VOLUME 2

UNDER-UTILISATION OF MATERNAL AND CHILD HEALTH CARE

BY

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APPENDICES

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Dear

Re: 'Positive Pathways' Research Project - Selection of 'Users' and 'Non-Users' of Child Health Services.

You have probably already heard something of the above study, which is a research programme into factors affecting maternal take-up of local child health services during the first postnatal year. Part of the study will involve interviews with a sample of mothers to obtain their views of the services. Interviews will be carried out with both 'users' and 'non-users' of the relevant services. Therefore, one important step in the design will be systematically to divide the mothers into 'users' and 'non-users', so that equal numbers of each may be identified, and their responses compared. It is in devising an instrument to carry out this 'user'/'non-user' separation that we would be very grateful for your help.

Accompanying this letter is a checklist of possible contacts which a mother may have with the services during the first postnatal year. The items are in no particular order, and we would be very grateful if you could assign a relative weighting to each by writing its number in ONE of the five boxes athe the top of the page. The significance of each box is explained on the checklist, at the bottom of the page.

Please allocate each of the 20 items to an appropriate box, adding to the list any items of importance which you feel to have been missed; and allocating them, too, to an appropriate box, by writing in the number(s) which you have assigned to each extra item.

If you feel any item to be irrelevant, or not applicable in your area, please indicate this by placing a cross in the left hand margin beside the item.

When all completed forms are received, we will arrive at a consensus weighting of the checklist, and use it to 'group' the mothers.

NB: Responses will be used anonymously and in the strictest confidence. All we ask is that you indicate to which professional group you belong by deleting appropriately at the top of the response sheet before returning it in the envelope provided.

Please accept our grateful thanks for your most valuable help.

Yours sincerely,

AREA HEALTH AUTHORITY/SHEFFIELD CITY POLYTECHNIC

'POSITIVE PATHWAYS' PROJECT: CHECKLIST FOR SELECTION OF 'USER'/ /'NON-USER' GROUPS OF MOTHERS.

SHEET NUMBER:.....

This sheet has been completed by a HEALTH VISITOR / SENIOR HEALTH VISITING or MIDWIFERY STAFF / CLINICAL MEDICAL OFFICER / GENERAL PRACTITIONER (Please delete as appropriate).

LEAST IMPORTANT	FAIRLY IMPORTANT	IMPORTANT	VERY IMPORTANT	ESSENTIAL

INSTRUCTIONS:

Below is a checklist of items numbered from 1 to 20. Please enter the number of each item in the box above which you think most accurately conveys its importance for ensuring adequate surveillance and health of mother and child during the first postnatal year. Please put a cross in the left-hand margin beside any item you feel is irrelevant (i.e. does not apply in your area). PLEASE ADD ANY ITEM(S) YOU THINK HAVE BEEN OMITTED, and put the corresponding number in the appropriate box. Thank you very much for your help.

CHECKLIST:

1. Attended third (11-month) immunisation session
2. Attended social and other similar events at clinic
3. Attended antenatal relaxation classes
4. Visited GP in connection with pregnancy/antenatal care
5. Attended for baby hearing test(s)
6. Baby has received BCG inoculation
7. Mother accessible for Health Visitor visits (e.g. at 14,21,28 days)
8. Baby has received DPT inoculation
9. Attended second (tenth-month) medical examination by doctor
10. Responsive to advice on first visit by Health Visitor
11. Attended first (sixth-week) medical examination by doctor
12. Baby has received polio immunisation
13. Attended for three-month developmental check
14. Mother initiated early booking for delivery
15. Attended for two-month developmental check
16. Attended second (fifth-month) immunisation session
17. Attended parentcraft classes
18. Attended first (third-month) immunisation session
19. Baby has received measles inoculation
20. Attended other antenatal groups/classes (besides parentcraft and relaxation classes)
21. .....
22. .....
23. .....

(Please continue on separate sheet if necessary)

KEY TO BOXES:

LEAST IMPORTANT = item desirable, but could be missed; FAIRLY IMPORTANT = item fairly important, should not be missed if possible; IMPORTANT = item should really be taken up; VERY IMPORTANT = item should always be taken up; ESSENTIAL = item essential, and it must be ensured that it is taken up.

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1.3. ANALYSIS OF RESPONSES

CHECKLIST FOR SELECTION OF 'USERS' AND 'NON-USERS' OF CHILD HEALTH SERVICES

Following interdisciplinary discussion, a 20-item checklist of 'significant' features of maternal contact with the child health services was prepared. This checklist was subsequently submitted to a multidisciplinary panel for ordinal rating of its individual items. 18 out of 24 professionals approached submitted completed ratings - a response rate of 75 per cent. The validation panel consisted of:

Consultant Paediatricians:	2	Senior Health Visiting staff:	5
General Practitioners:	2	Senior Midwifery staff:	1
Clinic Medical Officers:	2	Health Visitors:	6

Items on the checklist were ordinally rated by assigning numerical values to qualitative responses as follows:

LEAST IMPORTANT 0 FAIRLY IMPORTANT 1 IMPORTANT 2 VERY IMPORTANT 3

ESSENTIAL 4

INFORMANT NUMBER:	CHECKLIST ITEM NUMBER:																			
	1	2.	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
4 CMO	3	0	2	4	4	0	4	3	3	2	2	3	0	3	0	3	2	3	0	0
5 CMO	4	2	2	4	4	0	2	4	3	0	4	4	0	1	0	4	3	4	0	2
6 HV	3	0	3	4	4	0	4	3	2	2	4	3	1	3	0	3	1	3	2	0
7 HV	3	0	4	4	3	4	3	0	4	3	3	3	2	3	1	3	3	3	3	2
8 HV	3	1	2	4	3	2	2	2	2	1	4	4	3	4	1	3	2	4	3	1
9 HV	4	0	1	4	4	1	4	3	3	2	3	3	3	3	0	4	1	4	3	0
10 GP	3	0	2	4	3	0	4	3	0	2	4	3	3	4	2	3	0	3	3	0
12 HV	4	0	2	4	4	0	3	4	4	3	4	0	0	3	0	4	2	4	3	1
13 SHV	4	0	2	4	4	4	4	0	3	3	4	4	3	4	2	4	3	4	4	4
15 SMW	0	0	2	4	0	0	3	0	0	3	0	0	0	4	0	0	2	0	0	0
16 SHV	3	0	2	4	4	3	4	3	2	2	3	3	2	3	0	3	2	3	2	3
19 GP	4	0	1	3	4	0	2	3	1	2	3	4	3	3	2	4	1	4	1	0
20 HV	3	0	3	4	3	0	2	3	1	1	2	3	0	4	0	3	2	3	0	2
21 SHV	1	1	2	4	3	0	4	1	2	3	4	1	3	3	3	1	2	1	0	2
22 SHV	2	0	2	4	2	0	4	2	2	2	3	3	3	3	0	2	2	2	3	1
23 SHV	4	0	2	3	4	0	4	4	2	2	1	4	3	3	3	4	2	4	2	0
25 C PAED	2	0	2	2	4	1	3	2	4	3	4	3	3	3	2	2	3	3	2	2
TOTALS:	50	4	36	64	57	15	56	40	38	36	52	48	32	54	16	50	33	52	31	20
$\bar{X}$:	2.94	0.24	2.12	3.76	3.35	0.88	3.30	2.35	2.20	2.12	3.10	2.82	1.88	3.20	0.94	2.94	1.94	3.10	1.82	1.20
RANK:	7.5	20	12.5	1	2	19	3	10	11	12.5	5.5	9	15	4	18	7.5	14	5.5	16	17

The hierarchy of checklist items thus became as follows:

(contd)

CHECKLIST ITEM NO:	RANK NO:	CHECKLIST ITEM:
4	1	Visited GP in connection with pregnancy/antenatal care
5	2	Attended for baby hearing test(s)
7	3	Mother accessible for HV visits (e.g. at 14,21,28 days)
14	4	Mother initiated early booking for delivery
11	5•5	Attended first (sixth-week) medical examination by doctor
18	5.5	Attended first (third-month) immunisation session
16	7•5	Attended second (fifth-month) immunisation session
1	7•5	Attended third (11th-month) immunisation session
12	9	Baby has received polio immunisation
8	10	Baby has received DPT immunisation
9	11	Attended second (tenth-month) medical examination by doctor
3	12•5	Attended antenatal relaxation classes
10	12•5	Responsive to advice on first visit by Health Visitor
17	14	Attended parentcraft classes
13	15	Attended for three-month developmental check
19	16	Baby has received measles immunisation
20	17	Attended other antenatal groups/classes (besides parent-craft and relaxation classes)
15	18	Attended for two-month developmental check
6	19	Baby has received BCG inoculation
2	20	Attended social and other similar events at clinic

The original checklist had sought to be as inclusive as possible of items advanced by health professionals as potentially important features of 'effective' maternal contact with the child health care services. In addition, participants invited to assist in validating the checklist were requested to add any further items which they personally felt to be important, and which had been omitted from the original checklist. This 'open-ended' invitation produced the following additional items:

(1) 'Mother's post-natal examination' (Clinic Medical Officer);

(2) 'Made acquaintance of Health Visitor before birth of baby' (a Senior Health Visitor and a Health Visitor);

(3) 'Mother should be given the telephone number of her Health Visitor, and be encouraged to ring when worried' (Health Visitor);

(4) 'Attended for antenatal care at GP/antenatal clinic on a minimum of six occasions' (Senior Midwife);

(5) 'Responsive to advice from midwife in antenatal period and in first 28 postnatal days' (Senior Midwife);

(6) 'Establishment of early relationship between mother and Health Visitor.....accessibility of Health Visitor during first six weeks of baby's life' (Health Visitor);

(contd)

(7) 'Baby registered with GP' (Senior Health Visitor);

(8) 'Mother seen by Health Visitor during antenatal period' (Senior Health Visitor);

(9) 'Mother able to recognise illness in her own child.... understands how to contact appropriate services..... able to monitor her own child's progress and to give a good account to the Health Visitor/Medical Officer' (Consultant Paediatrician).

However, inspection of proposed new items showed that in the main they either:

(a) described desirable changes in care patterns over which clients could not be expected to exert any control, rather than describing 'desirable' features of individual client behaviour within the existing child health care context (cf. e.g. Items (2), (3), (6), (7), (8) above): or

(b) proposed criteria of 'effective' takeup so subjective as to be difficult or impossible to describe in operational terms (cf. e.g. Items (5) and (9) above. Problems relating to this type of item were well put by a Senior Health Visitor:

> 'It is difficult to ensure 'response' to advice, especially if the advice contains foreign concepts concerning health or behaviour. This may take many visits.....'

and by a Consultant Paediatrician:

> 'I don't know any objective way of measuring this (Item 10 on original checklist), and it is out of place in that the other items are concerned with uptake of services rather than response to advice given. There is also no way of telling whether the advice given was actually appropriate for that particular mother and her particular baby!'

Thus the only proposed additional item not falling into either of these 'difficult' categories was that concerned with antenatal care (Item (4) above), which it was felt was taken up under certain other items in the original checklist (e.g. Items 3, 4, 17).

