
	149	100	

The range was very wide, from no non-routine contacts at all to 41 where the mother was regularly and constantly visited at home at her request. Most of the interviewees had at least one non-routine contact with the health visitor i.e. 86.4% scored 1 or more. It was unusual for there to be more than 4 though, i.e. half of the sample scored above and below 4, and extremely rare for mothers to seek such a service on more than 9 occasions. i.e. only 27% of the sample scored more than 9.

Most interviewees then were using the health visitor service in a non-routine way, but it was very uncommon for such contacts to be numerous. This table represents non-routine recorded contacts with the health visitor but cannot be considered as definitive in any way. There may well have been other contacts not considered significant enough for entry into the records by health visitors. In the records of home visits by health visitors, again the range is very wide. (These figures do not include inneffective visits.)

Table 17 Home visiting pattern

No.of home visits recorded	Fr.	% sample
1	2	1.3
2	10	6.7
3	18	12.0
4	24	16.1
5	15	10
6	20	30.4
7	8	5.2
8	19	12.3
9	7	4.5
10	7	4.5
11	2	1.3
13	4	2.6
14	2	1.3
15	1	.65
16	2	1.3
17	1	.65
18	1	.65
20	2	1.3
22	1	.65
24	1	.65
33	1	.65
40	1	.65
	149	100

All interviewees were visited at home at some point, but there are wide differences in the number of visits. It was unusual to be visited more than 5 times at home. Half of the sample received 5 or less visits and 78% received 8 or less. It was very unusual to be visited in excess of 15 times, over 91% of the sample fell below that figure. This table adds credence to that showing non-routine contacts with the health visitor, showing a similar pattern, of some extremes and the most common pattern.

Interviewees were even less likely to ring the health visitor at any time to ask for assistance.

Table 18 Number of recorded requests by telephone to Health Visitor

Number of calls	FR	% sample
0	111	74.4
1	18	12.0
2	10	6.7
3	9	6.0
5	1	.6

None rang more than 5 times during the first 18 months, and the vast majority, 74% did not ring at all. 24% rang between 1 and 3 times.

Item 11. Non-routine contacts with the CMO at clinic

These were documented for each interviewee whereby medical examinations and immunisations were omitted from the total number of contacts they had with the CMO.

Table 19 Non Routine Contact with CMO

No. of non routine contacts	FR	% sample
0	128	85.9
1	12	7.8
2	5	3.2
3	2	1.3
	149	100

Mothers were very unlikely to have any but routine contacts with the CMO at clinic, their contacts were limited to specific tasks or medical procedures. Only 12% had any non routine contacts, N = 21 and no one had more than 4. 85.9% had no non-routine contacts at all, showing this to be a rare source of non routine advice or usage by the interviewees.

Comparison of scores on user scale

In order to facilitate comparison between groups, the distribution was divided into deciles, each one reflecting low, medium or high usage.

range of scores = 4 - 125

mean score = 69.65

The scores were ordered into deciles and compared with one another to see if the scoring patterns between each decile group were sufficiently distinct to be treated as separate groups. There were statistically significant differences found which was taken as sufficient justification for treating the decile groupings as distinct.

ITEM ANALYSIS OF ORIGINAL REVISED USER SCALE:

Item:	Section:	r:	t:	df:	p;
1	HV assessments	0.317	4.046	147	0.0002 (HS)
2	Self-initiated HV contact outside clinic	-0.005	0.054	147	0.977 (NS)
3	Immunisation takeup	0.265	3.326	147	0.001 (HS)
4	Hearing test	0.397	5.251	147	<0.0001 (HS)
5	Clinic attendance	0.684	11.369	147	<0.0001 (HS)
6	'Gap score'	0.854	19.937	147	<0.0001 (HS)
7	Baby's age at first attendance	0.593	8.927	147	<0.0001 (HS)
8	Baby's age when last attended clinic	0.732	13.032	147	<0.0001 (HS)
9	Duration of attend-ance	0.757	14.069	147	<0.0001 (HS)
10	Takeup of first medical examination	0.318	4.075	147	0.0002 (HS)
11	'Non-routine'contacts with HV in clinic	0.525	7.488	147	<0.0001 (HS)
12	'Non-routine' contacts with medical officer in clinic	0.215	2.673	147	0.0082 (HS)

(NB: NS = not significant; HS = highly significant. All probability values are two-tailed).

DECISION:

All scalar items correlate with a high significance, except for item 2, which is not significantly correlated and indeed displays a slight negative correlation to the total scale score. Therefore the final version of the user scale will consist of all the above items with the exception of item 2 (i.e. eleven items in all).

ITEM ANALYSIS OF FINAL REVISION OF USER SCALE:

X,Y scores of the main sample (N = 149) were item-analysed using a nonparametric correlation technique (Spearman, C., 1904,1906) and the equation $Y = Y - X_n$ (Oppenheim, A.N., 1966, p. 139) with appropriate correction for tied ranks (Siegel, S., 1956, pp 206--210).

ITEM:	SECTION OF SCALE:	rho;	rho_c:	t:	df:	p:
1	HV assessments	0.296	0.264	3.318	147	<0.01
2	Immunisation takeup	0.492	0.253	3.165	147	<0.01
3	Hearing test	0.499	0.322	4.128	147	<0.001
4	Clinic attendance	0.783	0.779	15.059	147	<0.001
5	'Gap score'	0.844	0.843	19.008	147	<0.001
6	Baby's age at first attendance	0.542	0.506	7.115	147	<0.001
7	Baby's age when last attended clinic	0.613	0.548	7.955	147	<0.001
8	Duration of attendance	0.659	0.647	10.297	147	<0.001
9	Takeup of first medical examination	0.454	0.264	3.314	147	<0.01
10	'Non-routine' contact with HV in clinic	0.616	0.615	9.447	147	<0.001
11	'Non-routine' contact with medical officer in clinic	0.457	0.230	2.871	147	<0.01

NB: All probability values are two-tailed

DECISION:

All scalar items in the final revision of the user scale correlate either significantly ($p<0.01$) or highly significantly ($p<0.001$) with the score obtained from the scale minus that of the item concerned. There is therefore statistical support for the proposition that each item score is predictive of the trend in other item scores.

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INDIVIDUAL SCORES ON REVISED USER SCALE:

SUBJECT:	SCORE:	SUBJECT:	SCORE:	SUBJECT:	SCORE:
FIRST DECILE: (Scores 0-33)					
28	33	59	29	103	32
31	4	62	31	105	6
32	27	66	8	110	32
50	6	75	32	112	4
58	33	86	27	117	22
SECOND DECILE: (Scores 34-57)					
21	55	83	49	116	45
55	41	85	36	140	46
65	52	88	52	145	57
72	54	95	56	29	57
82	55	111	55		
THIRD DECILE: (Scores 58-64)					
12	61	45	60	92	63
16	62	60	59	96	59
33	63	79	60	98	58
39	61	80	64	100	59
44	61	84	64	130	64
FOURTH DECILE: (Scores 65-70)					
20	68	49	65	113	70
27	69	73	67	125	69
34	67	76	70	126	67
35	69	93	69	129	70
40	65	99	67	131	70
41	67	109	64	156	65
FIFTH DECILE: (Scores 71-73)					
9	73	63	73	123	73
14	73	67	71	124	72
23	71	69	72	128	73
26	73	74	72	132	73
37	73	87	73	135	73
46	73	90	73	136	73
51	73	115	73		
SIXTH DECILE: (Scores 74-76)					
10	74	25	76	106	75
11	76	52	76	118	74
15	76	70	75	151	74
22	76	102	76		

SUBJECT:	SCORE:	SUBJECT:	SCORE:	SUBJECT:	SCORE:
SEVENTH DECILE:	(Scores 77-81)				
3	77	64	79	154	81
6	77	78	77	157	81
24	78	91	80	158	78
38	78	141	80		
43	81	146	80		
EIGHTH DECILE:	(Scores 82-85)				
2	82	36	84	97	85
7	85	47	82	127	85
8	85	48	83	134	82
17	84	56	84	138	85
30	83	94	85	144	83
NINTH DECILE:	(Scores 86-91)				
1	91	104	89	152	90
5	87	114	89	153	90
71	89	137	87	155	87
81	91	142	86	159	86
101	89	147	91		
TENTH DECILE:	(Scores 92-125)				
4	92	68	93	139	103
13	98	77	125	143	97
18	93	89	95	149	92
19	101	108	95	150	99
61	111	133	105		

REVISED USER SCALE: STATISTICAL COMPARISON OF DECILES.

COMPARISON:	U:	n_1, n_2:	U_{crit}:	p:
1 Between first and second deciles:	3.5	15,14	36	<0.002 (HS)
2 Between second and third deciles:	0.0	14,15	36	<0.002 (HS)
3 Between third and fourth deciles:	1.5	15,18	51	<0.002 (HS)
4 Between fourth and fifth deciles:	0.0	18,20	76	<0.002 (HS)
5 Between fifth and sixth deciles:	0.0	20,11	37	<0.002 (HS)
6 Between sixth and seventh deciles:	0.0	11,13	20	<0.002 (HS)
7 Between seventh and eighth deciles:	0.0	13,15	32	<0.002 (HS)
8 Between eighth and ninth deciles:	0.0	15,14	36	<0.002 (HS)
9 Between ninth and tenth deciles:	0.0	14,14	32	<0.002 (HS)

NB: HS = highly significant. All significance levels are two-tailed.

COMMENT:

Having ordered a distribution of scores into deciles for descriptive purposes, it is necessary to ascertain whether the scoring differences between adjacent deciles are slight and probably chance-determined: or whether they represent altogether more substantial statistical differences, possibly indicative of critical variations within/between the groups. Accordingly, each decile of scores on the Revised User Scale was subjected to this type of comparison using the Mann-Whitney U test (cf. Mann, H.B. and Whitney, D.R., 1947; Siegel, S., 1956). It became obvious that there exist statistically highly significant differences between scoring patterns in each adjacent decile of scores; differences considerable enough to justify employing these discrete groups for purposes of further comparisons in the content-analytic phase of the study.

REFERENCES:

MANN, H.B. and WHITNEY, D.R. (1947):

On a test of whether one of two random variables is stochastically larger than the other. Ann. Math. Statist., 11, 367-392.

SIEGEL, S. (1956):

Non-parametric Statistics, pp. 116-127 New York: McGraw-Hill.

