

UNDER-UTILISATION OF MATERNAL AND CHILD HEALTH CARE

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*** All identifying names have been omitted throughout
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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 Authority'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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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).

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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).

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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).

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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

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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

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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".

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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.

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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:

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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

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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' receptions, 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

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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:

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"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.

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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,

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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

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"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.

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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

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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.

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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

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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)

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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 sovereignty 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

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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

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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

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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 denegated, 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

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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.

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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.

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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.

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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.

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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.

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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.

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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

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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.

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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

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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.

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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

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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

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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

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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.

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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 aspects, 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

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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

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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

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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, RB 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

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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

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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

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can play to get their own way. This is admittedly unfair to those who are not adept at establishing brief interpersonal relationships 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

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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

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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

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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

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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 compatibility 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

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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).

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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

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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

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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

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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-economic 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;

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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).

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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.

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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 withholding 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 withholding 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,

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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.

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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

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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

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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 derogatory 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.

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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.

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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. Dates (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 considerations, 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 produced 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. (Colliver (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

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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 homogeneity'. 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.

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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

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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

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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

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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 idiosyncratic.

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

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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:

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"...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.

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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.

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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.

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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).

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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

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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; CPAO, 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

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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 take-up and utility of the services during the critical first year of life. There is a tendency for systematic take-up 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

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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.

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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)

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- 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. alcoholism 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 nally.

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 Dates 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

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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

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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

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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.

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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

<u>Item of care</u>	<u>Informant Number</u>					
	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 examination of baby	+	+	+	+	-	-
Attended for Health Visitor's developmental check	+	+	+	+	-	-
2 or more immunisations requested	+	+	+	+	+	+
Total score:	8	9	9	9	7	5

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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

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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 constitutes 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

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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.

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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 child's 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 discriminating 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 mother's 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 child's 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 child's 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, assessment 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 its 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 categorical 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

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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

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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

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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

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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 be 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 exercise 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, Selltitz 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.

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- 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 precategory 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 quantify 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.

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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

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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 exercise 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

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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

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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 discrepancies 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 exercise. 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 desirable 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 overriding 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 seem to 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.

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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 exercise in any sense as the researcher must judge when this is happening to the extent that it 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:

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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;

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'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 interviewer'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 exercise. 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 categorical 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 discharge 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 inaccurate 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 thoughtfully 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 problems 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.

Question construction

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 unbiased 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.

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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 naïve 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 openness and a bracketing of all prejudice are the desired features. Importance is not assigned on the basis of frequency of occurrence 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 users:

'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 desirable 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 exercise 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.

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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.

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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 occurred 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 omitted 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 arbitrary (biased) decisions are guarded against both a painstaking and illuminating task.

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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

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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 omitted 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

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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

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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 idiosyncratic 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.

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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 research.

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.

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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.

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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 sociodemographic data for this sample, mainly because there is no single or consistent record of such

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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 its 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 foreseeable 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).

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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 child's life

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(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 child's 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 child's 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.

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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 child's 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).

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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.

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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 occurrence 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

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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 child's 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 idiosyncratic.

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.

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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 child's 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

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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 child's 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 contribution to underusage. Each score was, however, unambiguous and ascertainable.

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

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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 desirable to make the scores themselves 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 it 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.

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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.

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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.

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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 exercising 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).

Occupation	WHOLE SAMPLE		PARTICIPANTS	
	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		Participants	
	Frequency	%	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	-

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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

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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

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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.

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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.

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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 child's 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).

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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

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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 be 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

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locality over the first 16 months of her child's 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 child's life) was rare

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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

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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.

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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 distinction 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

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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

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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.

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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.

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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

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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.

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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

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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)

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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)

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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%):

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"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 inappropriate 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 predominantly 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 B1, 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 B2, Appendix A11)

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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)

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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)

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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.

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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)

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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).

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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;

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"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) concurred with these sentiments (45%), but continued attending as a safeguard for their child's 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%)

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"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:

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"they said there was something wrong with her child's legs, which upset my friend... when they went to specialist they found nothing wrong, it were a bad diagnosis, 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).

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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)

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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 undesirable 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;

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"Only 6 times isn't very often is it?" (142)

"I don't think 3 times in a child's 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)

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"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 because 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%)

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"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).

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Reluctance to seek advice

Those who claimed they were on the whole reluctant to seek advice and help from the services were further investigated 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;

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"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;

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"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)

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"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%)

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"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.

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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 child's 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

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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 inappropriate 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 child's 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.

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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, preferring to cite having a

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'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 desirable aims i.e. that health visitors are supposed

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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 undesirable. 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

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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.

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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.

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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.

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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 respondent felt competent and in control.

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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).

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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 presumably more acceptable

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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.

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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

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'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 midwives' 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:-

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"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 inappropriate for this group, as this would mean they were a certain sort of person

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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

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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.

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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 even taken round labour suites" (E,79ff)

Such inaccessibility seemed unnecessary 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 (,AB0ff) 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, rattling 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 (AB0ff) 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 child's 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 child's 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 child's 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)

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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 unnecessary 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)

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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;

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"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)

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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.

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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) exceptionally minimal purpose (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) Real help is hard to come by:

Help of any consequence was not forth coming;

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"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)

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Without such real help, mothers are left ignorant and terrified for their own and their child's 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)

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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) They blunder and make mistakes

(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)

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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).

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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 contemptuous 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 noseey", 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 unnecessary 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. The experience of motherhood

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

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"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 child's 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 involve partaking in demeaning situations 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).

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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

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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) The loss of freedom 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.

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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) There can be a significant loss of social contact

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"

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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) There is a loss of variety of roles

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 dissatisfaction springs from an inability to accept such a limited variety of roles imposed by motherhood (E,38-41)

f) Mothers can miss chances to work and progress

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 child's 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 child's welfare must come first

Major worries revolve around the child's 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 child's 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 fulfill 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 husband's 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).

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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've 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 hostile 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), child's 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)

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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. The whooping cough dilemma

The decision to take or avoid the whooping cough vaccine was a major source of anxiety for the interviewees.

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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; "That'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)

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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 child's 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 doctor's 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)

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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).

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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 respectfully 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 child's 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 opaque

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 privileged 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.

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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 unrecognisable. 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 child's 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 accounts, 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 bureaucratic 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 desirable 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 incompetence. 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.

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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.

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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.

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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

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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 (Braham, 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. The concept of alienation may refer to low self esteem

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 child's 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

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(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 prerogative, 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 child's 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 idiosyncratic 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.

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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

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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. Proffered 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.

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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.

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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. The meaning of waiting for clients

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.

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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.

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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. The imputed group identity rejected by clients

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 present 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 occurrence, 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 one's 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 prominence 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 professionals. 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.

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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

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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 child's 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.

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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 threatening 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

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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 (1978) 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-economic 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

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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

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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 interviewees 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 inappropriate 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 services, 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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