An interesting procedural suggestion concerning infant immunisation records was made by a General Practitioner:

> 'We asked for the Child Benefit Book to contain the immunisation record of the child. If this had to be completed and signed by a given GP or Health Visitor (where signature was known at the relevant Post Office), it would provide a good lever to persuade parents to have their infants checked. Unless payment/non-payment is made a stimulus for having babies checked, a significant number of parents will never use the services properly. Compulsion sadly is now necessary!'

SIMPLIFICATION OF THE CHECKLIST:

At this stage, preparing and ranking the checklist had accomplished two objectives: firstly, it had assembled a number of fairly clearly-defined features of client behaviour about which there existed a professional consensus regarding their 'importance' for effective child health care contacts. Secondly, it had indicated relatively 'high-ranking' and 'low--ranking' behaviours within that number, from the perspectives of a multidisciplinary group of health care professionals closely connected with the child health services. However, a checklist of 20 items is very large; especially bearing in mind that if it is to exercise a useful selective function for 'user' and 'non-user' groups, it would be necessary to compare <u>every</u> first-time mother with a child aged 12-15 months in <u>every</u> health care context under study on <u>every</u> item of the checklist, in order effectively to define the parameters of usage for comparative purposes. Clearly, what was now needed was a means of reducing the number of items on the checklist, whilst retaining its essential selective features and eliminating only relatively 'low-ranking' and imprecise items. This it was felt could be achieved by a dual process of elimination of 'low-ranking' items and appropriate conflation of some related 'high-ranking' items. This part of the process was carried out with the valuable advice and assistance of a Consultant Paediatrician to the Area Health Authority, who prepared a detailed critique of the checklist as it stood at this point.

(A) <u>Elimination of 'Low-Ranking' and Imprecise Items:</u>

Items 2, 6, 19 and 20 were eliminated on the basis of the discussion so far. Similarly, it was decided not to include the proposed new item on 'responsiveness' to midwifery advice for related reasons.

(B) <u>Conflation of Related 'High-Ranking' Items:</u>

<u>Item 14</u> ('Mother initiated early booking for delivery'), though important with a rank of 4, was considered rather vague, and was sharpened by specifying an appropriate stage in the pregnancy, becoming 'Mother initiated booking for delivery before 20 weeks with either GP or hospital'. <u>Items 3, 17 and 20</u> (ranking 12.5, 14 and 17 respectively) were brought together as: 'Mother attended relaxation, parentcraft or other antenatal preparatory classes'. These revised and conflated items were then brought together into a sub-section of the checklist dealing with care in the <u>antenatal period</u>.

<u>Item 7</u> ('Mother accessible for HV visits, e.g. at 14, 21, 28 days') was ranked highly at 3, and clearly had to be represented, as had the equally important accessibility to midwifery visits hinted at in one of the newly--proposed items (cf. <u>Item (5), Page 2 above</u>). A doctor comments:

> 'Item 7 is imprecise. Many mother are out when the Health Visitor calls for perfectly innocent reasons. It is those mothers who consistently refuse or avoid access whose babies are most likely to be 'at risk'. Secondly, a small proportion of babies are in hospital for the first month, and it is worth specifying 'the first month following the baby's return home'. The accessibility of the midwife is as important as that of the Health Visitor'.

Thus Item 7 becomes <u>two</u> items, both relating to maternal accessibility for home visits: 'Mother accessible for midwife's home visits at least twice in the week following discharge from hospital': and 'Mother accessible for HV home visit at least once during the first month following the baby's return home'.

Item 4 ('Visited GP in connection with pregnancy/antenatal care'), ranking 1 on the checklist, had now been taken up in the first conflated item (cf. Section B, first paragraph, Page 4 above). The item on baby hearing tests, Item 5, ranking 2, was allowed to stand as a most important feature of developmental care. Item 11 ('Attended first (sixth-week) medical examination by doctor') and Item 9 ('Attended second (tenth-month) medical examination by doctor') were re-phrased for flexibility and comprehensiveness, as: 'Attended for first medical examination by doctor between four weeks and three months, either at child health clinic, GP's surgery or hospital baby follow-up clinic': and 'Attended for second medical examination by doctor between six months and nine months, either at child health clinic, GP's surgery or hospital baby follow-up clinic'. Items 13 and 15 ('Attended for three-month developmental check': and 'Attended for two-month developmental check'), both referring to Health Visitor developmental checks , ranking 15 and 18 respectively, were conflated as a single new item: 'Attended for at least one HV developmental check in the first six months'. These four items were brought together into a sub-section of the checklist dealing with uptake of developmental examinations.

Finally, Items 18, 16, 1, 12, 8 dealing with immunisation programmes and ranked 5.5, 7.5, 7.5, 9 and 10 respectively, were conflated as a single new item: 'Attended child health clinic or GP surgery for two or more immunisations within first year, whether immunisation actually given or not'. A doctor comments:

> 'I don't see the point of listing each individual immunisation attendance. Attendance without immunisation being given has to be distinguished from failure to attend for immunisation. Items 6 and 19 are inappropriate as most children are not offered BCG and the measles vaccination is normally given after one year of age'.

REVISED CHECKLIST:

Thus the revised checklist in its final form includes nine items in place of the original twenty items, as follows:-

SECTION A: CARE IN THE ANTENATAL PERIOD.

1 Mother initiated booking for delivery before 20 weeks with either GP or hospital

2 Mother attended relaxation, parentcraft or other antenatal preparatory classes

SECTION B: MATERNAL ACCESSIBILITY FOR HOME VISITS.

3 Mother accessible for midwife's home visits at least twice in the week following discharge from hospital

4 Mother accessible for HV home visit at least once during the first month following the baby's return home

SECTION C: UPTAKE OF DEVELOPMENTAL EXAMINATIONS.

5 Baby hearing test completed

6 Attended for first medical examination by doctor between four weeks and three months, either at child health clinic, GP's surgery or hospital baby follow-up clinic

7 Attended for second medical examination by doctor between six months and nine months, either at child health clinic, GP's surgery or hospital baby follow-up clinic

8 Attended for at least one HV developmental check in the first six months

SECTION C: IMMUNISATION PROGRAMME.

9 Attended child health clinic or GP surgery for two or more immunisations within the first year, whether immunisation actually given or not

SUGGESTED SCORING SYSTEM:

In its final concentrated and flexible form, the checklist represents nine basic items of considerable importance in ensuring effective health surveillance during the antenatal period and first year of life. In this sense, it would seem invidious to attempt a weighting of such highly disparate and equally important items one against the other; and in any case the ordinal character of the ranking data does not sustain such numerical comparison in a meaningful sense. It was therefore decided to score each item on the checklist on an 'all or nothing' basis, assigning equal weighting to all items included, and deriving mean and deviant clinic scores accordingly during the process of selecting 'user' and 'non-user' samples of mothers for the purposes of the study.

SHEFFIELD CITY POLYTECHNIC

DEPARTMENT OF HEALTH STUDIES: 'POSITIVE PATHWAYS' STUDY

CHILD HEALTH CARE SERVICES: CHECKLIST FOR SELECTION OF 'USER' AND 'NON-USER' MATERNAL SUB-SAMPLES

HEALTH CARE CONTEXT:..... DATE:.....

CLIENT NAME/REFERENCE NUMBER:.....

CHECKLIST COMPLETED BY:.....

SECTION:	ITEM NO:	ITEM:	SCORE:
A	1	Mother initiated booking for delivery before 20 weeks with either GP or hospital	YES 1 NO 0
	2	Mother attended relaxation, parentcraft or other antenatal preparatory class(es)	YES 1 NO 0
B	3	Mother accessible for midwife's home visits at least twice in the week following discharge from hospital	YES 1 NO 0
	4	Mother accessible for HV home visit at least once during the first month following the baby's return home	YES 1 NO 0
C	5	Baby hearing test completed	YES 1 NO 0
	6	Attended for first medical examination by doctor between 4 weeks and 3 months, either at CHC, GP's surgery or hospital baby follow-up clinic	YES 1 NO 0
	7	Attended for second medical examination by doctor between 6 months and 9 months, either at CHC, GP's surgery or hospital baby follow-up clinic	YES 1 NO 0
	8	Attended for at least one HV developmental check in the first six months	YES 1 NO 0
D	9	Attended CHC or GP surgery for two or more immunisations within the first year, whether immunisation actually given or not	YES 1 NO 0
TOTAL SCORE ON CHECKLIST:			

NB: Please complete by ringing appropriate score by each item on checklist and entering total score in space provided above.

A checklist should be completed for each first-time mother in the health care context whose child will be aged 12-15 months during the period in which the health care context is under study.

APPENDIX 2

COMPILATION OF REVISED USER SCALE

Referred to in text 3.5.4.

Contents

THE REVISED USER SCALE:

(1) HEALTH VISITOR ASSESSMENTS:

8 voluntary takeup of four assessments (i.e. 3, 6, 10, 18 months)
6 voluntary takeup of any three assessments
4 voluntary takeup of any two assessments
2 voluntary takeup of any one assessment
0 no assessments taken up

(2) TAKEUP OF IMMUNISATION:

4 three or more entries on immunisation card
2 two or less entries on immunisation card
0 no record of immunisations

(3) HEARING TEST:

4 hearing test voluntarily taken up
0 hearing test not voluntarily taken up

(4) CLINIC ATTENDANCE:

	PERCENTAGE POSSIBLE ATTENDANCES:	FREQUENCY OF ATTENDANCE: (N=60)	(N=30)
9	90-100	54-60	27-30
8	80-89	48-53	24-26
7	70-79	42-47	21-23
6	60-69	36-41	18-20
5	50-59	30-35	15-17
4	40-49	24-29	12-14
3	30-39	18-23	9-11
2	20-29	12-17	6- 8
1	10-19	6-11	3- 5
0	0- 9	0- 5	0- 2

(5) 'GAP SCORE':

15 no missing months of surveillance
14 one missing month
13 two missing months
12 three missing months
11 four missing months
10 five missing months

9 six missing months
8 seven missing months
7 eight missing months
6 nine missing months
5 ten missing months
4 eleven missing months
3 twelve missing months
2 thirteen missing months
1 fourteen missing months
0 fifteen missing months

(6) AGE OF BABY AT START OF CLINIC ATTENDANCE:

15 began in first month
14 began in second month
13 began in third month
12 began in fourth month
11 began in fifth month
10 began in sixth month
9 began in seventh month
8 began in eighth month
7 began in ninth month
6 began in tenth month
5 began in eleventh month
4 began in twelvth month
3 began in thirteenth month
2 began in fourteenth month
1 began in fifteenth month
0 never attended at all

(7) AGE OF BABY AT END OF CLINIC ATTENDANCE:

15 fifteen months and over
14 fourteen months
13 thirteen months
12 twelve months
11 eleven months
10 ten months
9 nine months
8 eight months
7 seven months
6 six months

5 five months
4 four months
3 three months
2 two months
1 one month
0 never attended at all

(8) DURATION OF CLINIC ATTENDANCE:

15 attended for fifteen months or more
14 attended for fourteen months
13 attended for thirteen months
12 attended for twelve months
11 attended for eleven months
10 attended for ten months
9 attended for nine months
8 attended for eight months
7 attended for seven months
6 attended for six months
5 attended for five months
4 attended for four months
3 attended for three months
2 attended for two months
1 attended for one month
0 never attended at all

(9) FIRST MEDICAL EXAMINATION OF BABY:

4 attended clinic for the examination
0 did not attend clinic for the examination

(10) NON-ROUTINE CONTACTS WITH HEALTH VISITOR:

The score equals the absolute frequency of contacts, given by the equation:

$$\text{TOTAL CONTACTS WITH HV IN CLINIC} \text{ (minus) } \left(\text{'WEIGH ONLY' ENTRIES} \text{ (plus) } \text{ASSESSMENT VISITS} \text{ (plus) } \text{HEARING TEST VISITS}\right)$$

(11) NON-ROUTINE CONTACTS WITH MEDICAL OFFICER:

The score equals the absolute frequency of contacts, given by the equation:

TOTAL CONTACTS WITH MEDICAL OFFICER IN CLINIC (minus) MEDICAL EXAMINATION VISITS AND IMMUNISATION VISITS

APPENDIX 3

INTERVIEW SCHEDULES

Referred to in text 3.6.