FIGURE: Shape of User Distribution on Revised User

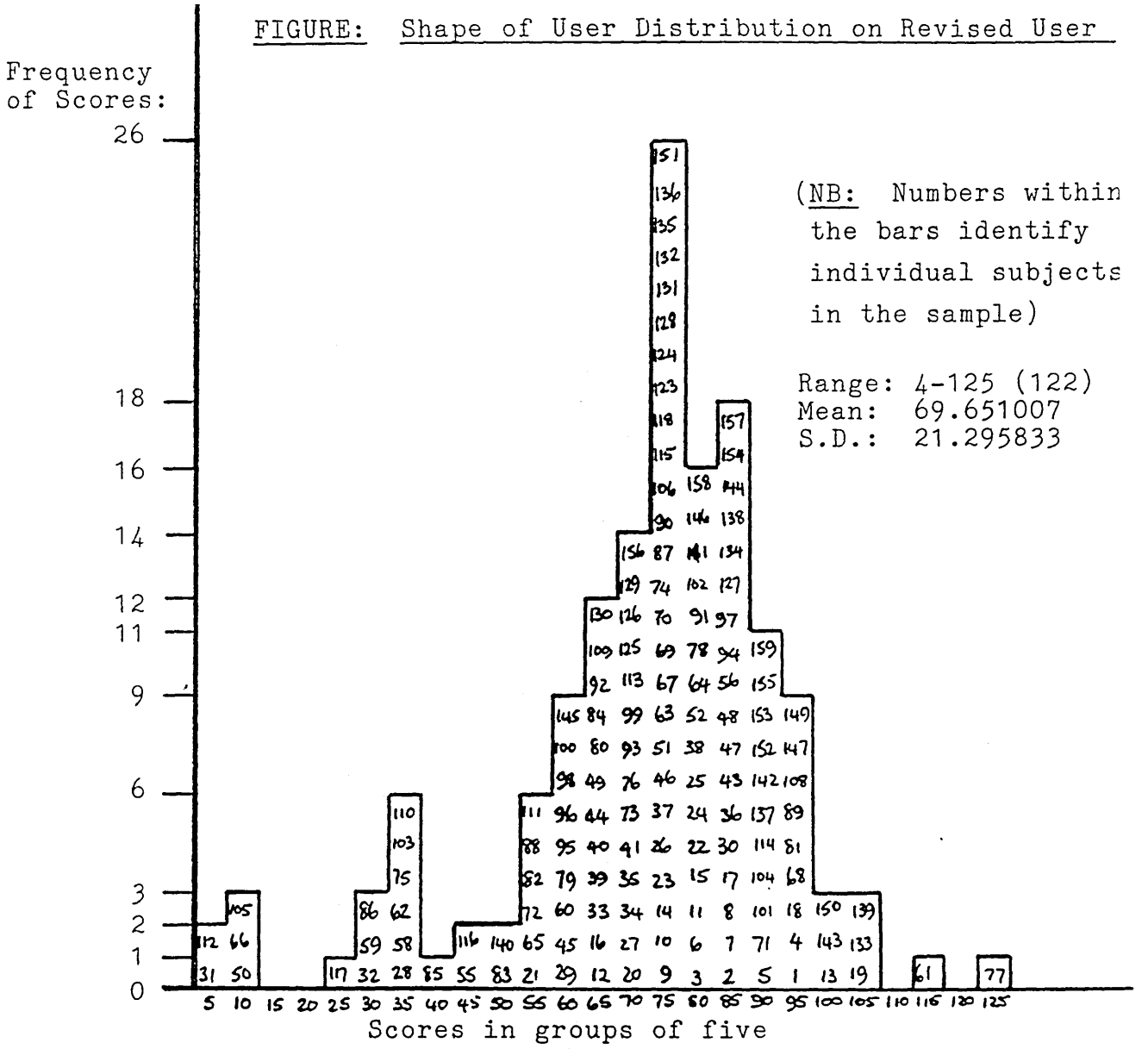

FIGURE: Membership of Deciles

		98	129 131 156	135 136 124 128 132					
110 112 117	140 145	96 100 130	113 125 126	90 115 123		158	134 138 144	155 159	149 150
86 103 105	29 111 116	80 84 92	93 99 109	69 74 87	118 151	146 154 157	94 97 127	147 152 153	133 139 143
62 66 75	85 88 95	45 60 79	49 73 76	51 63 67	70 102 106	78 91 141	47 48 56	114 137 142	77 89 108
50 58 59	72 82 83	33 39 44	35 40 41	26 37 46	22 25 52	38 43 64	17 30 36	81 101 104	19 61 68
28 31 32	21 55 65	12 16	20 27 34	9 14 23	10 11 15	3 6 24	2 7 8	1 5 71	4 13 18
Decile no: 1	2	3	4	5	6	7	8	9	10
Range: 0-33	34-57	58-64	65-70	71-73	74-76	77-81	82-85	86-91	92-125

NB: The number of subjects included in each decile is slightly unequal, due to the need to keep like scores in the same decile (true decile value = 14)

7.8. Typical profiles of usage for each decile group

It is necessary now to show what membership of each decile means in terms of usage.

For decile 1, N = 15, the scores ranged from 4 - 33, a fairly wide range. In terms of usage;

a) none of them had voluntarily taken up the 4 assessments on offer, and 11 had none of them done. The remaining 4 had one or two done.

b) 10 of them had had their immunisations done, 3 had none and the remaining 2 had partially completed the course.

c) 11 did not voluntarily have the hearing test completed

d) None of them scored well on clinic attendance, they did not go either at all, or on more than 2 occasions.

e) Most months of the last 16 were characterised by no contact with the clinic or health visitor

f) 6 of them came to clinic early (scoring over 12) but ceased attending almost immediately. 2 came later and made a subsequent visit around the 12th month/age of their child. The remaining 5 never attended at all.

g) Only one persons attendance at clinic spanned over 12 months, the remainder lasted for one month.

h) 8 did not have a medical examination, 7 having had it done at clinic.

i) 6 had non-routine contact with the health visitor, and none had any non-routine contacts with the CMO at clinic.

In summary then, the only feature of service provision made use of was prophylaxis, they had attended for immunisations either at clinic or their general practitioner. Those scoring over 8 did so because of early attendance at clinic, and having had the medical examination done.

The bottom scorer - score 4 in decile 1

Did not voluntarily take up any health visitor assessments, had her immunisations completed, but did not have the hearing test done, did not go to clinic at all, had no voluntary contact with the health visitor or clinic over the 16 months of the study, did not have a medical carried out or have any non-routine contacts with clinic personnel.

The top scorer - score 33 in decile

Did not voluntarily take up any health visitor assessments, had her immunisations completed, did not have the hearing test done but attended clinic twice, once at 9 months and once at 11 months (age of child). For 14 months she had no contact with the health visitor or clinic. She had her childs medical done and had 2 non routine

contacts with the health visitor, and none with the CMO at clinic. Usage of the services then was minimal for this group, the bare essentials of contact being the only matters contributing scores on the index, namely immunisations.

For the 5th decile N = 20

The range of scores was much less variable. 71-73, giving a fairly homogenous picture for both the top and bottom scorers. Their profile of usage was as follows:

a) 10 (half) of them did not voluntarily take up the 4 health visitor assessments on offer, 6 had them all done and the remaining 4 partially completed them.

b) All but one member had had their immunisations done.

c) only one member did not have the hearing test done.

d) their clinic attendance rate was low, 8 members attended less than 19% of possible sessions (less than 11 or less than 5 visits) whilst the remaining 12 persons attended less than 40% of possible sessions (= less than 29 or less than 14 visits)

e) They all had gap scores below 6, showing that for long periods of time they neither attended clinic nor saw their health visitor.

f) They all however attended clinic early and attended again later in their childs life, giving high scores on duration of attendance.

g) Only 2 members did not have the medical examination

h) None-routine contacts with the health visitor were commonplace, all scoring more than 2, but none scoring more than 8.

i) Only 2 had non-routine contacts with the CMO at clinic.

For the 10th decile N = 14

The scores ranged from 92-125, a wider spread of scores, but the higher score can be attributed to an extreme value on item 10 by one interviewee.

a) Only one member did not voluntarily take up 4 health visitor assessments. 12 of them had 3 or more of them done.

b) Only 1 member had only partially completed immunisation uptake.

c) All members had had the hearing test done.

d) All had attended clinic for more than 39% of possible visits, and 3 members attended for over 79% of possible visits.

e) They all had low rates of gaps in care, showing that they had regular contact with the clinic or health visitor. Any gaps were for less than 4 months of the last 16 months. None had more than 4 missing months.

f) They all attended clinic early in their childs life (usually the first month) and were still attneding when the child was 16 months old, giving their duration of attendance exceeding one year.

g) They all had a medical examination carried out.

h) Non routine contacts with the health visitor were the norm all having had in excess of 11, active instances of uptake in this way.

i) 4 had non routine contacts with the CMO at clinic, so that even for high users this remained a rare point of usage.

The bottom and the top scorers in decile 10 can be distinguished best on items 4 and 10, i.e. clinic attendance and non routine contacts with the health visitor. Both of these pushed up the top scorers score more than any other item.

Each decile contains certain patterns of uptake. Most noticeable is the variability in scores evident in the 1st decile, in contrast to the more homogenous scoring in the 5th and 10th.

In the first decile the high and low scorers showed quite different patterns of usage. Those scoring less than 8 had not been to clinic at all or had not had the medical examination carried out. Those scoring above this had made some contact with the clinic (which was not sustained) early in their childs life and had had the medical done, and/or non routine contacts with the health visitor.

7.9. COMPARISON OF DECILES 1, 5 AND 10 ON EACH FEATURE OF UPTAKE

Table 20 H.V.Assessments

H.V. Assessments	not voluntarily done	some done	voluntarily done
N=15 Decile 1	11	4	0
N=20 Decile 5	10	4	6
N=14 Decile 10	1	5	8

In comparison to the higher deciles 5 and 10, those in the bottom were significantly less likely to have voluntarily had the assessments carried out.

Those in the 5th decile still show a marked reluctance, which is reversed in decile 10, where most voluntarily had them done.

Table 21 Immunisation Uptake

Immunisation uptake	not voluntarily done	some done	voluntarily done
Decile 1	3	2	10
Decile 5	1	0	19
Decile 10	0	1	13

Both users and none users can be seen to have immunisations carried out. Very low numbers in each decile did not voluntarily have them done.

The patterns of uptake change in a regular and ordered fashion as we move from decile 1 to decile 10 e.g.

Although each decile contains members who did not voluntarily have assessments done and those who had some done, the trend is clear. Larger numbers in the lower deciles did not voluntarily go for assessments, whilst large numbers did go for voluntary assessment in the higher deciles. The change seems to occur at the 4/5 decile when voluntary uptake becomes the norm.

Those in the lower deciles (4 and below) were slightly less likely to attend for immunisation uptake, however, the majority in these deciles did go for some at all of them (to either GP or clinic)

Table 22 Hearing Test

Decile	voluntarily done	not voluntarily done
1	4	11
5	19	1
10	14	0

The hearing test scores were significantly different for members of the bottom deciles. They were very unlikely to have voluntarily had this done, whilst almost all those in the upper deciles had.

Table 23 Attendance at clinic

Decile	High	Medium	Low
1	0	0	15
5	0	12	8
10	14	0	0

High - defined as more than 40% of possible attendances
Medium - as between 19% and 40%
Low - as less than 19% of possible attendances

Those in the bottom decile scored low on attendance at clinic, which is reversed for those in decile 10. Those in the 5th decile could still be characterised as low users, none of them scoring above 40% of possible visits.

Table 24 Gap Scores

Decile	low	medium	high
1st	0	0	13
5th	4	9	7
10th	14	0	0

Low - defined as less than 4 months missing
Medium - as less than 6 months and
High - as more than 6 months

Gap scores reflect position on the usage scale exactly.

Those in the 1st decile all had in excess of 6 months out of 16, during which they did not see the health visitor or go to clinic. Of those in the 5th decile most had less than 6 months during which no contact was made, and those in the 10th decile had very infrequent gaps.

Table 25 Early and late attendance at clinic

Decile	Minimum uptake	Medium uptake	Maximum uptake	Non uptake	T
1	9	1	0	5	15
5	0	0	20	0	20
10	0	1	13	0	14

Minimum usage - defined as came early and ceased early, or came late and ceased early
Medium usage - as came late and ceased late.
Maximum usage - as came early and ceased late

There is much more variability in decile one than either of the other 2 deciles. Unlike the other 2, it contained some members who did not go at all, some who came and ceased attending early, came late and ceased attending early, which can all be regarded as evidence of minimal or non usage of the clinic.

Both decile 5 and decile 10 members were concentrated in those having made maximum use of the clinic by attending early and carrying on attending late.

Table 26 Duration of attendance
(time between 1st and last attendance).

Decile	4 mths or less	5 - 11 months	12 months or more	T
1	14	0	1	15
5	0	0	20	20
10	0	0	14	14

Only those in decile 1 had attended clinic for the minimum length of time i.e. less than 4 months. Both deciles 5 and 10 members attended for much longer i.e. 12 months, showing a clear difference between the lower and higher deciles.

Table 27 Medical examination

Decile	done	not done
1	7	8
5	18	2
10	14	0

Decile 1 unlike the others was evenly divided between those who did and did not have the medical carried out. The majority in decile 5 did have it done, whilst decile 10 members all had it done.

Table 28 Non-routine contacts with HV

Decile	none	medium 1-8	high 11
1	9	6	0
5	0	20	0
10	0	0	14

Once again a clear pattern is evident, those in the bottom decile were unlikely to have had any such contact with the HV, and those who did, were more like members of 5th decile in terms of the medium number of contacts characteristic of the group. For members of decile 10, a large number of contacts was the norm, all scored in excess of 11.

Table 29 Non-routine contacts with CMO

Decile	none	medium	high
1	15 all	0	0
5	18	2	0
10	10	4	0

Many non routine contacts with CMO were not found in this study, those who had such contact were confined to deciles 5 and above. For members of decile 1, they did not occur at all.

There is a section then of the sample studied who made less use of all the services monitored by the index. The very low users in the lower deciles were made up of people who had some contact with the services, and those who had none, producing more variable scores in these groups. It is evident then that even in the lowest scoring groups, some attempt to use the services had been made.

APPENDIX B

DIVISION OF DECILES INTO LOW, MEDIUM AND HIGH USER GROUPS

Referred to in text 4.4.4.

Contents

8.1. DIVISION OF DECILES INTO LOW, MEDIUM AND HIGH SCORERS

The deciles were grouped together to facilitate statistical analysis in the following way.

Table 30a Grouped Deciles

	Deciles	N in each decile	T	% of sample
Low Scorers	1	15	44	29.5%
	2	14		
	3	15		
Medium Scorers	4	18	62	41.6%
	5	20		
	6	11		
	7	13		
High Scorers	8	15	43	28.8%
	9	14		
	10	14		
		149	149	

Table 30b Participants in relation to decile membership

	Deciles	No. of participants	T	% of decile
Low Scorers	1	5	19	43
	2	8		
	3	6		
Medium Scorers	4	12	40	64
	5	14		
	6	5		
	7	9		
High Scorers	8	8	28	65
	9	10		
	10	10		
		87		
whole sample		58%		

Lower scorers, all scored well below the mean for the sample as a whole. Medium scorers scored at or around the mean, whilst high scorers scored well above the mean for the sample as a whole.

From the discussion of patterns of usage, those appearing in the lowest decile showed more variability in scoring patterns than the more homogenous scoring for those higher up the scale. It seems then that lower scorers can be regarded as showing at least 2 fairly distinctive kinds of uptake (non uptake), half of them showed profiles of usage which resembled that for the majority of the sample, whilst the other half was relatively different (see discussion of bottom decile). It is then necessary to examine this group more closely, in order to more fully understand kinds of underusage, and thus particular attention was drawn in the qualitative section which presents a detailed and rich comparison of their usage of the services. For comparative purposes in a statistical breakdown though, they were grouped with deciles 2 and 3 to form the lower using section of the sample.

The following tables show how the 3 groups can be contrasted in terms of uptake, showing them to be sufficiently distinct from one another to be treated as separate groups in the analysis. As noted in the paragraph above some within group differences e.g. in the lower deciles are worthy of further analysis.

8.2. COMPARISON OF LOW, MEDIUM AND HIGH SCORERS IN TERMS OF USAGE

% = % of decile membership

* = % of sample overall

Table 31 Voluntary uptake of HV assessments

Usage Group	% of decile group encouraged	% of decile group voluntary	% of decile group some voluntary	T
Low	61%	0%	38	44
Medium	38%	32%	29	62
High	15%	55%	27	43
				149

The 3 groups are quite distinctive in terms of health visitor assessments, none of the lower group had voluntarily had them done. High scorers were very likely to have voluntarily had them done whilst the medium scorers follow the pattern for the sample as a whole.

Table 32 Immunisation uptake

Usage Group	% of decile group encouraged	% of decile group voluntary	% of decile group some voluntary	T
Low	11%	77%	11%	44
Medium	3%	94%	3%	62
High	0%	96%	4%	43
				149

More members of the lower decile group were to be found over represented in those not having voluntarily had them done, or having partial prophylaxis. The percentage having voluntarily had them done in the lower group was below that for the sample as a whole. Middle scorers were more likely to have had them done, whilst still having members who were partial uptkers or non voluntary ones. The highest scoring group has no members in the first column, and exceeds the percentage for the sample as a whole having voluntarily had them done.

Table 33 Hearing test take up

Usage Group	% of decile group encouraged	% of decile group voluntary	T
Low	38%	61%	44
Medium	9%	91%	62
High	7%	93%	43
			149

Only those in the lower scoring groups were under represented in the group who voluntarily had the hearing test carried out. The middle and high scoring group show no marked differences here, both being over represented in those voluntarily having it done.

Table 34 Attendance at clinic

Usage Group	attended 19% or less sessions	attended 20%-40% sessions	attended over 40% sessions	T
Low	100%	0	0	44
Medium	38%	56%	4%	62
High	3%	58%	39%	43
				149

All of those appearing in the low scorers, attended clinic for less than 19% of possible visits, unlike both medium and high scorers who were more likely to have attended clinic for between 20% to 40% of possible visits, whilst high scorers are the only group over represented in the high attendance column. The 3 groups are quite distinct in terms of the number of attendances made at clinic.

Table 35 Gaps in clinic attendance

(% in each decile group).

Usage Group	Less than 4 months	4-6 months	6 months plus	T
Low	0%	2%	98%	44
Medium	6%	48%	45%	62
High	72%	27%	0%	43
				149

High scorers were over represented in those having the fewest gaps in their visiting pattern, making them fairly consistent in take up terms. Medium scorers fall in the middle range of gaps for the sample as a whole, whilst low scorers are over represented in the group

having the largest number of gaps in take up, making them the least consistent attenders. The groups are distinct in their patterns of contact with the services.

Early and late attendance at clinic

Four patterns of usage of the clinic were identified in the data, whereby an interviewee may make minimal use of the clinic by;

1. coming to clinic early in their childs life (i.e. before 4 months) of age, but stop coming early also (i.e. before the child was 12 months old).
2. coming to clinic late (i.e. after child was 4 months old) and ceasing attendance early (i.e. before child 12 months old).

Medium use of the clinic by

3. coming late (i.e. after child was 4 months old) and ceasing attendance late (after 12 months old).

or

maximum use of the clinic by

4. coming to clinic early (i.e. before child was 4 months old) and ceasing attendance late (i.e. after 12 months old).

Table 36 Uptake of clinic sessions
(% of each decile group)

Usage Group	Minimal Uptake		Medium Uptake	Maximum Uptake	T
Type	1	2	3	4	
Low	36%	6%	6%	38%	44
Medium	0	0	0	110%	62
High	0	0	29%	97%	43

The lower scorers were the only group to contain members who did not go at all, or made minimum use of the clinic. Whether they came to clinic early or late in their childs life, they finished coming early also. Unlike medium scorers they could also be found in those who came to clinic late and carried on attending up to 12 months of age. All of the medium scoring group made maximum use of the clinic in terms of attendance, whilst the high scoring group was made up of both medium and maximum attenders.

Table 37 Duration of attendance
(% of each decile group)

Usage Group	less than 4 months	5-11 months	12 months plus	T
Low	36%	22%	40%	44
Medium	0	6%	93%	62
High	0	2%	98%	43
				149

Only the lower scorers contained members who attended for 4 months or less out of the first 16 months of their childs life. They were over represented in those attending for 5 - 11 months of the time and under represented in those attending for over 12 months.

Both medium and high scorers were over represented in the group with longest duration of attendance. Almost all of the higher scorers were in this group.

Table 38 Uptake of medicals

Usage Group	Medical done	Medical not done	T
Low	65%	34%	44
Medium	83%	17%	62
High	95%	5%	43
			149

The 3 sets of scorers were quite distinct on this feature of uptake. The lower scorers were the only ones over represented in those not having had the medical examination and under represented in those having had it done. Middle scorers followed the pattern for the sample as a whole, whilst higher scorers produced exactly the opposite profile to the lower scorers, they were over represented in those having had it done and under reprsented in those who had not.

Non routine contacts with health visitor

(taken to represent particularly active and voluntary uptake by clients)

Table 39 None routine contact with HV
(% of each decile group)

Usage Group	none	few contacts	many contacts	T
Low	29%	70%	0%	44
Medium	1%	80%	17%	62
High	0%	20%	80%	63
				149

The groups of scorers were again quite distinct on this feature of uptake. Only lower scorers were over represented in the group having had no non routine contacts, whilst the higher scorers were over represented in those having had many such contacts.

Table 40 None routine contacts CMO

(% of each decile group).

Usage Group	none	1 - 4 contacts	T
Low	95%	5%	44
Medium	87%	13%	62
High	74%	26%	43
			149

Lower scorers were over represented in those having no non routine contacts with the CMO at clinic, and under represented in those having some contacts. Medium scorers were more like the sample as a whole, whilst high scorers were under represented in those having none and over represented in those having had some. Again the 3 groups of scorers were quite distinct on this feature, higher and lower scorers showing exactly opposite profiles.

From the tabulated comparisons outlined above, there seem to be good grounds for treating the 3 groups of scorers as separate and distinct in terms of usage.

On 7 of the features (items 1, 2, 4, 5, 9, 10 and 11) all 3 groups were quite distinct from one another in scoring patterns. On the remaining 3 items the distinctions were blurred by higher and medium scorers showing broadly similar scoring trends (items 3, 6/7 and 8).

The clear differences are further clouded by those members of the lowest scorers who scored differently from middle scorers, but not in an opposite direction from them.

Table 41 Comparison of scoring trends across usage groups
(Number of features on which the usage groups when compared are similar and disimilar)

Comparisons	similar scoring trends	different + opposing scoring trends	different not opposing scoring trends	different scoring trends
low & medium	0	8	2	10
low & high	0	10	0	10
medium & high	3	5	2	7

a) On all 10 of the features of usage, the higher scoring group and lower scoring group produced scoring patterns which were exactly opposite from each other. Their scoring profiles were quite different and showed opposing trends. The medium scoring group tended to follow the patterns of scoring found for the sample as a whole.

b) Lower scorers displayed quite different and opposing trends in their scoring patterns from the medium scorers on 8 features, and quite different but not opposing trends on the remaining 2 features. On these 2 features (items 5 and 10) a significant percentage of the lower scorers were to be found in the same categories as the majority of the medium scorers.

c) Higher scorers displayed quite different and opposing trends to middle scorers on 5 of the features; similar scoring patterns on 3 features and quite different but not opposing trends on the remaining 2 features. (items 2 and 4).

d) Features of the index identified in the 3rd column od table 41 above were those on which scoring patterns between the groups were different from one another (i.e the percentages for each decile grouping were different from that for the other groups), but where a

significant number of the members of the decile group were to be found in the same categories as the majority of the medium scorers. This indicates that a significant number of the lower or higher groups were behaving in terms of usage, like the majority of members of the medium group on certain features of usage.

e) In terms of the scale then, both lower and higher scoring groups differed markedly from the middle scorers on most features, and from each other on all features.

f) It is worth noting that caution must be excercised with regard to how exceptional the lower and higher scoring groups are seen to be in relation to trends in uptake for the sample as a whole. They are not to be regarded as exceptional in every sense, as on some features of usage, both higher and lower scoring groups can be regarded as part of the majority trends evident in the sample as a whole. On each feature of usage, it was noted (in the section discussing the scale) where the majority of the sample fell.

Table 42 Summary of majority trends

Feature no.	Majority Trends
1	69% had either none or only some voluntary assessments done
2	89% voluntarily took up immunisations
3	83% voluntarily had their hearing test done
4	86% were low or medium attenders at clinic
5	75% had gaps in usage of 4 months or more
6/7	81% started attending clinic early and ceased attending late, i.e. made maximum use of the clinic.
8	79% attended clinic for 12 months or more
9	82% had their medical carried out
10	60% had between 2 and 4 non routine contacts with HV
11	85% had no routine contacts with the CMO at clinic

User groups in comparison to the majority trends

On each feature, the medium scoring group were to be found in with the majority trend. Lower scorers, were very different from this on only 2 features (items6/7 and 8), for most items, a majority of them were to be found in those categories which held the majority of the whole sample. The high scorers, were markedly different from the majority on 4 features (items 1, 4, 5 and 10).

8.3. Summary

The patterns of scoring (in terms of percentages) in each decile grouping, when compared with the patterns of scoring for the sample as a whole, show there to be 3 usage groups which were distinct from one another. These are referred to as low, medium and high scorers. The high and low scoring groups were found to have nothing in common in their patterns of scoring, they scored differently and in opposing directions. They also differed from the medium scoring group on most features of the index.

Clear distinctions are blurred by a), the high and low scoring groups containing significant numbers of members scoring similarly to the majority of medium scorers, and b) high and low scorers appearing with the majority of the sample, on certain features.

APPENDIX 9

FATE OF THE ORIGINAL SAMPLE N = 159

Contents

MAIN MATERNAL SAMPLE: DISPOSAL, EXCLUSIONS AND LOSSES.