Contents

SHEFFIELD CITY POLYTECHNIC

DEPARTMENT OF HEALTH STUDIES: 'POSITIVE PATHWAYS' STUDY

MATERNAL INTERVIEW SCHEDULE

HEALTH CARE CONTEXT:..... INTERVIEW NO:.....

INTERVIEWER:..... DATE:.....

SECTION A: INTRODUCTORY

INTERVIEWER: We're trying to find out what it's really like for a mother when she has her first child - what sort of problems she has, what kind of help she gets with these problems, and so on. The idea is to look at what sort of help mothers really need at this important time, and try to find out the best ways in which this help can be given. So we wondered if you could tell us a little bit about your own experiences? This sort of information can help us to improve the services for (young) mothers - help us really to give the sort of help that's needed most!

Everything you say will be ABSOLUTELY CONFIDENTIAL - nobody else except me will hear this tape - and I shan't be putting anybody's name in the report, only the sort of comments made and the sorts of problems discussed. We think that what mothers feel is very important if you're to get the sort of help you really need. So could you help us? We'ld be very grateful if you could!

SECTION B: BACKGROUND INFORMATION

B1 SURNAME:..... FORENAME(S):.....

B2 ADDRESS:.....

.....

B3 AGE LAST BIRTHDAY:..... D.O.B.:.....

B4 AGE AT BIRTH OF FIRST CHILD: Under 16 16-21 22-25 26-30

(please ring as appropriate) 31-35 36-40 41-45 Over 45

B5 EDUCATIONAL BACKGROUND: Secondary Modern Comprehensive School Grammar School Other (specify)

(please ring as appropriate) .....

B6 AGE LEFT SCHOOL:.....

B7 QUALIFICATIONS (please specify):

C.S.E.:	'O' Level:	'A' Level:	Other:
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....
.....	.....	.....	.....

B8 HEALTH EDUCATION AT SCHOOL:

(please ring as appropriate)

Human Biology | Domestic science/ /cookery | Sex Education | Baby Care | Other (specify).....

.....

B9 JOB(S) SINCE LEAVING SCHOOL: .....

.....

CURRENT OCCUPATION (where appropriate): .....

.....

EARNINGS:..... MATERNITY ALLOWANCE:.....

HOW OLD WAS BABY WHEN WORK RESUMED?:.....

PARTNER'S OCCUPATION:.....

PARTNER'S EARNINGS:.....

Does N's father work long hours? Do you see much of each other?

B10 PLACE OF ORIGIN:

WHERE BORN:.....

(Where appropriate) How long have your parents lived in this country?

.....

LENGTH OF TIME IN PRESENT ACCOMMODATION:.....

LENGTH OF TIME IN PREVIOUS ACCOMMODATION:.....

Where did you live before?:.....

Have you moved about a lot?:.....

CURRENT CONTACTS: Do you have

Family/mother nearby?	Close friends with young children?	Regular Visitors?	(please ring as appropriate)

B11 ACCOMMODATION:

(please ring as appropriate)

Private house | Private flat | Council house | Council flat | Owned property | Rented property | Separate accommodation | Shared accommodation | (with family/ /with others)

Number of rooms:..... Number of people resident:.....

BRIEF DESCRIPTION OF PROPERTY:.....

.....

B11 ACCOMMODATION (contd):

DISTANCE FROM CHILD HEALTH CLINIC:.....

DISTANCE FROM G.P.s SURGERY:.....

MODE OF TRAVEL TO CLINIC/SURGERY:.....

COST OF TRAVEL TO CLINIC/SURGERY:.....

Mother possesses car / has access to a lift / is dependent on public transport (please delete as appropriate)

B12 DOMESTIC FACILITIES:

Q: Do you like living where you are now?

PROBE: Are there any particular problems with the accommodation - does it seem too small, crowded etc?

(If NOT happy) What sort of accommodation would you really like?

Q: Do you have: Hot water Fixed bath Inside WC all of which work?
Cooker
(please tick as appropriate)

Q: Do you have a telephone? (If NOT, where is the nearest place you can phone from?)

Q: Do you have a washing machine?

PROBE: Are there good facilities for drying and airing clothes? (If NOT, how do you manage?)

Q: Do you have a pram/pushchair for N?

B13 MARITAL STATUS: (NB: This can be delicate. Decide whether or not to obtain relevant information from HV before the interview)

Married Single Divorced Separated Widowed Common law partner
(tick as appropriate)

YEARS WITH PRESENT PARTNER:.....

LENGTH OF TIME MARRIED BEFORE BIRTH OF CHILD:.....

B14 PERSONAL EXPERIENCES OF CARE: (NB: Try to obtain prior information from HV regarding family stability of respondent's parents; if herself/partner have been/are under any statutory supervision. DO NOT QUESTION THE RESPONDENT ON THESE MATTERS)

Q: Have you any brothers/sisters? (NO: .....)

Q: Do you feel you learned a lot from your own mother about bringing up children - for example, by watching/helping her to look after younger brothers and sisters?

B14 PERSONAL EXPERIENCES OF CARE (contd):

(NB: This is a gentle probe to ascertain whether the mother was brought up in an ordinary family, or 'in care')

Q: How long were you in hospital when N was born?

(NB: This may be a partial index of professional perceptions of the mother's need for continued support, where the stay was relatively long in absence of specific pathology)

B15 FAMILY CHILD CARE:

Q: Do you get any help in looking after N? (please tick)

Mother alone	Help from mother	Help from father	Help from sister	Help from grandmother

Help from other(s) (specify):.....

SECTION C: PRIOR/CURRENT KNOWLEDGE OF CHILD HEALTH FACILITIES

C1 PLANNED PREGNANCY:

Q: Could we start right back at the beginning, when N was first expected. Did you plan for N to come along when he/she did? Or did you really want to wait a bit longer before starting a baby? Had you had any other 'scares'?

PROBE: If she says she wanted to wait, then: 'Some of us don't get much family planning advice at school. Was there any in your school? How did you get to know about it?

C2 REALISATION OF PREGNANCY:

Q: How long had N been 'on the way' when you first found out? How did you first get to know for sure?

PROBE: Was it your family doctor - or a nurse etc - who first told you for sure? What advice did he/she give you at that time?

C3 EARLY CONTACT(S):

Q: Who did you go to first when you found out you were pregnant?

PROBE: Did she go to a member of her family? A friend? Or did she seek professional advice? What advice was she given?

C4 EARLY KNOWLEDGE OF HEALTH FACILITIES:

Q: Looking back right to the beginning, can you remember how much you knew about where to get help at that time?

PROBE: Did she know what a 'health clinic' was? Where it was? Who worked there? What sort of things went on there? If so, where had she got this information?

C5 REASONS FOR ATTENDANCE AT CLINIC:

Q: Were there any relaxation or parentcraft classes at your clinic? Or what else did you mainly go to the clinic for before N was born?

C6 EARLY IMPRESSIONS:

Q: Thinking about your very first visit to the clinic - what did you expect would happen when you got there? What actually happened?

C7 CURRENT KNOWLEDGE OF HEALTH FACILITIES:

Q: I guess you soon get to know a fair bit about it! Could you tell me a bit about your own clinic?

PROBE: Whereabouts is it? Who works there? What sorts of things go on in the clinic? When are the clinics/other sessions held?

C8 STAFF ROLES:

Q: There are a number of people working in the child health clinics - doctors, nurses and Health Visitors for example. Could you tell me a bit about the Health Visitor - what she does etc?

PROBE: Probe similarly for her knowledge of doctors' and nurses' roles.

C9 CONTACT WITH HEALTH VISITOR:

Q: Who is your own Health Visitor? (PROBE for name) Does she visit you very often? When did you first meet her? Is it your Health Visitor who asks you to come to the clinic, or do you get written invitations - or just go when you feel like it?

PROBE: Do you keep the Health Visitor's card somewhere handy? Have you got her telephone number? Do you feel you could ring her anytime? Is she the sort of person you can talk to freely, without embarrassment etc? Is her card up-to-date, so you know where you are?

C10 WEIGHING AND CHECKING:

Q: There's a lot of weighing and other checks which go on in baby clinics. Do you think there's too much, or do you think it's important?

PROBE: Weight checks? 'Screening' (does she know what sort of screening and why? 'Milestones' (can she give an example?) (Note her non-verbal communication here).

C11 MEDICAL EXAMINATIONS:

Q: How many medical examinations is N meant to have up to now? Has he/she had them all? Where?

C12 IMMUNISATION:

Q: One thing we have/haven't already mentioned is N's injections to stop him/her getting various illnesses. Does N get those at the clinic, or at your family doctor's?

PROBE: Does she know what the immunisations are? When they should be given? How they protect her baby?

C13 CONSTRAINTS:

Q: Do you still feel that the Health Visitor wants you to go to clinic regularly? If so, why? How often are you expected to go to clinic? Do you feel 'obliged' to go/guilty if you don't go?

C14 CHILD CARE LITERATURE AND EDUCATION:

Q: Looking back, would you say you've learned a lot about looking after baby from the doctor, Health Visitor and others, or not? Did you get any baby books, or read anything else to help you look after N? Did any of this material come from the clinic? Or from your family doctor?

C15 CURRENT ADVICE-SEEKING:

Q: Who would you go to now if you needed advice about N? Would you contact the Health Visitor for any reason? Have you ever asked for a home visit by a clinic doctor or Health Visitor? Why do you feel the Health Visitor comes to see you now?

SECTION D: CHILD CARE EXPERIENCES DURING THE FIRST YEAR

INTERVIEWER: Now let's think a bit about everything that's happened during N's first year.....

D1 DISCHARGE FROM HOSPITAL:

Q: .....first of all, right back at the time when you were getting ready to leave hospital after having had N. Were any arrangements made to make things a bit easier for you when you went home from hospital?

PROBE: Was transport arranged? Did N's father/yourself get to know when you were leaving in good time? Did you have any home help arranged, either officially or by the family? If not, did you feel you could have done with some? How long was it before you were visited?

D2 WORRIES ON DISCHARGE:

Q: When you knew you were going home, did you have any particular worries?