Of the original sample of 159 mothers with children in the appropriate age group, ten were excluded at outset for various reasons such as removal from area; change of general practitioner; and possession of children other than the baby born during the selection period. Subsequently two further mothers had to be excluded due to removal from the area but were included in studies of the user scale since basic usage data was obtained prior to their departure. Disposal within the reduced main sample involved in user scale studies was as follows:

FIRST DECILE:	*TOT:*	SECOND DECILE:	*TOT:*
TI: *32,59,112*	3	TI: *21,29,65,72,111,140,145*	7
I: *103,110*	2	I: *95*	1
R: *31,86*	2	R: *116*	1
NI: *28,58,66,75,115,117*	6	NI: *55,82,83*	3
L: *50*	1	L: *85,88*	2
O: *62*	1	O:	0
TOT: (10.07 per cent)	15	TOT: (9.39 per cent)	14
THIRD DECILE:		FOURTH DECILE:	
TI: *12,16,39,44,96*	5	TI: *40,109,113,125-6-9,131*	7
I: *130*	1	I: *41,73,76,93,156*	5
R: *79,100*	2	R: *99*	1
NI: *33,45,60,80,84,92,98*	7	NI: *20,27,34,35,49*	5
L:	0	L:	0
O:	0	O:	0
TOT: (10.07 per cent)	15	TOT: (12.14 per cent)	18
FIFTH DECILE:		SIXTH DECILE:	
TI: *26,51,67,74,115-23-4-8,-35-6*	10	TI: *70,102,106,118*	4
I: *37,46,69,87*	4	I: *52*	1
R: *63*	1	R: *15,22,25*	3
NI: *9,14,23,90*	4	NI: *10*	1
L: *132*	1	L: *11,151*	2
O:	0	O:	0
TOT: (13.40 per cent)	20	TOT: (7.39 per cent)	11
SEVENTH DECILE:		EIGHTH DECILE:	
TI: *3,38,78,141,154*	5	TI: *2,47,48,97,134*	5
I: *43,91,157,158*	4	I: *94,127,144*	3
R: *6,146*	2	R: *7,30,138*	3
NI: *24,64*	2	NI: *8,17,36,56*	4
L:	0	L:	0
O:	0	O:	0
TOT: (8.69 per cent)	13	TOT: (10.07 per cent)	15

NINTH DECILE:	TOT:	TENTH DECILE:	TOT:
TI: *1,5,71,101-14-42-53-55-59*	9	TI: *18,19,68,133-39-43-49-50*	8
I: *81*	1	I: *77,108*	2
R: *104,152*	2	R:	0
NI: *137,147*	2	NI: *4,13,61*	3
L:	0	L:	0
O:	0	O: *89*	1
TOT: (9.39 per cent)	14	TOT: (9.39 per cent)	14

GRAND TOTAL: TI=63 (42.25) I=24 (16.16) R=17 (11.4)
NI=37 (24.75) L= 6 (4.12) O= 2 (1.32) TOT=149

NB: TI: taped interview obtained from informant; I: an interview obtained but not taped; R: refused to be interviewed, either directly or by not keeping repeated arrangements; NI: never in - i.e. the mother was never found at the premises in spite of repeated visits after notes and letters warning of the visit had been delivered; L: 'lost' - i.e. premises found to be empty on arrival; O: omitted from the sample due to removal from area of study.

9.2. FATE OF THE ORIGINAL SAMPLE (N = 149) IN DECILE GROUPS

Table 43 — Fate of original sample
% of each decile group shown

Decile No.	Taped Interview	Interview only	Refusal	Never in	Lost	Ommitted	T
1	20 (3)	13 (2)	13 (2)	40 (6)	6 (1)	6 (1)	15
2	50 (7)	7 (1)	7 (1)	21 (3)	7 (2)	0	14
3	33 (5)	6 (1)	13 (2)	46 (7)	0	0	15
4	38 (7)	27 (5)	5 (1)	27 (5)	0	0	18
5	50 (10)	20 (4)	5 (1)	20 (4)	5 (1)	0	20
6	36 (4)	9 (1)	27 (3)	9 (1)	18 (2)	0	11
7	38 (5)	30 (4)	15 (2)	15 (2)	0	0	13
8	33 (5)	20 (3)	20 (3)	26 (4)	0	0	15
9	64 (9)	7 (1)	14 (2)	14 (2)	0	0	14
10	57 (8)	14 (2)	0	21 (3)	0	7 (1)	14
T	42 (63)	16 (24)	11 (17)	24 (37)	4 (6)	1 (2)	149

Table 44 — Comparison of participants across deciles
(% of each decile group shown)

Decile No.	Participated
1	33 (5)
2	57 (8)
3	40 (6)
4	66 (12)
5	70 (14)
6	45 (5)
7	69 (9)
8	33 (8)
9	71 (10)
10	71 (10)

Table (43) details the fate of each member of the sample according to decile membership. From tables 43 and 44 it can be seen that:

Taped interviews

Only 20% of decile 1 agreed to a taped interview, every other decile group contributed a larger percentage of their membership. In only 4 of the deciles were 50% or more of the members agreeable to a taped interview but these were spread across the usage scale (i.e. deciles, 2, 5, 9 and 10). The remainder contributed a third or more of their members for taped interview. The numbers agreeing to a taped interview then were low, most often less than 50% of the decile agreeing to this, particularly in decile 1 where there was a marked reluctance.

Interviews not taped

The remaining members of the participants who agreed to be interviewed but would not have it taped are spread across the deciles fairly evenly. As a percentage of the decile membership for each group however, it can be seen that non taped interviews were a small contribution to the number participating in each decile.

Refusals

In 6 of the deciles over 10% refused to take part in the study. Decile 10 is exceptional in there being no outright refusals. Deciles 2, 4 and 5 also contributed a small percentage of their membership to the number of refusals. The 6 deciles in which over 10% refused are spread across the usage range, 2 from the lower end of the scale, 2 from the middle and 2 from the upper end. Non users under users and high users then were almost equally likely to refuse participation in the study directly.

Never in

Those whose fate was classified in the 'never in' column can probably be considered as refusals. Even though they did not directly refuse participation, they were never available when the researcher called, and did not acknowledge any message left there. In 8 of the deciles 25% or less of the membership were never available for participation. These are spread across the usage scale (i.e. deciles, 2, 4, 5, 6, 7, 8, 9 and 10). In the remaining 2 deciles over 40% of the membership could not be contacted by the researcher. These were both the lower scoring deciles i.e. 1 and 3, where the percentage 'never in' exceeds both those participating (33.3% and 40% respectively) and those refusing (13.3% and 13.3%). In every other decile more took part than were never found in. Thus those appearing in the lower deciles were extremely difficult to secure for participation in the study.

Lost and omitted

Those persons who were lost to the study were members of the 2 lowest deciles (1 and 2) and the 2 middle deciles (5 and 6), whilst those who were omitted came from deciles 1 and 10. There were no particular patterns then worthy of comment.

9.3. PARTICIPANTS DETAILED BY DECILE MEMBERSHIP

From table 45 it can be seen that decile 1, contributed only 5.7% of those (87) participating in the study, every other decile contributed a higher percentage. Deciles 2, 3, 6 and 8, can also be regarded as having contributed a low percentage of participants to the 87 total. The remainder all contributed over 10% of participants. Deciles 1, 3 and 6 were distinct in that they each contributed relatively low percentages of participants in the study (5.7%, 6.8% and 5.7% respectively).

Table 45 Percentage of each decile to participants in study

Decile No.	Approx. % contribution to participants N = 87
1	5 (5)
2	9 (8)
3	6 (6)
4	13 (12)
5	16 (14)
6	5 (5)
7	10 (9)
8	9 (8)
9	11 (10)
10	11 (10)

Table 46 Comparison of ideal and actual percentage participation

Decile no.	Ideal % Contribution	Actual % Contribution
1	10	5
2	9	9
3	10	6
4	12	13
5	13	16
6	7	5
7	8	10
8	10	9
9	9	11
10	9	11

When the varying number of persons in each decile is taken into account, a more accurate assessment of each deciles participation can be reached. According to the number of persons each decile contributed to the sample as a whole, their ideal percentage contribution to those taking part can be arrived at and contrasted with the actual percentage contributed by each decile. (Table 46). This allows us to see the extent to which each decile was under/over or ideally represented in those participating.

Deciles 1, 3, 6 and 8 were under represented and 7 and 3 were severely under represented in comparison to deciles 6 and 8.

Both the two lower scoring and 2 higher scoring deciles were under represented in the participants. Only the 2nd decile contributed a percentage consistent with the ideal projected for them. The remaining 5 deciles (4, 5, 7, 9 and 10) were on the whole contributing a higher than ideal percentage of participants in the study.

The numbers dealt with in each decile are small, and it is difficult to attach any significance to the figures themselves. However, as the under represented deciles are spread across the usage groups, as are those over represented, there was no consistent relationship between taking part in the study and position on the usage scale. Some high scorers were as likely to take part(and not take part) as low scorers. At the lowest end of the scale the percentage participating was noticeably lower.

There was then no direct link between underusage and poor participation in the study, those preferring not to take part came from high, low, and medium scoring deciles. There was though a tendency for the lower scorers, i.e. under users to prefer not to participate.

When the deciles are grouped together to form the lowest 3, middle 4 and upper 3, (i.e. low, medium and high usage groups) the reluctance to take part in the lower scoring groups can more clearly be seen. (Table 47).

Both the middle scoring and high scoring groups were over represented in the participants, and only the lowest scoring groups were under represented. The differences are not however, so large as to make the

participants in the study a totally biased sample, i.e. biased in favour of the higher scorers, but the under representation of the lowest scoring groups will be taken into account in any interpretations of the findings.

It could still have been possible however, for those participating in the study to be untypical in some way, e.g. they may be a particular part of each decile group. Their scores then on the usage scale were compared, to see if they were typical scorers for their decile.

Table 47 Decile groups percentage participation in relation to sample as a whole

Decile Group	% of Sample (N)	% Participated (N)
Low	29 (25)	22 (19)
Medium	42 (37)	46 (40)
High	29 (25)	32 (28)

Table 48 Mean scores of participants and non participants in each decile

Decile No.	Participants mean score	Whole Decile mean score
1	24.8	21.7
2	54	50.7
3	61	61.2
4	67	67.6
5	72	72.6
6	75.2	75.2
7	79.2	79
8	83.3	83.8
9	88.5	88.7
10	100.3	99.9

Table 48 tabulates the mean scores of participants in each decile, and compares these with the mean score for the decile membership as a whole.

Participants from deciles 1, 2, and 10 scored slightly higher than the

mean score for their decile as a whole. The difference was not large though and when the range of scores is checked it can be seen that participants scored both the highest and lowest scores possible in their respective deciles. So, both ends of each decile were represented in the participants. Only decile 2 remained problematic in that the mean score for participants, exceeded that for the decile membership as a whole, and the lowest scoring participant still scored higher than the lowest scorers in that decile.

Participants from the remaining deciles (3, 4, 5, 6, 7, 8 and 9) produced means consistent with those for their decile as a whole. Participation in these deciles also included the highest and lowest scorers for each group.

APPENDIX 10

SOCIODEMOGRAPHIC COMPARISON OF USAGE GROUPS

Referred to in text 4.4.6.

Contents

CORE MATERNAL SAMPLE: SOCIODEMOGRAPHIC DATA USED IN STATISTICAL COMPARISONS, BY DECILES.

(NB: S = subject number; U = score on user scale; N = nominal scaling, utilised for frequency counts only; O = ordinal data; I = interval data.

		CATEGORY OF DATA:																	
S:	U:	1	2	3	4	5	6	8	9	10	11	12	13-4	15	16	17	18	22	23	24
31	4	34	-	-	-	-	-	3	-	-	-	-	-	-	-	-	-	-	-	-
32	27	22	3	16	2	3	5	5	1	8	2	4	1	2	6	30W	15B	3.5	0	1
59	29	22	2	15	2	2	3	0	1.5	4	2	3	0.66	1	0	5B	5B	0.5	0	0
103	32	23	2	16	1	0	4	2	1.3	4	3	2	0.66	1	2	5W	15B	0.5	1	0
110	32	23	1	16	0	3	4	3	3.0	2	3	4	0.66	3	7	10W	10W	2.0	6	1
112	4	17	2	15	0	1	0	2	1.4	2	3	4	1.00	0	0	10W	15B	0.0	0	0
21	55	30	1	15	0	1	4	3	0.5	7	2	2	1.00	3	7	20W	15B	8.0	1	0
29	57	22	1	16	0	3	4	3	2.0	2	2	5	1.00	2	5	10W	10W	0.5	3	1
65	52	25	2	15	0	2	4	2	1.3	3	2	4	0.66	2	7	5W	10B	1.0	1	1
72	54	20	1	16	0	3	4	0	1.5	2	3	4	0.30	0	0	20W	45B	0.0	5	0
95	56	22	2	17	2	3	4	3	2.5	3	3	2	0.66	3	6	30W	--B	1.0	0	1
111	55	25	2	15	0	1	3	2	1.0	3	3	2	0.66	3	6	20W	10W	0.8	1	0
140	46	24	3	15	0	1	5	3	2.0	2	2	2	0.66	3	7	30W	30W	0.0	2	-
145	57	21	1	16½	2	1	3	0	3.5	3	1	5	0.66	0	0	5W	20B	2.0	3	1
12	61	18	2	15½	2	1	0	2	2.0	2	2	4	0.66	2	4	10W	10W	0.2	2	-
16	62	22	3	15	2	3	3	3	2.0	3	0	5	1.00	0	4	20W	20W	1.0	3	0
39	61	23	2	16	2	3	1	2	3.0	3	2	2	1.00	2	6	10W	10B	1.5	2	1
44	61	23	1	16	0	2	4	3	1.6	2	1	4	1.00	3	7	10W	10B	0.3	0	-
96	59	26	2	16	2	2	5	3	-	-	-	-	-	-	-	-	-	-	-	-
130	64	20	2	-	-	-	-	2	-	-	1	-	-	-	-	2W	-	-	-	-
40	65	22	2	16	0	1	4	3	1.5	3	2	4	1.00	0	0	3W	20B	0.2	2	0
41	67	29	3	16	2	2	5	4	5.0	3	0	2	1.00	3	7	20W	10C	3.0	0	1
73	67	19	2	16	2	1	5	3	1.4	3	2	4	1.00	0	5	15W	--B	0.0	0	0
76	70	23	1	16	1	1	4	3	4.0	5	3	2	0.66	3	7	30W	--B	3.0	0	1
93	69	26	2	15	0	2	4	3	2.0	2	3	3	0.66	3	6	10W	5B	0.2	0	0
109	64	30	1	15	0	2	4	4	2.0	4	3	2	0.66	2	5	10W	15W	3.0	1	1
113	70	27	1	16	1	2	4	5	4.0	6	1	2	0.66	2	6	10W	15B	3.0	1	1
125	69	33	1	15	0	1	3	2	2.0	5	1	2	1.00	3	6	5W	5W	11.0	0	-
126	67	25	2	18	2	3	5	3	3.0	2	1	2	1.00	3	7	10W	10B	2.0	1	-

		CATEGORY OF DATA:																		
S:	U:	1	2	3	4	5	6	8	9	10	11	12	13-4	15	16	17	18	22	23	24
129	70	21	3	16	2	1	4	3	1.1	3	3	4	1.00	3	7	10W	10W	2.0	1	-
131	70	22	3	16	2	0	3	3	2.0	2	1	2	0.66	2	7	15W	15W	0.2	0	-
156	65	22	3	16	2	1	4	4	1.0	3	2	3	1.00	2	5	15W	15C	2.0	2	1
26	73	29	1	16	0	3	4	4	5.0	2	2	2	1.00	3	6	10W	10W	4.0	-	1
37	73	23	3	17	2	2	4	4	4.0	2	3	2	1.00	3	6	5W	--B	3.5	1	1
46	73	34	1	15	0	2	5	4	2.0	10	3	2	1.00	3	7	15W	15B	0.7	1	1
51	73	30	1	15	0	1	2	3	6.0	2	3	2	1.00	3	7	15C	15C	8.0	0	-
67	71	23	2	16	2	2	3	-	0.2	5	2	4	0.40	2	6	5W	10W	-	0	0
69	72	21	1	16	1	3	4	3	2.0	5	2	2	1.00	2	6	15W	30B	0.7	2	0
74	72	33	2	17	2	2	5	5	1.0	3	3	2	1.00	3	7	5W	--B	9.0	2	0
87	73	23	2	16	0	1	4	5	3.5	2	3	2	1.00	3	6	2W	2W	2.0	1	0
115	73	21	-	15	2	1	5	2	2.0	7	1	4	0.66	0	5	10W	90B	1.0	2	1
123	73	23	1	16	1	2	4	3	1.5	4	3	4	1.00	3	6	10W	10W	2.0	4	-
124	72	21	1	16	2	2	5	4	2.5	4	1	2	0.66	3	6	30B	30B	0.5	2	-
128	73	26	2	16	0	2	4	3	5.0	2	0	2	1.00	3	7	10W	10W	2.0	1	-
135	73	21	2	18	3	0	1	1	1.1	6	2	4	1.00	2	6	10W	15B	-	1	-
136	73	18	2	16	1	2	3	0	1.1	3	1	4	0.66	1	4	15W	15B	0.1	1	-
52	76	35	3	18	3	2	5	2	3.5	6	2	2	1.00	3	7	20W	7W	2.5	0	1
70	75	29	1	18	3	3	5	5	7.0	2	3	2	0.66	3	7	10W	30W	5.0	3	1
102	76	28	3	17	3	1	5	3	3.0	2	2	2	0.66	3	5	20W	20B	1.5	0	0
106	75	23	1	26	1	1	4	2	1.0	4	3	2	0.66	3	6	3W	5B	2.0	0	-
118	74	27	1	14	1	3	4	2	4.5	2	3	2	0.66	3	6	20W	10W	3.0	1	1
3	77	24	1	16	0	3	4	4	4.0	2	3	2	1.00	3	7	15B	15B	3.5	1	0
38	78	28	3	18	2	1	5	4	3.5	10	0	2	1.00	2	6	10W	10W	8.0	3	0
43	81	25	1	15	0	1	3	3	2.0	5	3	2	0.75	3	6	1W	1W	2.0	3	1
78	77	22	2	16	0	1	4	3	0.6	2	2	4	0.60	3	6	2W	--B	0.5	2	-
91	80	35	1	15	0	3	4	4	7.0	2	3	2	1.00	3	7	15W	5W	6.0	0	1
141	80	24	2	16	1	2	4	3	1.5	3	2	4	1.00	3	7	2W	2W	2.0	0	-
154	81	23	3	16	3	3	5	3	1.5	3	3	2	1.00	3	7	2W	2W	0.4	1	0
157	81	32	3	18	3	1	5	5	4.0	7	0	2	1.00	3	7	20W	20W	2.0	0	1
158	78	21	3	16	0	1	4	2	1.2	3	3	2	1.00	3	7	2W	2W	2.0	0	0
2	82	28	3	18	4	2	5	5	3.0	3	3	2	1.00	3	7	20B	20B	4.0	-	1
47	82	18	1	16	1	2	4	3	0.1	3	3	4	1.00	0	4	5W	10B	0.4	1	-
48	83	36	3	16	2	2	5	4	1.5	3	3	2	1.33	3	7	10W	4C	16	0	0
94	85	29	2	16	2	2	4	3	4.0	4	3	2	1.00	3	6	10W	10B	7.0	1	1

S:	U:	CATEGORY OF DATA:																		
		1	2	3	4	5	6	8	9	10	11	12	13-4	15	16	17	18	22	23	24
97	85	27	1	15	0	2	4	3	3.0	2	2	2	0.66	3	6	5W	30B	1.0	0	1
127	85	23	3	17	2	2	4	0	1.0	3	2	4	0.66	3	7	10W	10W	-	1	1
134	82	25	1	18	2	2	4	4	5.0	8	3	2	0.66	2	7	5W	5W	4.0	0	-
144	83	24	3	16	0	1	4	3	0.5	2	3	4	1.00	2	6	-	-	2.0	2	1
1	91	30	1	15	1	3	4	3	1.0	4	2	2	1.00	2	6	20W	10W	-	-	0
5	87	24	1	16	1	3	4	4	1.0	2	3	2	0.66	2	7	10W	10W	1.0	0	1
71	89	19	1	16	2	3	4	2	1.5	2	0	4	1.00	1	6	60W	60B	0.5	1	-
81	91	20	2	16	0	0	3	0	1.5	2	3	3	0.33	3	5	10W	10B	1.0	0	1
101	89	27	1	16	0	3	4	3	9.0	3	0	2	0.50	3	6	10W	10W	0.3	0	0
114	89	23	1	16	2	2	5	3	4.0	2	1	4	1.00	3	6	10W	20B	1.0	2	1
142	86	24	1	15	0	1	3	0	5.5	2	3	3	0.66	3	7	2W	10B	4.0	0	-
153	90	20	2	16	1	2	4	3	0.6	5	2	2	0.66	3	6	10W	10W	0.4	1	0
155	87	20	3	16	3	2	3	2	0.2	3	1	4	1.00	1	7	10W	10W	1.3	1	-
159	86	20	2	16	0	2	4	0	1.0	2	2	4	1.00	3	1	5W	10B	0.1	3	-
18	93	30	3	18	4	3	5	5	2.0	3	3	2	1.00	3	7	10W	10W	2.0	0	1
19	101	21	2	16	0	3	3	3	1.3	3	2	2	1.00	3	7	10W	10W	0.3	5	0
68	93	23	2	15	0	1	4	3	1.0	4	3	3	0.40	3	6	15W	30W	0.2	1	0
77	125	20	1	15	0	3	3	3	4.0	2	0	2	0.50	2	3	10B	15B	0.7	3	0
108	95	21	1	16	0	2	3	2	1.0	7	3	4	1.00	0	4	5W	5W	1.0	1	1
133	105	32	3	16	2	1	1	5	5.0	4	2	2	1.00	3	7	20B	20B	3.0	2	-
139	103	30	1	15	0	1	3	2	6.0	3	1	2	0.66	2	5	10W	10W	5.0	1	1
143	97	21	3	16	2	1	4	3	2.0	2	3	2	1.00	3	7	20W	20W	1.0	0	-
149	92	31	1	15	0	2	3	3	8.5	2	3	2	0.66	3	6	10W	10W	7.0	3	1
150	99	23	1	16	0	2	3	3	1.5	3	2	4	1.00	3	7	5W	10B	0.2	1	-
DATA TYPE		I	N	I	C	N	N	N	I	I	O	N	I	N	O	I/N	I/N	I	I	N

NOTE: Two categories need further explanation. The measure given by conflation of categories 13 and 14 gives an index of relative space available in dwellings: i.e. the amount of bedroom space per person living in the property, given by dividing the number of residents by the number of bedrooms. Similarly, the scoring in category 23 represents the number of siblings which a mother may have been involved in bringing up to some extent: given by the number of siblings younger than herself in her parental family.

APPENDIX 10

10.2. STATISTICAL COMPARISON OF USAGE GROUPS ON EACH SOCIODEMOGRAPHIC FEATURE

a) Low, medium, high usage scores were grouped together.

low = deciles 1, 2, and 3
medium = deciles 4, 5, 6 and 7
high = deciles 8, 9 and 10

As the study is dealing with relatively small numbers, categories for comparison were also combined in an attempt to avoid expected frequencies falling below the convention of 5. (Robson 1973, page 88) for X2 calculation.

b) Varying numbers of responses were available for each factor depending on its source, i.e. factors which could be ascertained independently of the interviews show a higher response rate than those dependent on interview for collection. As mentioned earlier 1 tape was faulty rendering the data unuseable so that for most factors N = 86.

c) the factors were chosen as pertinent to the study in order to facilitate comparison with past research on underusage, to see if similar or different trends were in evidence here.

Table 52 Summary of relationships between usage groups and sociodemographic characteristics tested for significance

Usage Groups with factors	X2	df	PL	Significance
1. Age of mother	9.56	4	.05	NS*
2. School type	5.49	4	.30	NS
3. Qualifications	2.02	2	.50	NS
4. Health topics	2.84	2	.50	NS
5. Previous Occupation	3.11	2	.30	NS
6. Partners Occupation	7.77	2	.05	NS*
7. Years in accommodation	3.43	2	.20	NS
8. House moves	4.73	2	.20	NS
9. Contacts	0.3	2	.20	NS
10. Property type	10.80	2	.01	NS*
11. Clinic journey	2.49	2	.30	NS

* Percentage tables were drawn up to investigate trends which almost reached significance

None of the relationships tested reached a significant result, so that caution is necessary in the interpretation of trends noticeble in the data.

Three of the relationships almost reached significance and tabular summaries of the data in percentages allows us to see the trends.

Table 53 Age of Interviewee/Decile Group

(% of each decile group shown)

Decile Group	Age Group		
	17-21	22-26	27-36
Low	25	65	10
Medium	20	42	37
High	35	28	35

High scoring users were more likely to be younger than the rest of the sample, i.e. between ages 17 - 21, whilst lower scorers were older 22

- 26, but not in the oldest group, 27 - 36 years. The trend was not consistent though, and did not reach significance level showing the participants in this study to be tending towards partial confirmation of results found in other studies of underusage. Past research has identified younger mothers as the most likely to underuse the services, here they were one of the higher scoring groups. The partial confirmation lies in the lower users being under represented in the oldest age range of 27 - 36 years.