PROBE: Did you feel well/confident/able to cope, or not? How did you feel when you arrived back home? Were you glad to be back? Was anyone at home to meet you?

D3 EARLY COPING:

Q: Most mothers seem to find the first few days at home a bit difficult - not quite knowing what to do, and so on! Did you feel like this?

PROBE: If anything happened during those early weeks, where did you go for help or advice? What did you feel was the worst time with N? Who was most helpful to you at that time/these times?

D4 EARLY PROBLEMS:

Q: What would you say was/were the biggest problem(s) for you and N when you got back home?

PROBE: Practical 'coping'? Financial? Lack of advice/help? Attitude of N's father/others? Illness of self/baby? Coping with other responsibilities, etc?

D5 WORRIES DURING FIRST YEAR:

Q: What sorts of things have worried you concerning N during the rest of his/her first year?

D5 WORRIES DURING FIRST YEAR (contd):

PROBE: Practical 'coping'? Financial? Lack of advice/help? Attitude of N's father/others? Illness of self/baby? Coping with other responsibilities, etc?

D6 BABY CARE - FEEDING:

Q: Did you bottle-feed N? Did N take his/her food well, or were there any difficulties there?

PROBE: If a problem, who advised her? How successful was the advice? Would she, with hindsight, have approached somebody else?

D7 BABY CARE - SLEEPING:

Q: How long did N sleep at night when you first came out of hospital?

PROBE: If a problem, was it because you felt he/she wasn't getting enough sleep? Or was it because yourself/N's father/others were disturbed, getting up tired? How long did the problem last? Who advised her? How successful was the advice? Would she, with hindsight, have approached somebody else?

D8 FEELINGS OF COMPETENCE:

Q: Did you feel you were the one who really knew what was best for N?

PROBE: Or were there things you didn't feel too sure about? Who was most helpful in bolstering up your self-confidence?

D9 LAYETTE:

Q: When N was on the way, did you know what sorts of things to buy ready for his/her arrival? Did you manage to get everything ready?

PROBE: Who advised you on the sorts of things you'ld need?

D10 FINANCIAL ASPECTS:

Q: Was having N more expensive than you expected?

PROBE: How did you manage to find the extra money you needed? Did you put any money to one side for N? How did you budget for the extra things you've had to buy? How helpful was the maternity grant?

D11 OTHER DEPENDENTS:

Q: I expect you've had to look after N's father during this first year pretty much as usual. Have there been any other people besides N and his/her father that you've had to devote your time and attention to?

PROBE: What other people/things have you had to look after? How well have you managed to fit all these other things in?

D12 ADAPTATION TO BABY:

Q: How do you think yourself and N's father have adapted to having a new member of the family - not 'just yourselves' anymore?

PROBE: Do you find you cope with the extra work okay? How does N's father 'get on' with him/her? Does N's routine fit in with your work/his-her father's work?

SECTION E: THE FIRST YEAR - PERSONAL RETROSPECT

E1 CONFIRMATION OF ROLE:

Q: Looking back, have you enjoyed this first year?

PROBE: If she has, what has she enjoyed most about the first year? Would she do the same again? If she hasn't, what hasn't she enjoyed, and why does she think this is? Would she rather be doing something else?

E2 BETTER OR WORSE?:

Q: On the whole, would you say your life has changed for better or worse since having N?

PROBE: What has she missed most since having N?

E3 SOCIAL CONTACTS:

Q: Some mothers tend to feel a bit 'trapped' in the home because of the baby. Have you ever felt like that?

PROBE: Have you ever felt a bit lonely or isolated at any time this last year? Since N arrived, have you found much time for other things - social life and so on? Or does everything seem to revolve around N? Have you had to give up doing things because of N? Do you find you get any free time to do the things you like doing? Is it fairly easy for you to get out and about?

SECTION F: CHILD HEALTH CARE - PROFESSIONAL PROGRAMMES

F1 REACTION TO HOSPITAL CARE:

Q: When you had to go into hospital for N's arrival, didyou enjoy your stay there?

PROBE: Or were there things you didn't like about it? What did you like about it? What did you not particularly like about it? Had you ever been in hospital before? (Probe for reason, and quality of prior experience) Would you rather have had N in hospital, or at home?

F2 HEALTH CENTRE/HEALTH CLINIC - PHYSICAL LAYOUT:

Q: You go to X (Health Clinic/Health Centre) with N. Tell me a little bit about the clinic/health centre. What kind of a building is it?

PROBE: What is the waiting area like? Is there a place for prams? Are there refreshments available? Do you feel it's private enough? Is it on the way to the shops, or on the way to anywhere you'ld normally go?

F3 HEALTH CENTRE/HEALTH CLINIC AMBIENCE:

Q: Is the clinic/health centre a nice place to visit? Do you enjoy your visits there?

PROBE: Do you feel 'welcome' there? Or do you perhaps feel reluctant to go? (If so, why?) Do you feel it 'does you good' to go? Or do you perhaps feel worse for having been to the clinic/health centre? What do other mothers you know feel about going there? How does N behave in the clinic/health centre?

F4 CONTINUITY OF CARE:

Q: Do you generally know who you will see at the clinic/health centre? Do you always see the same doctor/nurse/Health Visitor there?

PROBE: (If NOT) Would you prefer always to see the same person(s) there?

F5 MAIN REASON(S) FOR ATTENDING:

Q: What would you say are the main reasons for which you go to the clinic/health centre now?

F5 MAIN REASON(S) FOR ATTENDING (contd):

PROBE: Attendance at classes/other groups? To get advice or leaflets etc about how to look after N? To get baby foods etc? Worries about N's health? To check on N's development? Immunisations? To meet other mothers? Any other reasons?

F6 OTHER REASON(S) FOR ATTENDING:

Q: What other things go on at the clinic/health centre which you've been to, or like to attend when you can?

F7 CLINIC ROUTINES:

Q: Thinking back to a typical visit to the clinic/health centre with N, say in the last few months or so, can you tell me what happens from the time you arrive at the clinic/health centre until it's time to leave?

PROBE: Do you spend much time just 'waiting about'? About how long, would you say? Is the routine always the same?

F8 APPOINTMENTS SYSTEM:

Q: Are you given an appointment to go to the clinic/health centre, or how do you go about getting one?

PROBE: Are appointments rigid or flexible? Do you find the session times convenient for you to get there? Do you have to plan in advance to be able to go, or are you able to 'pop in' while you're shopping or just passing by? What happens when you don't go? Do you get any reminders for clinic sessions? (If YES, for what activities? Who do the reminders come from?)

F9 SOCIAL FEATURES:

Q: Have you made many friends at the clinic sessions?

PROBE: Do many other people go - have you met many other mothers there? Do you get talking much to the other mothers there? Do the mothers you've met and talked to seem to go about as often as you - or more often or less often?

F10 SOCIAL FEATURES - INVOLVEMENT OF OTHER FAMILY MEMBERS:

Q: Do you ever feel able to take any friends or relatives with you to the clinic - N's father for example?

F11 RELATIONSHIPS WITH STAFF:

Q: How well do you know your own Health Visitor/Clinic Medical Officer?

PROBE: Do you feel you know her pretty well? Do you like her? Would you have preferred a choice? Do you feel she knows you pretty well? Who is the person you like seeing most at the clinic/ /health centre? Do you enjoy the visits paid to you at home by your Health Visitor?

F12 PERCEPTIONS OF HEALTH PROFESSIONALS' ROLE-PERFORMANCE:

Q: Do you find your own Health Visitor's/Clinic Medical Officer's advice helpful/useful?

PROBE: How do you mainly see her - I mean, as a friend? as an adviser? as a teacher? - or perhaps as 'a bit of a pain' sometimes!? Do you feel free to ask her advice about anything? (If NOT), What sorts of things do you feel you couldn't really ask her about? Do you feel she knows much about looking after a baby from a practical point of view?

F13 CONSTRAINTS IN INTERACTION WITH HEALTH PROFESSIONALS:

Q: Which of 'the professionals' would you turn to first if you had a problem with N?

PROBE: Family doctor? Clinic doctor? Nurse? Health Visitor? (In relation to each of these staff), Do you ever feel 'stupid' to ask him/her anything? Do you ever feel afraid to ask questions? Does the Health Visitor spend most time with you, or with N? Do you feel important to her as a person in your own right - not just as a 'mum'?

F14 HEALTH VISITOR CONSULTATION:

Q: If you had a problem with N, would you ring up Y (the Health Visitor) without hesitation?

PROBE: Would it just 'come naturally' to do it? Do you feel more confident having her around, or does it work the opposite way - perhaps make you a bit nervous? Will you go on seeing her quite happily when necessary during the second year?

F15 FAMILY ATTITUDES TO HEALTH CARE:

Q: What does N's father/your mother/(other close family member(s)) think of the clinic/health centre?

F15 FAMILY ATTITUDES TO HEALTH CARE (contd):

PROBE: Does your mother/N's father think it's a good idea for you to go? Has your mother ever talked about what it was like when she went to clinic with you and/or your brothers and/or sisters? Do you/ /she think it's changed a lot since then or not?

F16 PEER-GROUP ATTITUDES TO HEALTH CARE:

Q: Have you talked to any friends who've got young children about the same age as N, about the clinics they go to? What do they think about going to clinic?

PROBE: What do the other mothers at your own clinic/health centre think of it? Do you feel a sort of need or obligation to go.....feel guilty at all if you don't go? Would you personally advise anyone else with young child(ren) to go?

NB: The probes here are intended to pick up more practical aspects of other mothers' attitudes to health care received, as distinct from their reactions to clinic ambience, discussed in F3.

F17 RESPONSE TO GP/OTHER HEALTH CARE:

Q: Would you say that your experiences with other types of health care - I mean, for example, visits to your family doctor, - have made you more keen or less keen to go to the clinic/health centre, and be visited by a Health Visitor?

PROBE: Are you happy to go to your family doctor for most things, including advice about N? How do you 'get on' with him/her? Do you think that he/she knows you very well? Did N get examined/immunised by your family doctor? How often do you go to see him/her for advice about N? Is there any other health professional - a nurse etc - who you would go to for advice/help with N?

F18 NON-ATTENDANCE:

Q: Can you tell me why you prefer NOT to go to the clinic/health centre with N?

PROBE: Was it difficult to find time to go? Or do you feel you don't really need their help? (If NOT), Why not? Is the advice you get useful, or perhaps a bit confusing? Who/what would you say is your main source of advice about N? Do you now feel that the clinic could have helped you in any way?

F19 NON-TAKEUP OF IMMUNISATION PROGRAMME:

Q: Have you any particular reason(s) for not getting N immunised?

PROBE: Had anyone told you anything about it that made you not want to have it done? Had you read anything about it? Did you perhaps feel it might be harmful to N in some way? Did your mother get you immunised when you were small? (If NO to all these, probe for other reasons, religious or conscientious).

SECTION G: SUGGESTED IMPROVEMENTS AND FUTURE PLANS

G1 SUGGESTED IMPROVEMENTS IN CHILD HEALTH CARE:

Q: Looking back on the sort of care that you and N have received during this last year, are there any changes you would like to see happen - I mean, is there anything you feel might have helped you more?