Table 54 Partners Occupation Across Decile Groups
(% of each decile group shown)

Decile Group	Professional/ Non Manual	Unemployed/ Unskilled
Low	13.8	86
Medium	39	60.7
High	21	78
Whole Sample	26.4	73.6

Those having unemployed, unskilled partners, were slightly over represented in the low usage group (as compared with the sample as a whole) and under represented in the medium scorers. The lower social class groups have consistently been identified as those most likely to underuse the services, and this trend would seem partially confirmatory in this respect. Those with college students, non manual or professional partners were more likely to be members of the medium scoring group, and unlikely (under represented) in the low scoring group. High scorers were made up of both occupational groupings in the same proportions to those for the sample as a whole.

The trends are not marked enough to be significant though, some members of the higher occupational groups underuse the services, but they are more likely to be medium, and not high scorers.

The lower occupational groups are to be found both in the lower and upper usage groups more so than in the medium scoring ones. Those members of the lower occupatinal groups making high usage of the services are rarely commented upon in research on usage.

Table 55 Property type occupied

Usage Group	Private	Rented
Low	33	66
Medium	70	30
High	62	37
Whole Sample	58.2	41

Those underusing the services were over represented in the tied accommodation category, and under represented in the private accommodation category. As another indicator of social class membership, this result is in line with that described in table 54, and the very general findings that underusers are likely to be from the lower end of the social class scale. Those appearing in the private accommodation category are over represented in the medium user deciles again confirmatory of the trends identified in table 54.

Both items 6 and 10 tabulated above were collected as indicators of class membership, in order to make the study comparable to others. 2 other indicators were included for this assessment, the interviewees previous and present occupation.

Previous occupation of interviewee

Table 56 Previous Occupation of Interviewee
(% of decile membership shown)

Decile Group	None	Service Industry	Professional/semi
Low	16%	75	16
Medium	5	62	35
High	3	82	14
Whole Sample	5.8	69	24

Interviewees who had had no previous occupation were over represented in the lower scoring deciles, the professional group was over represented in the medium scoring deciles, and the service industry/factory workers group were over represented in the high scoring deciles. None of these trends were significant but they tend to be confirmatory of those already outlined above. Certain lower social group members tend to underuse the services, i.e. those who were unemployed prior to motherhood. Those employed in service/factory work were both more likely to appear in lower decile groups, or make unusually (for the sample as a whole) high usage of the services. The high users (at least according to this table) from the lower socioeconomic groups were likely to have been employed before becoming mothers rather than unemployed.

Present occupation of interviewee

In addition to being mothers, only 7 members of the sample were also employed outside the home. The remaining 79 for whom data was obtained were full time housewives. There were no comparisons in terms of decile membership possible with such small numbers.

An attempt was made to look at educational qualifications and schooling in relation to usage to allow for comparison with previous research.

Schools attended

Table 57 School Type Attended

Decile Group	Secondary	Comprehensive	Grammar
Low	31	52	15
Medium	40	30	30
High	51	22	25
Whole Sample	41.8	32	25

Less lower scoring interviewees had attended grammar school, most had attended comprehensives, and more middle scorers were to be found having attended grammar school. The differences did not reach significance though, and the only other feature was high scoring interviewees being over represented in the secondary modern school category.

A comparison with school leaving age shows clearer trends:

School leaving age of interviewees

Table 58 School Leaving Ages
(% of decile grouping shown)

Decile Group	Before 16	After 16
Low	94	6
Medium	77	22
High	85	14
Whole Sample	83	16.2

Those who left school at or before the age of 16, were more likely to be found in the lower scoring deciles.

Formal Qualifications of Interviewees

Table 59 Formal Qualifications of Interviewees
(% of decile grouping shown)

Decile Group	No Qualifications	Some Qualifications
Low	50	50
Medium	35	65
High	46	
Whole Sample	41	58

those appearing in the lower deciles were more likely to have no formal qualifications, whilst medium scorers were over represented in the group having qualifications.

Health education was assessed by means of documenting whether or not interviewees had covered subjects considered relevant to child care either in or out of school. They were merely to reflect whether the subjects of human biology, domestic science, sex education or baby care were covered or not (not their knowledge of such matters). There were no differences of any note between decile membership in terms of health education covered by interviewees.

Stability of Living Arrangments

An attempt was made in this study to monitor the 'stability' of living arrangements of the interviewees, as measured by the following features; number of years living in present accommodation, number of home moves made by the interviewee (excluding her parents home), marital status at time of interview, length of time the interviewee had known her childs father; and length of time they have been living together. The results are tabulated below.

Number of years living in present accommodation

Table 60 Years Living in Present Accommodation

Decile Group	Less than 2 years	Over 2 years
Low	52	48
Medium	32	68
High	53	47
Whole Sample	43	57

Both high and low scorers were over represented in those having lived in their present accommodation for less than 2 years. The middle

scorers were more likely to appear in those having lived in their present accommodation for over 2 years. On this table then, both low and high scorers would be considered to have less 'living stability' than medium scorers.

Table 61 Number of times interviewee has moved home
(% of decile group shown)

Decile Group	4 or less	over 4
Low	88	11
Medium	70	30
High	89	10
Whole Sample	80	20

Both high and low scorers were over represented in those having moved house 4 or less times, negating the implied lack of stability found in table 6. They were no more likely to move house many times than any other groups.

Marital status at time of interview

Table 62 Marital Status of Mother
(% of decile group shown)

Decile Group	Single	Separated	Married
Low	21	8	69
Medium	7	2	90
High	6	-	93
Whole Sample	10	-	86

The lower scorers were more likely to be single parents or separated than the sample as a whole, whilst high scorers were more likely to be married. The trends were not significant.

Table 63 Years interviewee has known father of child
(% of decile group shown)

Decile Group	2-4 years	4-6 years	over 6
Low	18	25	56
Medium	12	17	69
High	28	28	44
Whole Sample	18	22	58

High scorers were more likely to have known the childs father for less time than others, whilst medium scorers were more likely to have known him for over 6 years.

Table 64 Years parents have been living together
(% of decile group shown)

Decile Group	less than 2 years	2 - 4	4 - 6	over 6
Low	18	31	12	37
Medium	10	42	31	15
High	7	57	15	19
Whole Sample	11	45	22	21

Lower users were over represented in both extreme groups i.e. those who have been together for less than 2 years and those who have been together for more than 6 years, making assertions with regard to stability of living arrangements very uncertain.

Living conditions were further examined in terms of whether or not interviewees had regular contacts with their family friends and neighbours; the experience of over crowding and domestic facilities available to them. The condition of their home was assessed by the interviewees themselves, as to whether there were problems with their accommodation.

Table 65 Regular contacts in neighbourhood
(% of decile group shown)

Decile	only family	family, & others
Low	22%	77%
Memium	27.5%	72.5%
High	21%	78%
Whole Sample	24%	75.5%

There was no noticeable trend in evidence here.

Overcrowding was assessed in terms of the number of people whose home accommodated more persons than there were bedrooms for. In each decile group 3 persons had problems of overcrowding

Table 66 Condition of property
(% of decile group shown)

Decile Group	poor condition	OK/good
Low	35	64
Medium	10	90
High	15	85
Whole Sample	16	83

Lower users were over represented in those who assessed their property as very poor, or having a chronic problem e.g. damp, subsidence. Medium users were more likely to be content with their home.

Table 67 Domestic facilities available
(% of decile group shown)

Decile Group	no washing machine/ telephone or car	all facilities
Low	41	59
Medium	5	95
High	14	86
Whole Sample	15	85

lower decile members were over represented in the group having fewer domestic facilities, whilst medium users were more likely than others to have access to these 3 facilities.

Table 68 Journey to clinic
(% of decile group shown)

Decile Group	10 or less	over 10
Low	64	36
Medium	60	40
High	77	23
Whole Sample	65	35

It was slightly more likely for high users to live within 10 minutes or less of the clinic, and slightly more likely for the medium users to live further than 10 minutes away. Again the figures were not significant and the trends inconsistent with the notion that those nearer to clinic will make more use of it.

Table 69 Journey to general practitioner/minutes
(% of decile group shown)

Decile	10 or les	over 10
Low	52	48
Medium	54	46
High	70	30
Whole Sample	59	40

High users were over represented in the group where the general practitioners surgery was less than 10 minutes away, and lower users slightly over represented along with medium users in the group where it took over 10 minutes to get to their general practitioners surgery. The relationship between accessibility and uptake again is not a very robust or consistent one.

On the face of it, the number of house moves would seem more likely to reflect stability of residence, but as both high and low scoring interviewees tended to be younger than medium scorers, maybe this accounts for their lower rate of moves, older people being more likely to have moved house more times. If age were the main determinant of house moves, one could expect higher scorers to show more than lower scorers.

From Table 70 it can be seen that, this was not the case, both low and high scorers having made less house moves. In any case with such small numbers it is difficult to be sure if trends are to be treated seriously or not.

Table 70 Mean ages for each decile
(% of each decile group shown)

Decile Group	Mean Age
Low	22.3
Medium	26
High	24.7
Whole Sample	24.5

10.3. SELECTION OF CASE STUDIES FOR IN DEPTH QUALITATIVE ANALYSIS TABLE 71

Table 71 Fate of members in lowest 2 deciles
N = 29

Fate	Decile 1	Decile 2
Taped interview	2	4
Taped interview/HV	1	2
Interview, not taped	2	1
Never in	6	3
Refused	2	1
Lost	1	2
Omitted	1	0
	15	13

Ideally the researcher would have preferred to present detailed case studies for all those who took part from the lower deciles. In practice this was not possible.

Of the 29 persons falling into the lowest 2 deciles of usage (i.e. scoring 57 or less on the usage index), only 10 taped interviews were obtained. One taped interview was unusable as it had not recorded the interview clearly enough to be transcribed, another 3 were not suitable for analysis as the health visitor was present throughout the interviews, and they were noticeably different in tone and content from the others. This left 6 taped interviews which produced suitable data for analysis, which are presented in the qualitative section on underusers.

APPENDIX 11

TABULATED SUMMARY OF CONTENT ANALYSED INTERVIEW DATA

Referred to in text 5.2. and 5.6.

Contents

11.1 RESPONDENTS VIEWS ON BECOMING A MOTHER AND SERVICE PROVISION

Tabular summary of content analysis

Table 73 Learnt from own family re child rearing

Decile group	yes	no	T
Low	9	8	17
Medium	21	18	39
High	14	14	28
	44	40	84

X2 = 0.099
df = 2
N.S.

Lower scorers were not likely to claim to have learnt from family than any other decile group.

Table 74 Knowledge of provision

Decile group	none FR	some FR	T
Low	10	7	17
Medium	30	10	40
High	18	10	28
T	58	27	85

X2 = 1.741
df = 2
p = 0.419

All groups felt equally uninformed

Table 75 Mothers view of hospital stay

Decile Group	Problem Type 1	2	3	4	5	6	7	8	9	10*
Low	7	7	8	5	1	3	3	3	3	4
Medium	13	11	14	6	4	2	2	6	6	9
High	12	13	3	4	2	8	0	5	9	4
	32	31	25	15	7	11	5	14	9	117

X2 = 23.431
df = 18
no differences between deciles

p = 0.15

* 1 no problems
2 humiliat ed
3 felt neglected
4 staff inept
5 unnecessary pain
6 poor facilities
7 forced against will
8 depressed
9 terrifying experience
10 no rest

There were no significant differences between deciles in reporting problems in hospital stay, (columns 2 - 10) or reporting no problems (column 1). The most frequent reported problems were those of feeling humiliated by the hospital staff feeling neglected by staff and inept staff. These 3 accounted for 43.3% of responses of the remaining 37.5% responses, 21.3% concerned physical hardship e.g. unneccessary pain, poor facilities and lack of rest.

A sizeable minority reported depression and hospitalisation as a terrifying experience.

Table 76 Relationship with midwife

Decile	positive *	negative *	
Low	16	2	18
Medium	36	2	38
High	25	2	27
	77	6	83

X2 = 0.227
df = 2
p = 0.900
no differences

* Positive = knew her well and found her helpful
Negative = afraid of midwife/found her unhelpful

There was a consensus in favour of the midwifery service: being helpful and appreciated by the sample as a whole.

Table 77 Preparation for baby's arrival

Decile	Problem Type None	Housing	Money	Advice	Unmarried
Low	7	7	5	5	2
Medium	26	3	5	2	2
High	14	4	4	4	0
	47	16	14	8	4

X2 = 10.845
df = 8
p< = 0.250

There were no major differences. Over half had no problems. The problems cited were fredom (most frequently reported) houseing, unsuitable, and money problems, poor advice was important for some and being unmarried could be a difficulty.

Table 78 Major worries during first year
(1st few weeks of motherhood)

Decile Group	Worry Type 1	2	3	4	5	6	7	8	*
Low	7	6	3	2	1	4	1	0	
Medium	21	16	16	7	7	8	5	2	
High	16	12	7	7	5	0	0	1	
T	44	34	26	16	13	12	6	3	

* 1 Doing everything correctly
2 Worries made worse with child
3 Could not cope
4 Questioned ability as mother
5 Illness
6 No worries
7 Depression
8 Disfigured

X2 = 13.881
df = 14
p> = 0.500

In early days of motherhood, the interviewees recalled these to be their major worries.

Personal competence as a mother columns (1 + 4) was a major concern, as was worry about being able to cope with increased demands (2 + 3). Only 12 resported no worries, whilst the incidence of depresion was also low here.

The table does give some idea of a mothers major worries which could be taken into account in provision.

Table 79 Summary of problems for whole of first year

	Problem Type					
Decile Group	1	2	3	4	5	*
Low	5	2	2	5	6	
Medium	26	17	3	5	3	
High	13	8	8	3	3	
	44	27	13	13	12	

1. Feeding
2. Illness of baby
3. Immunisations
4. Difficult child
5. None

X2 = 21.989
df = 8
p< 0.01
X2 crit = 20.09

There were differences in reported problems across deciles. More mothers from the lower scorers reported no worries, more mothers in higher scorers reported problems to immunisations, whilst more of the lower scoring mothers reported having a 'cranky' baby. They were less likely to report problems in general, but when asked specifically about possible problems they had them too.

As some of the expected frequencies fell below N = 5 the X2 was invalidated, so comparison of differences in scoring pattern within each decile in relation to that for the sample as a whole was undertaken.

Table 80 Scoring patterns in relation to expected sample frequency from Table 79

Problem Type	Decile Group Low	Medium	High	Expected FR Whole Sample
1	25%	48%	37%	36%
2	10%	31%	22%	21%
3	10%	9%	8%	14%
4	25%	5%	22%	12%
5	30%	5%	8%	14%

X2 = 67.43
df = 8
p< = 0.01

Fewer of the lower scorers reported feeding or illness of baby as their major worries for first year whilst more of the middle scorers did. More lower scorers than would be expected reported immunisation problems. Less middle scorers reported having no problems or a 'cranky' baby. High scorers were more likely to report having a cranky baby.

For the sample as a whole, feeding was by far the most frequently reported problem; followed by illness of their baby and their child just being difficult (sleepless nights, constant crying, difficult to soothe child). Very few reported having no major problem, (11%) after each one had been asked about. Feeding was the most frequently mentioned problem (Confirmatory of Graham 1978 study). Whilst illness of the child was a major source of worry for 1/4 of the sample.

Table 81 Perception of help available

Decile Group	Problem Type 1	2	3	No Problem Type 4	5 *
Low	6	4	4	2	4
Medium	12	9	6	1	11
High	4	9	5	5	6
T	22	22	15	8	21

1 Forced to act alone
2 Not sure where to go
3 Unrealistic preparation
4 Just get on with it
5 Plenty of help

X2 = 7.54
df = 8
p = 0.5

Trying to manage alone because of unsatisfactory advice and being unsure of where to get help were the most frequent perceptions of help and advice. A similar percentage reported having had plenty of help.

Table 82 Types of Financial Problems

Decile Group	Problem Type 1	2	3	4	5	6	7 *
Low	3	8	6	3	4	3	1
Medium	3	18	6	8	5	4	8
High	2	17	6	6	5	2	0
T	8	43	18	17	14	9	9

* 1 No problem
2 Relied on family
3 Outlay
4 Unrealised cost
5 Constant problem
6 OK now
7 Just manage

X2 = 12.26
df = 12
p = 0.4

A small percentage had no financial problems to speak of; reporting that they/their partner was well paid. Most who had problems relied

on their family for back up, whilst the main problems were the initial outlay, being unexpectedly high or the problem of finance being a constant one.

Table 83 Illness of Mother Type

Decile Group	Problem Type 1	2	3	4	5 *
Low	11	7	3	4	0
Medium	23	8	7	3	1
High	16	4	5	4	2
T	50	19	15	11	3

* 1 no time to be ill
2 non specific ailments
3 depression
5 long term

X2 = 5,435
df = 8
p = 0.7 4 disfigurement

The most notable response here was the majority who reported they had not had time to be ill. Irritating problems, infections, pain, flu, rashes, etc. were the kinds of illnesses most frequently reported whilst 15% had found themselves depressed, during this first year and 11% felt disfigured from the pregnancy.

Table 84 Illness of Baby Type

Decile Group	Problem Type 1	2	3	4	5*
Low	9	6	4	3	4
Medium	21	20	12	6	4
High	15	11	4	3	9
T	45	37	20	12	8

* 1 Respiratory
2 Teething
3 Gastro intestinal

X2 = 7.5
df = 8
p = 0.5

The most frequently reported type of illness in children was respiratory type e.g. flu, infection colds) followed by teething problems followed by teething troubles as a major source of concern.

Table 85 Apprehension about clinic

Decile Group	Yes	No *
Low	16	3
Medium	27	13
High	19	9
T	62	25

* Yes = uncertainty/afraid to attend
No = positive expectations

X2 = 3.7
df = 2
p = 0.2

A majority of the respondents were apprehensive about going to clinic in the first place, only (25) i.e. 29% of responses were positive in expectations. They were on the whole uncertain of what it was all about, and some in addition were agraid to go. (table 86)

Table 86 Apprehension about clinic attendance in relation to expected frequency for sample as a whole

	Decile Groups %			Expected %
Apprehensive	Low	Medium	High	For sample
Yes	84	67	67	72
No	16	33	33	27

X2 = 9.84
df = 2
p< .01

Lower scorers were more likely to report feeling apprehensive about attendance (uncertain of what to expect and fearful).

The clinic was regarded as primarily there for the weighing of children, and to a lesser extent as a source of advice, or specific testing. Socialising was not regarded as a particularly major function.

Table 87 Perceived Functions of clinic

Decile Group	Function Type 1	2	3	4	5	*
Low	11	8	4	5	1	
Medium	31	15	15	9	4	
High	23	14	10	6	6	
T	65	37	29	20	11	

1 Weighing
2 Advice
3 Testing
4 Socialising
5 Post natal check up

X2 = 3.63
df = 8
p = 0.000

Lower scorers were more likely than the sample as a whole to report feeling apprehensive about attending clinic (being uncertain of what to expect and fearful) and less likely than the sample as a whole to report no apprehension about attending and positive expectations.

Table 88 Preferred system of attendance

Decile	Pop In	Combined	Appointments	Not Sure
Low	8	3	3	2
Medium	30	6	2	1
High	19	6	0	2
T	57	15	5	5

X2 = 9.4
df = 6
p = 0.2

An overwhelming majority reported preferring the pop in system whereby no appointment is necessary and it is up to the client to choose when to attend. (X2 = 11.719 df 1. p< 0.001).

Table 89 Productivity of Clinic Visit

Decile Group	Non Productive 1	2	Productive 3	4*
Low	7	2	4	4
Medium	17	6	9	5
High	15	4	6	4
	39	12	19	13

* 1 Only for weighing
2 Only as a safeguard
3 Just attend for essentials
4 Enjoy attending

X2 = 1.78
df = 8
p = 0.9

The overwhelming majority felt clinic was a waste of time regardless of whether they continued attending or not. ($X2 = 5.128$, $df = 1$, $p < 0.05$). Very few claimed they enjoyed attending. Those who did not think it a waste of time said it was because they only went when it was absolutely necessary to do so, for specific purposes or that they enjoyed going.

Reasons offered for underusage

The sample were all asked why they thought people didn't go to clinic.

Table 90A Underusage as mothers fault

Decile Group	Mothers failings types 1	2	3 *	T
Low	4	5	1	10
Medium	3	3	3	9
High	7	2	1	10
T	14	10	5	29

* 1. Due to idleness
2. Due to lack of care
3. Due to stupidity

Table 90b Underusage as Services fault

Decile Group	Service failings types 1	2	3	4*	T
Low	3	1	3	3	10
Medium	7	6	9	3	25
High	8	4	6	1	19
T	18	11	18	7	54

* 1. Interfering staff
  2. Staff don' care
  3. Advice is nonsense
  4. Clinic unpleasant

Table 90c Underusage as 'sensible' option

Decile Group	Sensible Options 1	2	3*	T
Low	4	4	2	10
Medium	12	13	6	31
High	8	6	2	16
	24	23	10	57

* 1. No reason to go
  2. No time to go
  3. Must be good reason

X2 = 15.7
df = 18
p = 0.60

Category c) reasons were the most frequently offered; followed by b) and lastly a). There were no links with decile membership, showing a reasonable consensus of views on this matter. Overall it was thought mothers had good reasons for not attending, e.g. it was of no use and they have more important things to do.

When the percentage distribution of responses for each decile was compared with that which would be expected from the sample as a whole; there were significant difference between the percentage frequency patterns for the decile groupings.

Table 90d Reasons for Underusage
Comparison of tables 90a-c with expected sample %

Reasons for Underusage		Decile Group Low	Medium	High	sample expected
A	1	13.3	4.6*	15.3	11.1
	2	16.7*	4.6	4.4	8.5
	3	3.3	4.6	2.2	3.3
B	1	10	10.8	17.8*	12.8
	2	3.3	9.2	8.9	7.1
	3	10	13.8	13.3	12.3
	4	10*	4.6	2.2*	5.6
C	1	13.3	18.5	17.8	16.5
	2	13.3	20*	13.3	15.5
	3	6.8	9.3	4.6	6.

Discrepancies which could be found in the responses and which contributed the highest figures to the X2 are marked *
There were no features of the responses on tables 90a-c which distinguished between the decile groups as a whole, but within each decile group the pattern of responses were found to be significantly distinct from that of the sample as a whole in some ways.

A higher than expected percentage of the lower scorers responses thought underusers did not care enough to attend clinic. Both middle and higher scorers were less likely to offer this as a reason.

Middle scorers were particularly unlikely to suggest underusers were lazy or idle.

Lower scorers were more likely to suggest the unpleasantness of the clinic as a reason for underusage, in contrast to higher users, who were more likely to suggest that it was because of the health visitor's interfering attitude. The middle scorers were more likely to suggest that mothers haven't got the time to go to clinic.

This table does not reflect what each group thought of themselves or underusers exactly, but which popular reason for underusage they invested in. Lower scorers then seemed more aware of the possibility of blame being put on underusers themselves, as uncaring mothers, or to see the clinic as being unpleasant. Middle scorers were more in favour of seeing underusage as a sensitive course of action for busy mothers. Higher scorers, were aware that the health visitor might be regarded as interfering, and unlikely to consider the clinic premises themselves as unpleasant as a popular reason for underusage.

Table 91a The importance of Services at clinic

Decile Group	Affirms Importance	Questions Importance	Denies Importance	T
Low	9	4	1	14
Medium	26	6	6	38
High	25	2	0	27
	60	12	7	79

The majority affirm the importance of checks. When the percentage response (out of responses from each decile group) are tabulated, there is a significant difference between frequency patterns for each decile grouping ($X2 = 35.838$, $df = 4$. $p<.001$

Table 91b Comparison of Table 91a with expected frequencies for sample as a whole

Response Type	Decile Groups % Low	Medium	High	Expected % sample
Affirms	64.3*	68.4	92.6*	75.1
Questions	28.6*	15.8	7.4*	17.26
Denies	7.1	15.8*	0 *	7.63

* indicates where observed freuqency of percentage response was noticeably distinct from the expected frequency percentage for the sample as a whole.

Lower scorers were slightly less likely to acknowledge the importance of health as a whole. Middle scorers were more likely to suggest that the tests could be irrelevant to a mother's real concerns. The higher scorers were unlikely to question either the relevance or importance of the checks.

Table 92a Adequacy of Home Visiting

Decile Group	Infrequent 1	2	3	Frequent 4	5*
Low	6	7	0	0	1
Medium	15	14	5	4	2
High	14	11	3	0	1
T	35	32	8	4	4

* 1. not as often as desired
2. not often but OK
3. only for problems
4. often and valued
5. often and reliable

The majority of responses indicated that the health visitor was not perceived as a frequent visitor, whilst attitudes toward this state of affairs was quite variable. When the percentage responses from each decile are compared there are significant differences in the frequency patterns within the deciles ($X2 = 37.494$, $df = 8$, $p, 0.001$)

Table 92b Comparison of % responses in Table 92a with expected frequency for sample as a whole

Response Type	Decile Group Low	Medium	High	Expected % whole sample
1	42.9	37.5*	48.3*	42.9
2	50 *	35	37.9	40.9
3	0 *	12.5*	10.3	7.6
4	0 *	10 *	0	3.3
5	7.1	5	3.4	5.16

$X2 = 37.4$
$df = 8$
$p< 0.001$

Only higher scorers were more likely to indicate they would like to be visited more often, whilst lower scorers and middle scorers were content with infrequent visiting. Middle scorers were slightly more likely to see increased frequency of visiting as an indication of a problem family, whilst none of the lower scorers mentioned this interpretation. Only middle scorers mentioned being well pleased with the frequent initial visits made by health visitor.