PROBE: More continuity of care - seeing the same people all the time? A 24-hour phone-in service? More flexibility in the appointments system? Sessions a bit more private? Seeing a doctor who is able to prescribe for N/yourself? More contact with the doctor, or see the doctor every time you go? More contact with Health Visitor/other staff? Warning given before a home visit? Or anything else?

G2 FAMILIARITY WITH SERVICES:

Q: Looking back again, do you feel you 'know your way around' the services better now than you did a year ago?

PROBE: What would you do differently next time? Do you think it will be 'easier' next time? What problems do you think you will be able to avoid which you experienced this time, if you have another baby?

G3 FUTURE PLANS:

Q: What would you do in future - say, if N seemed ill?

G4 IMMUNISATION PROGRAMME:

Q: Will you have N's future immunisations done or not?

PROBE: (If YES) Who will you ask to do them? (If NO) Why not? (if not already picked up in F19)

END OF MATERNAL INTERVIEW SCHEDULE

SHEFFIELD CITY POLYTECHNIC

DEPARTMENT OF HEALTH STUDIES 'POSITIVE PATHWAYS' STUDY

MATERNAL INTERVIEW SCHEDULE

HEALTH CARE CONTEXT.....INT. NO.....

INTERVIEWER.....DATE.....

SECTION A INTRODUCTORY

We're trying to find out what it's like for a mother when she has her first child - what sorts of problems she has, what kind of help she gets with these problems and so on. The idea is to look at what sort of help a mother really needs at this important time and try to find ways in which it can be given. So we wondered if you could tell us abit about your own experiences? This sort of information can help to improve the services for mothers so that they get the sort of help that's needed most!

Everything you say will be absolutely confidential, noone else except me will hear this tape and I will not use any names in the report, only the sorts of comments made and the kinds of problems discussed. Also please feel free to tell me if there are any questions which you would prefer not to answer. We think that what mothers have to say is very important if the services are to provide the sort of help that's really needed, So could you help us? We'd be very grateful if you could!

SECTION B BACKGROUND INFORMATION

B1 AGE LAST BIRTHDAY.....B2 AGE AT CHILDBIRTH.....

B3 EDUCATIONAL BACKGROUND

Secondary Modern Comprehensive Grammar Other(Specify)

B4 AGE LEFT SCHOOL.....

B5 QUALIFICATIONS

CSE O'LEVEL A'LEVEL PROFESSIONAL OTHER (SPECIFY)

B6 HEALTH EDUCATION AT SCHOOL

Human Biology D.S. Sex Education Baby Care

B7 OCCUPATIONS 1.Since leaving school.....

2.Current occupation.....3.Earnings.....

3.Age of child when work resumed..... .....

4.Maternity allowance.....

5.Partners occupation.....6Earnings.....

7.Does N's father work long hours? Do you see much of each other?

B8 MOBILITY 1.Length of time in present residence.....

2.How many houses have you lived in altogether?

B9 CURRENT CLOSE CONTACTS 1.Do you have any regular visitors? Are your family or friends nearby?

2.Do you have any friends with young children nearby?

B10 ACCOMODATION 1.Type of property; Private house/ Private flat/ Council house/ Council flat/ Other

2.Number of rooms.....Number of people.....

3.Seperate or Shared 4.Condition of the property.....

.....

5.Distance from Child Health Clinic.....

6.Distance from G.P. surgery.....

7.Mode/cost of travel.....

B11 DOMESTIC FACILITIES 1.Do you like living where you are now?

2.Are there any particular problems with this accomodation?

What sort of accomodation would you really like?

3.Do you have; Hot water,Fixed bath,Inside W/C,Cooker,Telephone Washing machine,Facilities for drying and airing clothes, Pram/pushchair for N?

B12 MARITAL STATUS (Delicate, ask HV)

1. MARRIED/ SINGLE/ DIVORCED/ SEPERATED/ WIDOWED/ COMMON LAW

2.Years known present partner.....Years married.....

3.How long married before birth of child.....

B13 PERSONAL EXPERIENCES OF CARE

1.Do you feel you learnt a lot from your own mother about bringing up children?

2.How many children were there in your own family? Position in family, younger members of family to look after?

SECTION C REALISATION OF PREGNANCY

C1PLANNED PREGNANCY

Could we start right back at the beginning,when N was first expected.1Did you plan for N to come along when he/she did? Or did you really want to wait a bit longer before starting a family?

2.Had you ever had any scares before when you thought you may have been pregnant?

3.Some of us don't get much family planning advice at school did you? How did you get to know anything about it?

C2 FIRST CONTACT WITH THE MATERNITY SERVICES

1.How long had N been on the way when you first found out?

2.How did you know for sure?

3.Who did you tell the news to first?

4.Which health care professional did you see first? Why?

5.What advice were you first given by your family?

by your doctor?

C3 KNOWLEDGE OF WHAT TO DO

1.Can you remember how much you knew at first about where to get help and advice should you have needed it?

2.Did you knew what a health clinic was, where yours was, or who worked there?

3.Can you remember where you got all this information from? Family / friends / HV / GP ?

SECTION D ANTE NATAL CARE/ HOSPITAL CARE

D1 ANTE NATAL SERVICES

1.I'd like to talk a bit about the care you recieved during the nine months you were carrying your child, Did you have any checks by your doctor? How many?

2.Did you attend ante natal classes at all?

3.Did you attend any parent craft classes at all?

4.Did your husband get involved at all?

D2 HOSPITAL/HOME DELIVERY

1.When you had to go into hospital for N's arrival, did you enjoy your stay there? Were there any things you did not like about it?

2.How long were you in hospital for?

3.Had you ever been in hospital before for any reason?

D3 DISCHARGE FROM HOSPITAL

1.When you were getting ready to leave the hospital, were any arrangements made to make things a bit easier for you when you got home?

2.Was transport arranged? Who took you home?

D3 continued

3. How long was it before you were visited by the Midwife? and the Health Visitor?

4. Did you know what sorts of things to get ready for N? Who advised you on the sorts of things you would need or the cheapest places to get hold of baby things? Did you manage to get eveything ready in time?

SECTION E MAIN PROBLEMS IN COPING WITH A NEW BABY

E1 WORRIES ON DISCHARGE

1.When you were going home did you have any particular worries? Did you feel well / confident / able to cope?

2.How did you feel when you arrived at home with the new addition to your family?

3. Were you glad to get home?

E2 WORRIES DURING THE FIRST YEAR

1.Most mothers seem to find the first few days at home a bit difficult not quite knowing what to do and so on, Did you feel like this?

2. If anything happened during those early weeks, where did you go for help and advice?

3. What sorts of things have worried you concerning N during this first year? What would you say has been your biggest problem?

4. Have any of the following presented problems for you?

a) Practical day to day coping with demands,tiredness?

b) Lack of help or advice?

c) Financial problems? Was having N more expensive than you anticipated? How did you manage to find the extra money that you needed? How useful did you find the maternity grant

E2 continued

d) Attitude of N's father or other members of the family?

e) Illness of yourself?

f) Illness of N?

g) Have you ever lost much sleep with N?

h) Did feeding ever present any problem? Did you bottle feed?

i) Has there been anyone else you have had to devote your time and attention to this year? If yes how did you manage?

E3 CONFIDENCE

1. Did you feel most of the time that you knew what was best for N? or were there things you just weren't sure about at all?

2. Who would you say has been most helpful in bolstering your self confidence?

SECTION F POST NATAL CARE

F1 EXPECTATIONS OF THE CLINIC

1. Thinking about your very first visit to the clinic, what did you expect would happen when you got there? Were you apprehensive about going at first?

2. What actually happened when you got there?

F2 CURRENT KNOWLEDGE OF THE CLINIC

I guess you soon got to know a fair bit about the clinic, Where is it? Who works there? What sorts of things go on there? When are the sessions held for you and N?

F3 PHYSICAL LAYOUT/ EASE OF ACCESS TO CLINIC

1.What kind of a building is the clinic?

2. What is the waiting area like?

3. Is there a place for prams?

4. Are there any refreshments available?

5. Is it on the way to the shops or any where you would normally go?

6. Is it possible to have a private consultation with the Staff at the clinic?

7. Are you ever given an appointment to go to the clinic for any reason?

8. Do you prefer just being able to pop in, or would you rather have specific appointment times?

9. Have you ever recieved a reminder to go for any reason?

F4 POSSIBLE REASONS FOR NON ATTENDANCE

1. Have you ever preferred not to go to the clinic for any reason? eg Was it ever difficult to find the time to go?

2. Did you ever think it was just a waste of time when you did go?

3. Why do you think some people never go to the clinic?

F5 HEALTH CLINIC/CENTRE AMBIENCE

1.Is the clinic a nice place to visit? Do you enjoy your visits there?

2. How do other mothers you know feel about going?

F6 WEIGHING/CHECKING/SCREENING

1. There's a lot of weighing and other checks which go on

F6 continued

1.cont'd
Do you think there's too much or do you think it's important?

2. Do you understand what they're doing or looking out for

with the checks etc?

Can you give me an example of one of the tests they carry

out and why it is done?

3. How often did you go to the clinic at first? and now?

4. Did you have to spend much time just waiting about?

5. How many medical examinations (by a doctor) has N meant to have had up to now? Has N had them all?

F7 IMMUNISATIONS

1. One thing we haven't covered in anyn detail is N's immunisation (injections and sugar lump). Where has N had them done? Why?

2. Has anyone explained to you what the immunisations are for, in what way they help your child?

3. Have you had any problem with them or cause to worry?

4. Will you have all future immunisations done? Which ones has N to have in the future?

5. Did your mother have your injections and other immunisa -tions done? Where?

6. Did you recieve invitations to attend the clinic? If you did not manage to go did you recieve reminders?

F8 ATTENDANCE AT CLINIC

1. Do you still feel the Health Visitor wants you to go? How often are you expected to go and for what reason?

2. Did you feel obliged to go to the clinic, or ever feel

F8 Q2 continued

.....guilty for not going? Why?

3. Have you made any friends at the clinic? Do you manage to get to talk to any of the other mothers there?

4. How often do other mothers go? Would you say they went more or less often than you?

5. Have you ever been to the clinic for any other reason eg. jumble sales, social evenings, talks or any other local events?

SECTION G RELATIONSHIP WITH STAFF

G1 <u>RELATIONSHIP WITH HEALTH VISITOR</u>

1. Who is your own Health Visitor? (Probe for name)

2. When did you first meet her?

3. Does she visit you very often?

4. Is it your Health Visitor who asks you to attend clinic?

5. Have you her telephone number? Do you feel you could ring her at any time? Is she the sort of person you can talk to freely without embarasment?

6. Do you keep her card handy? Is it kept up to date so that you know where you are with her?

7. How well do you know her? Do you like her or would you have preferred a choice?

8. Do you feel she knows you fairly well?

9. Do you enjoy the home visits she has paid to you or would you prefer to see her at clinic?

10. Could you describe how you see the Health Visitors job? What sorts of things does her job entail? Is it just with mothers and young children?

G1 continued

11. Could you say that you have found her advice useful? Has she helped you with anything in particular? Does she understand your problems?

G2 RELATIONSHIP WITH DOCTOR AT CLINIC GP/CMO

1. Who is your own Doctor? (Probe for name)

2. When did you first meet him?

3. Do you visit him very often?

4. Have you got his telephone number? Do you feel you could ring him at anytime? Is he the sort of person you can talk to freely without embarasment?

5. How well do you know your Doctor? Do you like him or would you have preferred a choice?

6. Do you feel your Doctor knows you fairly well?

7. Could you say you have found your Doctors advice useful? Has he helped you with anything in particular? Does he understand your problems?

8. Have you ever asked for a home visit by your Doctor? What happened? Did you feel quite happy about calling the Doctor out?

G3 RELATIONSHIP WITH GP IF DIFFERENT FROM CLINIC DOCTOR

REPEAT ALL OF G2 QUESTIONS FOR GP

G4 PREFERENCES FOR CHILD CARE AND ADVICE

1. Looking back would you say you learnt most about looking after your baby from your Health Visitor, Doctor Family, Freinds or books?

G4 continued

2. What about baby books, did you find them very useful? Where did you get baby books from?

3. Who would you go to now if you needed help or advice with N?

4. Have you ever asked for a home visit from any of the health professionals?

5. Have you ever felt reluctant or afraid to go and see anyone when you needed some help?

6. Do you feel that the staff spend most time concerned with N, yourself or both?

7. Do you feel better having these people around to help you or does it work in the opposite way? eg. perhaps make you a little nervous?

8. Do you generally know who you will see at the clinic? Do you always see the same Health Visitor and Doctor at clinic? Would you prefer always to see the same person or do you sometimes find it easier to talk to someone you don't know?

G5 <u>FAMILY AND PEER GROUP ATTITUDES TO THE HEALTH SERVICE</u>

1. What does N's father think of the clinic, Health Visitor and others you have had contact with in the care of your baby? Does he approve/disapprove?

2. Has anyone ever accompanied you to the clinic eg. N's father, your mother or any of your friends? Do you prefer to go alone?

3. Have you talked to any friends about the clinic they attend? What do they think about it?

G5 continued

4. What do other mothers at your clinic think about it?

5. Would you personally advise other new mothers to go?

SECTION H THE FIRST YEAR PERSONAL RETROSPECT

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1. Looking back, have you enjoyed this first year?

Could you say what you have enjoyed most about it? If anything what would you rather be doing with your life?

2. Do you feel you have adapted well to being a mother, and all the responsibilities that entails?

3. What about N's father. Have you both managed to adapt to having a new member of the family, not just being the two of you anymore?

4. On the whole would you say your life has changed for the better or the worse since having N?

5. What have you personally missed most since having N?

6. Some mothers tend to feel a bit trapped in the home because of the baby. Have you ever felt like that?

Have you ever felt a bit lonely or isolated at any time?

7. What about your social life. Does everything revolve around the baby?

8. Is there anyone you can rely on to look after N if you do want to go out any time?

SECTION I FUTURE PLANS AND SUGGESTIONS

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1. Looking back at the sort of care that you and N have recieved are there any changes you would like to see -

I mean is there any way you think the services could have helped you more, or been more appropriate to your needs?

2. Here are some suggestions that have been made in the past, could you let me know what you think of them..

Continuity of care, seeing the same person regularly:

Flexible appointments, able to pop in anytime;

See more of the Health Visitor;

Prescribing Doctor at clinic;

Warning before a home visit;

ASK MOTHER FOR ANY SUGGESTIONS SHE MAY HAVE THOUGHT OF

3. Do you want to have more children or has this time put you off?

4. Do you really feel you know your way around the services now?

5. What would you do differently next time round? What sort of problems do you think you could avoid having the knowledge that you do?

END OF MATERNAL INTERVIEW SCHEDULE

APPENDIX 4

EXAMPLE PHENOMENOLOGICAL ANALYSIS OF ONE UNDERUSER INTERVIEW

Referred to in text 3.6.2.1. and chapter 6.

Contents

4.1. INTRODUCTION

The main goal of the method is to make sense of the data, rather than test hypotheses, and each step of the procedure is to be understood as serving this aim. Researchers who have adopted the phenomenological approach to interview data analysis follow a similar procedural process, but will vary to some extent in the application to their particular concerns, the aim being to tie the analysis very closely to a) the kind of data under scrutiny, and b) the aims of the research.

The level of abstraction is chosen as that which serves the research goals e.g. in this study the end product was to be kept as close as possible to the concrete descriptions offered by respondents. The procedure outlined below was arrived at in working through the general principles of anlysis (as outlined by Giorgi 1975) in relation to this particular research project, and so differs in some details when this was found necessary.

The procedure is divided into 3 stages, each of which is presented in full to show how the findings of the study were arrived at from the raw data generated in interview.

In stage 1, the verbatim transcript of interview data, which constitutes the text to be analysed is marked by division into meaning units. This stage encompasses steps 1 - 3 as outlined in the procedural outline.

In stage 2, the organised text is restated in the third person, and initial labelling of topic areas is carried out, which corresponds to step 4 in the procedural outline.

In the third stage, the central themes of relevance to the research interest are laid out, as they emerged in the analysis. This stage corresponds to steps 5 - 7 in the procedural outline.

4.2. THE PRINCIPLE STAGES OF THE PROCEDURE

1. Focussed, open ended, semi structured interview with respondent

Taped (where possible) from beginning to end

Tasks of the researcher

Focus on the topic of interest to the research, i.e. becoming a mother and relations with the services.

The interviewee is to be allowed to describe freely any areas of importance to her, to choose her own areas of relevance when asked to talk about such things. The interviewer pursues any ambiguous areas, asks for clarification when necessary and may return the subject to her descriptions when necessary to gain a deeper understanding of how she experienced the events. The questions asked should not primarily structure the conversation, but merely direct the interviewee to an area for her comments on it. The primary aim is to understand as fully as possible what is being said.

2. Verbatim transcript of the interview

This is the text to be analysed.

Tasks of the researcher

Both the interviewee and interviewer contributions are presented for later analysis, typed as a conversation, where the emotional tone of each part is recorded and breaks in the flow of talk noted.

3. Initial discrimination of natural meaning units

(a means of organising the text for analysis)

Tasks of the researcher

The text is divided into naturally occurring exchanges between the interviewee and interviewer, where one point has been made, at each change of focus of the talk this is marked with a number in sequence. A lively awareness of what is taking place in the conversation is to be maintained and notes put on the text to show major pauses, breaks, and other features of the situation (e.g. others coming in or out, any distractions.)

4. Discovering and labelling the central meaning of each unit as intended by the interviewee

The meaning units are restated in the 3rd person to facilitate identification of the main meaning.

Tasks of the researcher

An attempt is made to establish the interviewees self understandings, and the main meaning conveyed in each meaning unit. Obvious irrelevances can be put to one side (e.g. asking for a cigarette). The researcher attempts to summarise in short phrases the interviewees main concern at each point, a phrase which captures the meaning rather than transforming it with reference to other concerns. This can involve backtracking to other parts of the text and using imaginative variation to ensure the cenral meaning has not been distorted. The researcher must bracket any presuppositions, judgements and bias which occur as the text is read, the focus being tied firmly to the interviewees concerns at each stage, regardless of the researchers views.

5. Each meaning unit is taken in turn and interrogated for its relevance to understanding the interviewees experience, and the text is reorganised, regrouped around similar central themes.

Tasks of the researcher

The central meanings are the focus of interest to the researcher, and each meaning unit must be accounted for. Where the same meaning is being expressed in different parts of the text, these are put together as similar themes. An attempt is made to relabel the parts put together where a more accurate summary statement is arrived at e.g. 2 meaning units may be found on being put together to be revealing 2 aspects of a similar more general meaning which when relabelled can subsume and accurately convey them both.

6. The researcher adopts a particular 'set' towards understanding and analysing the text

Tasks of the researcher

The particular set of this researcher was a search for any meanings of importance to the interviewees relations with health carers, and becoming a mother. Each central meaning identified in step 5, is compared with the whole text, to see if there are interrelationships which could deepen an understanding of the issues. Importance is assigned on the primary basis of where the interviewee does to her concerns. The 'set' of the researcher is to articulate this individuals central meanings which convey how motherhood and contact with the services was experienced by her. The attitude adopted contains presuppositions and organising principles, but these are not specific enough to delineate precisely specific categories for selection. Each variation of a central theme is interrogated for its relevance to the research interests, so that the researcher is better able to see what is essential to an understanding of this individual.

7. Researcher restates the central themes identified in step 6

Independent analysis of the data is carried out for comparison.

Tasks of the researcher

These are the results of the individual case study, a regrouped and labelled text which summarises the interviewees relations with the services and experience of motherhood as found in the text. The themes so identified are considered to be the qualitative findings of the study which can then be compared with those of an independent observer who has followed the same procedure. Any differences being noted and a consensus established.

8. Comparison of general themes across interviews (N = 6) to establish transituational themes and those specific to individuals.

Tasks of the researcher

Whilst keeping contact with the original transcripts to avoid over generalising, the researcher sees if there are any relationships across the analysis which could be abstracted into more general themes. These would be regarded as general orientations shared by the respondents which can then be illustrated with the dimensions important to each one from the individual case studies. Revision and elaboration of the themes is carried out as found necessary, whilst parts are never to be forced together, there must be a clear link in meaning between parts.

9. For presentation of results, the results of step 8 are then laid out in relation to the research interest specifically.

Tasks of the researcher

Specific areas of interest arising from the research project are illustrated from the general themes which it is thought illuminate the problem. The focus then throughout is on a particular aspect of the more complex reality to be found in the text, the particular 'set' of the researcher setting limits to what is considered relevant, which implies presuppositions but not of the sort which specifically delineates precisely specific categories.

10. Past research results and comment can be compared with these results to establish correspondeces, divergences and any new knowledge gained from the approach.

Tasks of the researcher

The results are not directly comparable to past research results especially those which concentrated on quantitative factor analysis, as the results are different in kind. However, the explanations offered for underusage can be compared with the study's results to see if they are confirmed or brought into question. If totally divergent, then an attempt at an alternative explanation may be offered which is consonant with the results of the analysis.

4.3. STAGE 1. VERBATIM TRANSCRIPT OF THE INTERVIEW

(Corresponding to steps 1, 2 and 3 in the procedural outline).

The open ended interview is transcribed from beginning to end, preserving both the respondents and researchers contributions. The text is divided into meaning units (naturally occurring exchanges between the respondent and researcher) which are numbered, as a means of organising the text for further analysis.

THE MATERNAL INTERVIEW: A SPECIMEN VERBATIM TRANSCRIPT

INTRODUCTION:

Cathy (*) the young mother concerned, had been forewarned of the interviewer's visit by means of a note left at her house on the preceding day: and seemed very willing to share her thoughts with me. As Cathy had only just arisen, there was opportunity for an informal chat whilst she lit the coal fire and made some tea.

She asked about the nature of my work, remarking how unusual a job it was: and I made it clear that I was not a health professional myself, but simply interested in her own feelings and experiences for their own sake. During this talk I discovered that she was 21 years old, married and not currently in paid employment.