Table 93a Approachability of Health Visitor

Decile Group	Approachable 1	2	3	4	Not Approachable 5	6	7*	
Low	3	6	5	0	2	2	0	18
Medium	12	8	4	5	5	3	4	41
High	11	4	3	1	4	3	3	29
T	26	18	12	6	11	8	7	88

* 1. Yes when necessary
2. Yes experienced and helpful
3. Yes, but mother does not take up
4. Yes, even has HV number to ring
5. No, HV takes no notice
6. No, order mothers around
7. No, never approachable

The most frequently offered response was that the health visitor was approachable, when it was necessary to see her. 20% of the responses were very positive seeing her as a very helpful, whilst a small percentage recognised that the health visitor was meant to be approachable but they would never do so (13%).

A very small percentage of responses indicated the health visitor to be totally unapproachable whilst the other 2 main responses complained of her being rude or ordering interviewees around. When the pattern of responses offered by each decile group are compared there were significant differences. ($X2 = 56.583$, dr = 12, 9, 0.001).

Table 93b Comparison of % responses in Table 93a with expected frequency for sample as a whole

Response Type	Decile Group Low	Medium	High	Expected % Whole sample
1	16.7*	29.3	37.9	27.9
2	33.3*	19.5	13.8*	22.2
3	27.8*	9.7*	10.3*	15.9
4	0 *	12.2*	3.6	5.2
5	11.1	12.2	13.8	12.3
6	11.1	7.3	10.3	9.56
7	0	9.8	10.3	6.7

$X2 = 56.5$
$df = 12$
$p < 0.001$

Lower scorers were less likely than the sample as a whole to see the health visitor as approachable when necessary, and the higher scorers particularly likely to offer this response. The lower scorers also tended to invest in a 'credible' health visitor, i.e. one who was herself an experienced mother - a less likely criteria to be offered by higher scorers. Lower scorers were more likely than average to acknowledge the purported approachability of the health visitor, but add that they would never do so. Middle scorers were keen to report the fact that they had been given the health visitor's telephone number as an example of how approachable she was.

Table 94a Maternal perceptions of health visitor role

Decile Group	Role Types 1	2	3	4	5	6 *
Low	4	7	5	2	1	3
Medium	16	7	6	4	5	4
High	12	3	5	5	4	0
T	32	17	16	11	10	7

* 1. Checks for child abuse
2. Not sure at all
3. Checks homes for cleanliness
4. Familiar with role through work
5. Just visits mothers
6. Problem solver

6. Problem solver

Checking that babies were okay, and not suffering from abuse was by far the most numerous response. The next most frequent response was puzzlement, those not sure what the health visitor was there for. Only 11% knew exactly what she was there for, as a result of their work experiences. The percentage frequency response pattern within each decile group was noticeably in favour of certain interpretations of the health visitor role. (X2 = 45.158, dr = 10, p,0.001

Table 94b Comparison of % responses in Table 84a with expected frequency for whole sample

Response Type	Decile Group Low	Medium	High	Expected % whole sample
1	18.2*	38.1	41.4	32.5
2	31.8*	16.7	10.3	19.6
3	22.7*	14.3	17.2	18
4	9.1	9.5	17.2*	11.9
5	4.5 *	11.9	13.8	10
6	13.7*	9.5	0*	7.7

Lower scorers were less likely to mention the health visitor role as a policing agent with regard to the detection of child abuse, but much more likely to mention her checking for household cleanliness, or to be unsure of her role altogether. Both middle and higher scorers emphasised her policing role in child abuse and not house checking, whilst only higher scorers claimed to understand her role well, which did not include problem solving.

The two features most frequently offered by the interviewees were of the policing type work, checking the child for abuse and the house for cleanliness, giving a picture of health visiting distorted in this direction. These were perceived as the two main features of her role for all respondents.

Table 95 Mothers assessment of baby literature
(Comparison of % responses with expected frequency for whole sample)

Response Type*	Decile Group Low	Medium	High	Expected % whole sample
1	16.7	43.6*	16.7	25.6
2	22.2	20.5	22.2	21.6
3	22.2*	10.3	16.7	16.4
4	27.8	23.1	38.9*	29.9
5	11.1*	2.5	5.5	6.3

X2 = 33.5
df = 8
p< 0.001

* 1. Informative
2. Good for problem solving
3. Of limited use
4. Too General/limited
5. Caused more worry

Responses were almost equally divided between books being regarded as informative and too generalised to be of any use. The most frequent response for both high and low scorers was to find them of no use or limited use, whilst middle scorers found them informative. Lower scorers were particularly likely to regard them as liable to add to one's worries.

Table 96 Relationship with general practitioner
Whole Sample

Reluctance to seek help	Relationship with GP Poor	Good	T
Yes	17	15	32
No	14	41	55
T	31	56	87

X2 = 5.601
df = 1
p< 0.02

For the sample as a whole there was a significant relationship between those expressing a reluctance to seek professional help, and having a

poor relationship with their general practitioner. For lower scorers, the association was especially marked ($X2 = 8.83$, $df = 1$, $p<0.01$).

The same was not true for relationships with midwives, the majority reporting there to be a good one (90%), or for relationships with health visitors, where a majority reported a good one (72%).

Table 97 Respondents Advice to others re clinic attendance

Decile Group	Advice Type 1	2	3	4
Low	80%*	0	6%	13%*
Medium	69%	7%	15%	7%
High	63%	14%	14%*	7%
Expected % whole sample	70%	7.5%	12.3%	9.4%

* 1. Unreservedly would recommend attendance
2. Yes with some reservations
3. No advice is conflicting and unhelpful
4. No, there is nothing to be gained from attendance

Lower scorers were particularly likely to recommend attendance, whilst high scorers were more likely than the sample as a whole to recommend attendance with some reservations.

Table 98 Changes mothers would like to see in provision

Decile Group	Changes recommended type 1	2	3	4	5*
Low	8	5	4	2	6
Medium	14	14	10	10	6
High	13	8	6	7	6
T	35	27	20	19	18

* 1. More care shown towards mothers
2. Change in hospital care
3. Social outlets for mothers
4. Change in HV service
5. Change in medical care

All groups were most concerned about staff showing more care and concern for mothers, and changing practice in hospital procedures towards this end.

Table 99 Mothers major losses since advent of motherhood

Decile Group	Loss Type 1	2	3	4	5*
Low	10	9	6	4	1
Medium	24	12	12	12	3
High	20	8	7	7	3
T	54	29	25	23	7

* 1. Freedom and time to oneself
2. Having ones own money
3. Work outside the home
4. A social life
5. No losses

Freedom and time to oneself were the most frequently mentioned privation, followed by missed personal income and work outside the home.

Table 100 Mothers intentions for change in any future pregnancy

Decile Group	Changes intended type 1	2	3	4	5*
Low	6	4	3	0	1
Medium	27	18	2	0	2
High	17	11	5	1	2
T	50	33	10	1	5

* 1. Not to worry as much
2. Use services differently
3. Breast feed successfully
4. Have a home delivery
5. Don't know

Half of the respondents would be less worried next time, whilst 1/3rd would use the services in a different way, namely by having more control over what happened to them (especially in hospital).

11.2. SIMILARITIES BETWEEN USER GROUPS - SUMMARY

On the following areas no significant differences could be found between the usage groups.

Table 73

There were no differences between groups in relying on family for help and advice, those who could, did regardless of decile membership. It seemed unlikely that underusers could be distinct in this respect.

Table 74

A majority (69%) of respondents felt equally uninformed about the services or what to expect regardless of decile position.

Table 75

The likelihood of reporting a bad hospitalisation was unrelated to subsequent uptake but may have contributed to a general poor expectation of the services.

Table 76

All groups were equally appreciative of the midwifery service

Table 77

There were no differences between groups in terms of the likelihood of having problems in preparing for their childs arrival

Table 78

There were no differences between groups in either the type or likelihood of experiencing problems on first coming home from

hospital, whilst for the year as a whole some differences between percentage responses were found.

Tables 79/80/81

With regard to the frequency with which the most frequently mentioned problems occurred, there were no significant differences between the groups. (tiredness, feeding, sleep loss).

Table 81

There were no differences of note between the groups with regard to their views on help and advice, the sample being more likely to report problems of being unsure of where to go, or finding self reliance the only solution to conflicting, or unsatisfactory help available.

Table 82

There were no differences between usage groups in the reporting of financial difficulties, which had been a problem for most.

Table 83

Illnesses suffered during the year did not produce significant differences between the groups in either incidence or type, most suggesting they had no time to be ill.

Table 84

With regard to illnesses their babies had suffered through the year, there were no significant differences between groups in either incidence or type. Respiratory infections and teething being the most common.

Table 87

All groups were similar in their perceptions of the clinics function, i.e. mainly for weighing and to a lesser extent, for advice, tests, socialising or post natal check ups.

Table 88

All decile groups preferred the pop in system at clinic to any other suggested.

Table 89

There was no difference between the groups in the likelihood of their regarding visits to clinic as a waste of time or their preferences for attendance.

11.3. DIFFERENCES BETWEEN USER GROUPS - SUMMARY

Table 80

There were some differences in the patterns of responses in relation to their usage position with regard to problems they had encountered during the first year as a whole. Lower scorers were less likely than the sample as a whole to report feeding problems or illness of their child as their major concerns. They were more likely to offer 'no problems' as such. Middle scorers were more likely to report feeding and illness of baby as problems and less likely to suggest they had no problems or a 'cranky' baby. High scorers only differed from the sample as a whole in offering having a 'cranky' baby as a major problem.

Table 86

Although there were no significant differences between deciles with regard to apprehension towards clinic attendance, (Table 86b) within the deciles the profile of responses were significantly different from that of the sample as a whole to warrant comment. Only the lower scorers percentage response profile contributed large X2 values, they were more likely to report being apprehensive about attending clinic for the first time (did not know what to expect and were fearful) and less likely to have positive expectations about going.

Table 90b

There were some differences in the profile of responses offered by the different groups with respect to their favoured explanations for underusage (not going to clinic). Lower scorers seemed more aware of the likelihood that underusage could be indicative of an uncaring mother; and that the unpleasant environment at clinic could put people off going. Middle scorers were more inclined to suggest that underusage was a sensible option for a busy mother, whilst higher scorers were more likely to suggest that an interfering health visitor could put people off going.

Table 91b

Lower scorers were more likely to question the validity and importance of the checks and tests carried out at clinic, unlike the higher scorers who were unlikely to question them at all and more likely than any other group to unhesitatingly affirm their importance. Middle scorers were more inclined to suggest that they may not be relevant to a mothers concerns.

Table 92b

Only higher scorers were more likely to indicate that they would like more home visiting from health visitors. Middle scorers tended to stress the supposed link between frequent visits and problem families. Lower scorers in particular were content with few home visits.

Table 93b

Lower scorers were less likely to regard the health visitor as approachable, high scorers being more likely to regard her as approachable. Lower scorers in particular valued an experienced mother as a health visitor. Lower scorers also tended to stress the fact that health visitors were meant to be approachable but were not really.

Table 94b

Lower scorers were less likely to stress the health visitor checking for child abuse, but more likely to stress her checking one's home for cleanliness, or to confess to being unsure of her role altogether. Both middle and higher scorers stressed her role as looking out for child abuse, whilst higher scorers were more likely to claim to knowing all about health visitor roles and relevances.

Table 95

Middle scorers were relatively more likely to regard baby books as informative. Both lower and higher scorers were more likely to regard them as of limited use or no use at all.

Table 96

Lower scorers in particular demonstrated a significant relationship between reluctance to seek professional help and advice and having a poor relationship with their doctor.

Table 97

Lower scorers were more likely to not recommend attendance than the sample as a whole. Higher scorers were more likely to stress its value to those who were desperate for help.

Table 100

Middle scorers were more likely to suggest that they would worry much less should they have another child, and stress that they would make use of the services differently. Lower scorers in particular claimed they would like to get breast feeding right next time round.