Each topic was introduced, Cathy took the opportunity to expand and elaborate: e.g. she had very few visitors, only her husband's companions who '...used the house to dump stolen goods'; the house was very damp and difficult to heat; repairs were '...never done'; the neighbours were very unfriendly and hostile and '...had sent the police' to her home on a number of occasions.

At the start of our conversation, the tape recorder was switched on with her permission at the beginning of Section C of the interview schedule. Thus the transcript begins in mid-conversation at this point. Bracketed numbers refer to meaning units in the subsequent analysis of interview material.

* Throughout the transcript, the fictitious name Cathy (the mother) and Teresa (the interviewer) are employed.

TERESA: (indicating the tape recorder): It's a bloody big thing to carry around!

CATHY: It is, yeh (mumbled)

TERESA: I could have got a smaller one but they didn't have one. Right (returning to the subject)...right back at the beginning when your first baby was expected, did you plan ?

CATHY: No...

TERESA: Plan to have her then ?

CATHY: No (3) - we'd been trying for about two year - well, before we were married we were trying (4) and, er, I had three miscarriages and I thought I wouldn't be able to have kids (serious)

TERESA: (sympathetic): Did you, oh that must have been awful (5)

CATHY: (pursuing the story): ...and I'd been off t'pill like and I thought, well, we'll never be able to have kids (6) and the (meditative)...(7)...I think we must ha' been tryin' too much (8)... thanks a lot (accepts a cigarette)

TERESA: (encouraging her to carry on): Yes ?

CATHY: ... and then we dropped off (6)... I just got caught on with her (9) (fatalistically)

TERESA: (laughs sympathetically): Yes...

CATHY: Yeh, because... (hesitates)

TERESA: It's funny how it happens (implying 'I know what you mean') (10)

CATHY: (wishing to return to her explanation - there is more to it than the interviewer is making out): I think with miscarriages though... (pauses) ...I er... 'cos I knew I were pregnant right at t'beginning you know...

TERESA: Mmm mmm (indicates agreement)

CATHY: ...and I were trying to be careful and I must have...(10A)...but, er, with her I ...I didn't know I were pregnant up to being about four month on... (11)

TERESA: (encouragingly): Mmm...

CATHY: ...you see, so I carried her, I carried her pretty well (12). Y'know, I didn't expect to have a bairn (13)...

TERESA: Mmm...

CATHY: ...and now I'm breeding like a rabbit... I can't stop (giggles) (14)

TERESA: Mmm. (laughs) Right, would you rather have waited a bit longer before starting a family ?

CATHY: (quiet and serious) Ooh no, no I wanted one (15) while I were young mese'n you know (16)

TERESA: (quizzically): Mmm? (does she really mean this?)

CATHY: (sensing the need to explain): ...'cos I think, well, these older people that have bairns, I mean it's a tow (difficult task) for 'em, and there's t'age gap and that - I mean, I'm only really a bairn in mese'n, you know what I mean ? And so I can bring her up and she can bring me up (17)

TERESA: Mmm... Had you ever had any 'scares' before, when you thought you might have been pregnant, apart from your miscarriages - when you wouldn't have wanted to be pregnant ?

CATHY: No...Oh! Yeh I did, yeh, well...(18)... when (hesitates before an obviously sensitive disclosure)... when I were sixteen I were raped and that's when I had one of me miscarriages (pauses)

TERESA (expresses shock and fright): God, you poor thing!

CATHY: I got...I got er...I'd just left school and, er, this lad got hold of me and, er, I were pregnant to him and I lost, I lost t'bairn (20) - I were going' to get rid on it, anyway (20A)

TERESA: I don't blame you

CATHY:But I've had two... (an interruption here by child). (22)

TERESA: (righteous indignation): What hapened then - did the police deal with it ?

CATHY: Oh no, no I daren't tell t'police (23) because he were one of them sort that'd knife you or summat like that, so I just left it (coughs). (24) I ought to have done, but... (25)

TERESA: Has he bothered you since?

CATHY: (seriously): No...(pauses)...no, he's not bothered me at all (26)

TERESA: Did he know you before ?

CATHY: He knew me before, I'd been out with him before... (27)

TERESA: They say that, don't they - that most rapes are the people that you know ?

CATHY: (perfunctorily, probably not having heard this before): Yeh (28)

TERESA: (sympathetically): That's awful - were you not terrified ? (meaning during the attack itself)

CATHY: (taking Teresa to mean after the attack): Oh aye, yeh - it took me seven weeks to tell me Mam and Dad (29): and I lost it (had a miscarriage) when I were about eight week on, about three or four days after I'd telled Mam and Dad (39). I lost it at work - I were lifting heavy boxes or summat (31)

TERESA: (awed tone, quiet and intimate): I bet that was painful

CATHY: It were. Me, I can't get me job back through it 'cos I had that much time off, I've tried for me job back and they just wearnt (won't), you know, they wearnt have nowt to do with me. (Pauses, then defiantly) Min'st you though, I'm not bothered...I'm happy now, so... (33)

TERESA: Oh dear...Right, about family planning lessons at school - you said you didn't do any sex education. How did you find out anything about contraception ?

CATHY: Well, I found out...well, I'll be blunt with yer, I picked a Durex up that had been used when I were about thirteen, and I thought it were a balloon, and one of me mates telt me all about it then (35)

TERESA: Yes, that's how many people find out

CATHY: ...you see... and then me mother telt me when I were about

fourteen or so (37). I really knew before (38), but I didn't get to know all t'bad parts of sex education and I only got to know t'good parts, do you know what I mean ? (39)

TERESA: (probing for clearer information): What sort of bad parts do you mean ?

CATHY: Well...miscarriages and things like this (40) - you know you only get to know that sex is a good thing and... (41)

TERESA (encouragingly): Mmm, yes

CATHY (pauses): But I mean, once you're married, sex is just a routine (42), it's not , it's not a pleasure any more, you know what I mean (42A). It's just like having a cup of tea in a morning and that's what sex is to me (42B)...so, but (43)

TERESA: Whereas before you used to enjoy it? (matter of fact)

CATHY: Oh yeh, I...I think you do when you're courting because you're pinching it (44), you know, but once it's legal and that, er, all t'excitement goes out on it (45)

TERESA (laughs): Mmm, right (pauses, then continues in quite a bookish tone, as if reading from the page) Have you ever used any contraception at all ?

CATHY: Yeh, I used t'pill for a...(47)...when I was about fifteen I went on t'pill (48), and I come off when I was sixteen (49) and that's how I got caught on when that lad raped me (50), I'd only been off pill two days when it happened (50A)

TERESA: Oh... (meaning oh dear)

CATHY: ...and, er, I went back on t'pill up to being about seventeen-and-a-half (51), and then when I met B. I come off it...(52)

(the door opens and B. - her husband- comes in)

.... and then when I had this, this child I couldn't go back on t'pill because I were breast-feeding(53)

TERESA: Mmm (meaning 'Oh yes, I see')

CATHY: ...so we were using just ordinary contraceptives from there (54) (laughs) but with this one it were t'pulling out method that we used, wasn't it, B. (laughs again) (55)

TERESA: (apparently not hearing or understanding): It was what ?

CATHY: ...You know, t'pulling-out method

TERESA (resorting to labelling): oh yes, what's that called - is it withdrawal or...

CATHY: Yeh, withdrawal, aye, that's it, summat like that

TERESA: Mmm...so you didn't really want to get pregnant again this

time ? (matter-of-factly)

CATHY: Oh no, I could have done with it like a year, a year and a half, summat like that, you know (57)

TERESA (adding what was expected): You needed some time...

CATHY: Yeh, some time to get used to this one first (indicating her daughter) (58)

TERESA (returning to interviewer style to move the discussion along): Mmm, right - so how long had your first baby been on the way when you first found out - you said it was about four months, didn't you ?

CATHY (rather vaguely): Yeh, well...

TERESA (pressing the point): Was it about four months... and how did you know for sure ?

CATHY: Well, I were on a diet, and I'd been on a diet for some time, and I went down from a size 16 to a size 12 - and then suddenly I just started banging it back on again...(69)

(Teresa laughs)

...and I thought, well, it can't be t'diet because I'd got used to it you know - it'd taken me about four or five months to lose that weight, and I thought, well, I'm eating t'same stuff and I'm putting it back on (61) - and then I started with morning sickness

TERESA (seriously): Mmm...

CATHY: Well, I got it every morning after that (62): but t'doctor at, er, (names health centre) said it were wind I'd got (63) and, er, even when I told him I've (you know these chemists that do 'em and you pay so much, well, I had a test done there, and it come back positive)... (64,64A)

TERESA: Mmm, yes ?

CATHY: ... and it said on t'bottom "if you are pregnant tell your own doctor", so I went up (64B); and, er he says, er, 'Oh it isn't - it's gastric stomach you've got' (65). Well, B. went barmy 'cos I'd been badly (66), you see, and I thought I were losin' t'bairn (67), I were frightened to death of losin' t'baby (68); and he more or less had to carry me up to t'doctors (69), and t'doctor still insisted it were wind (79)- and up to me really showin' you know (71) - and then they changed their minds (72), but same as I said, I had a bit o'trouble carrying her (73). She were all right (74), but, if that doctor had of insisted it were wind (75), I'd have probably gone back to work and done summat heavy and lost it again (76), so...

TERESA: Mmm, right - who did you tell the news to first ?

CATHY: Er, me husband were there when I went and got t'results from that chemist (77)

TERESA: And what did he say ?

CATHY (laughs): He were as calm as owt; (laughs again) I were over t'moon, me, but he were, he were as calm as owt (78,79)

TERESA: Did your doctor give you any advice when he did confirm your pregnancy ?

CATHY: Not really, no. (she is obviously unsure of what Teresa means; did not apparently expect any advice from this source) (81)

TERESA:...just sent you to the hospital ?

CATHY: Yeh

TERESA (seeking fuller information): ... and booked you in and that ?

CATHY (misunderstanding): Well, I were working (83) and I were being badly-like (84) and I thought it were with carrying her (85), and, er, I went back to me doctor's (86) and they just turned round and says, well "pregnancy is not an illness" (87), and they wouldn't give me a sick note (88), and, em, I nearly got sacked through it for having time off (89). But, er, they don't give you any advice (90), you've got to go up and say "Look, I'm pregnant and I'm having problems..." and this, that and the other before they do try to sort owt out for you (91)

TERESA: Was this at the sewing factory where you worked ? (seeking clarification)

CATHY: Yeh, I were at (names a firm) when I were carrying her, and as soon as they found out I was pregnant they give me all...

(Breaks off the discussion to speak to B)

B: Are you going up to yer Mam's ?

CATHY: Yeh, I'll go up this afternoon

B: Right, I'll come back up there then (B. goes out)

CATHY: Er, I've forgotton what I were on about now (94)... oh aye, as soon as I found out I were pregnant (95), they took me off t'machines and they give me a right job (96), I had to, I was stood up all day - well, I used to have these fainting, dizzy spells you know (97)

TERESA: (encouragingly): Mmm ?

CATHY: .... and I asked for a chair and they wouldn't give me one (coughs) (98), so I caused a right stink-up about it (99). I started having time off work and that (100); and they were threateneing me with t'sack (101) but I weren't bothered (102). I mean, I was stood up eight hours a day on me feet, and I couldn't wear slippers or owt (103), so I thought "Bugger it!" (194). They even had to try, try to keep me; they used to try to make me clean the lavs out and that (105), and I thought, well, I'm not doing that (106). They were right ones with me - I wouldn't go back there, no chance! (107)

TERESA (sympathetic): It sounds horrible. (Moving the discussion on) Right, at first - when you fist knew you were pregnant - did you know where to get help or advice ?

CATHY: No - I didn't know

TERESA: You didn't know anything ?

CATHY: I didn't (109). I didn't know if there was sombody that come and booked yer into hospital or what (110). In fact (coughs) when t'midwife come and she says "How long 'ave your been booked in for ?" I didn't know what the bloody hell she were on about (111), because nobody telt me nowt - they just expect you to know (112)

TERESA (encouragingly): Yeh... ?

CATHY: ...and with yer second (child) it's even worse (113) - they, you know, they expect you to... (assumes the character of 'them') 'Oh, she's been through it before, you know - she'll know what to do' (114) (in posh voice)

TERESA (matter-of-factly): And you don't, of course.

CATHY: You've got a good idea, yeh (116): but little things like (117), like that, er, exemption certificate (117A) now, when I were carrying' t'first child I had that given to me (117B). Now, I don't know where to go and see about it this time (117C) and nobody's said nowt to me (117D) - I mean, one of t'lasses says "Oh, you should get it from t'hospital - they should gi' it yer" (117E) - but they've never even mentioned it to me (117F). You've got to keep asking! (117G)

TERESA (offers worldly wisdom): Yes, keep asking, mm...make sure you ask. (Encouraging her to pursue this matter) Otherwise you'll end up paying through the nose, won't you?

CATHY Yeh (unconvinced).

TERESA (moving the discussion on): Right - had you ever been to a (child) health clinic before?

CATHY: No I hadn't, no (118)

TERESA (echoing her reply): No... antenatally, when you were carrying your baby, did you have any checks by your own doctor?

CATHY: Yeh, well I were under me own doctor (120) for about two months, summat like that (120A), and I were going to clinic at (names clinic in neighbouring health authority) - they have an antenatal there, like - and I were going through and seeing them, and it were okay (120B) because I didn't have far to travel (121). But with this one (emphasises child she is carrying) they've made me stop (i.e. continue to attend) at (names more distant hospital-based antenatal clinic) (122), so I've got to catch two 'buses now if I want to go (123) - and plus me appointment is for nine in t'morning, so I've got to set off from here about quart' t'eight to get there (124) - and it's a bugger! (laughs) (125)

TERESA: So, were the midwives with the doctor when you went to see him? (trying to discover if she attended antenatal clinic proper).

CATHY: Yeh

TERESA: (in the vernacular): And what were they like when you went? (i.e. what was their attitude towards you?)

CATH (interprets question as referring to whole clinic context): Well, it were a bit strange at first 'cos I, I didn't know what were expected of me, you know (128). It were all questions t'first time I went, I know that (129), and I were in there ages (130); and they give me (an) internal (examination) and this, that and the other (131). But afterwards I didn't see me own doctor when I kept going to (names clinic in neighbouring health authority). I saw (pauses - names doctor) I think it were - yeh (names doctor) (132), and her sister (133). But (previously) I'd got used to seeing this... (134)... her brother, you see (135): 'cos he were right nice, I could have a good talk with him (136). But - with her being a woman - I think a woman seems to think "Well, she's only the same as me" - you know what I mean, they're rougher with yer (137) whereas a fella seems to be a lot more gentle (137A). Aye, yer just..yer just treated like a bag of flour passed from one place to another - and that's it! (137B). (giggles, both amused and exasperated by her own imagery)

TERESA: Hmmhuh (affirmatively - then pursues the question area) What...em...did you go to the hospital as well?

CATHY: Yeh I were. Well, it were silly really, because they were giving me appointments for t'antenatal (clinic) at (names clinic in neighbouring health authority) as well (138). I had to go to t'antenatal at t'hospital on morning (139) - then rush like bloody hell to come back for t'antenatal at (names clinic in neighbouring health authority) (139A) (raises her voice here to emphasise the ludicrous nature of the situation)

TERESA (empathic - laughs and repeats): At (names clinic in neighbouring health authority)

CATHY (affirmatively): At (names clinic) on t'same day! And I kept telling 'em (140), 'cos by t'time I got to (names clinic) they used to say (141), "Well, you've been to (hospital antenatal clinic) this morning, so there's no point in us doing owt (anything) to yer!" (142). But it were me having time off work, you know, and we had to clock in and clock out and that, and (her exasperation increases as she remembers) oooh, it were a bugger! (143)

TERESA (empathic, affirmative): Uhuh, uhuh... What did you think of the hospital when you went for your checks?

CATHY: Well, to be honest, it were (like) a load of women lining up to be slaughtered! (laughs) (145)

TERESA: Yeh, really?

CATHY: You found you were waiting there hours and hours (146); and if you were frightened about owt, it just used to make you worse with

waiting all t'time (147); and then half of t'times t'doctor (well,I were under (names consultant obstetrician) for t'first one (148A)), he hadn't got time for you, he couldn't...he couldn't gi' a chuff (i.e. was completely disinterested) you know - he just treat(ed) you like a little box in t'corner (148)

TERESA: Really? yeh..yeh?

CATHY (suddenly remembers): I know one o' t'times when I went he'd got some students in (149) and I felt stupid (149A). I'd to remove me dressing gown (149B) and they'd taken it right to t'other side of' t'room (149C) and I'd to walk across t'room (149D) and I had nowt on (laughs embarrassedly), to t'other side (149E). (explaining) I'd to get me dressing gown and I felt stupid (149F)

TERESA (seriously): That's really embarrassing

CATHY (also serious): It is, yeh. I'd, I'd... (pauses) (150)

TERESA (intuits what Cathy may be trying to say): None of them made an effort to get it for you or anything?

CATHY (bitterly): No. They just...they just treat you like little boxes, that's what it is (151)

TERESA (echoes C's feelings): That's awful

CATHY (philosophically): I know - I were embarrassed at first (152), but now I believe that a doctor don't see yer as a person; he sees yer just like an object (153)

TERESA (interrogative): Mmm?

CATHY: ...you know what I mean? So it doesn't bother you...(pauses) (154)

TERESA (echoes her, righteously indignant on her behalf): It doesn't bother you, yeh mind, I think that's bad, don't you, to be treated like that at all? (pursuing the outcome)... So did you mind going to the hospital then? (i.e. how did you feel about it?)

CATHY: I didn't <u>mind</u> (object to) going to t'hospital (156), but it were just all t'waiting and that (157), you know with me working (158). Like as now (without a job), I don't mind going, 'cos it's a break...

TERESA (affirmative): Mmm, uhuh (yes I see that)

CATHY: ...you know (159), and I don't mind waiting. But now with this one I'm in and out like nowt, whereas I were waiting longer with our N.(baby)(160)

TERESA (stumbling a little): Uhuh - did they em, answer any... (recovering) ... were you allowed to ask questions and stuff when you went - could you ask questions about anything?

CATHY: You could ask (162), but you very rarely got an answer - you got a question back for your answer... do you know what I mean? You

were just no wiser when you walked out of t'room (163). It's stupid really - you were expected to know; that were it, that's what it was (164). I mean same as this, this rash here (indicates rash) (165) - they don't know what it is (166) but they expect me to know what it is (167) 'cos he (the consultant obstetrician) says to me, he says "We'll have to send you to see a dermatologist (168). He says "Is it irritating?" (169) I says "'Course it's irritating!" (170). I says "I had treatment for scabies (171) and it's still spreading" (172) I says, er, "and it's driving me batty!" (173) I says "I'm going to be no good having this bairn 'cos of (lack of) sleep (174). I get, you know, I'm only getting one or two hours (each night) (175); and with a bairn to bring up and all (176), and with a husband as well (laughs) (177), it's a bit much you see..." (178). (addresses Teresa directly) But they're just not bothered wi' you. "Go and see yer doctor" they said (179).

TERESA: And that was it (Cathy nods). Did they, em, were there any antenatal classes - you know, the relaxation?

CATHY: Er. I went to one (180) - I only...I only wanted to go and find out how you do yer breathing when you actually have t'bairn, you know, and that's all I did - I went to that one to learn how to (181)

TERESA: ...do the breathing?

CATHY (affirmative): Mmm, 'cos I thought all the rest were really a waste of time - you know, stretchin' yer ankles and all this lot (slightly comtemptuous) (182). So I just went for to find out what t'breathing were (183) and then I didn't go no more (pauses) - so, that were it (184)

TERESA: Who asked you to go?

CATHY: I think it were (names a health visitor), I'm not sure (185)

TERESA: At the hospital or something?

CATHY (remembering): No, it were (names sister at hospital antenatal clinic) - she asked me to go (186)

TERESA: Uhuh - and so you didn't...did you enjoy the one you went to?

CATHY: It were okay, yeh (188) - they showed you films and this, that and t'other (189) (reflects on content) - "Bringing a child up" (190) and ... (decidedly)...but that's it, you can't - you can't go by films (191). I mean, everybody's got (to) bring their bairns up their own way - d'you know what I mean? (192)

TERESA (Affirmative): Uhuh?

CATHY: And (supposing) we were both working and we'd got plenty of money (193), probably we could have brought t'bairn up their way if we'd got money (194) - but with him losing his job and then me havin' to jack me job in...

TERESA (sympathetic): Yeh...

CATHY: ...we went from two wages to none, so we had to struggle (195). I mean, that bairn of mine, she gets Weetabix more often than not, and cornflakes, when she should be getting meat and fish and stuff like that (196) (becoming distressed) - but you just can't do it (197)

TERESA: I know - that's terrible...

CATHY (recovering herself but clearly not wanting to pursue these issues):
Come on - next question! (laughs) (198)

TERESA: Right - did your husband get involved antenatally? Did he go to any of the...?

CATHY (interrupts decidedly): He weren't interested at all. In fact he never, he never used to come and visit me when I were in hospital.

TERESA: Really? (honestly)

CATHY: Yeh (199). He, he'd just that calm about it as though...as though he'd got a thousand kids of his own, you know what I mean, he was... (exasperated)...men, they're unbelievable! I mean, to me it were t'best thing that ever happened in t'world! (200)

TERESA (sharing her enthusiasm): Yeh (I know!)

CATHY: I were on cloud nine, me, half o' t'time - but "Oh shurrup", he used to say, "let me watch t'telly" - you know, things like that (201) - and I wanted to share it with him, but he just weren't bothered (202). I think now, now she's talking and she's saying "Daddy" and this, that, t'other, he's taking more notice (203) - well, whereas when she were first born, as soon as she roared (cried) (imitating her husband handing back the baby) "Here, to yer Mam!" (204). He wouldn't change her or nowt, you know what I mean. (205) I was just like a one-parent family, just bringing t'bairn up by mese'n (206) - but now she's talking and clouting (hitting) him and that, he's takin' a lot more notice on (of) her (207)

TERESA: Right...when you went into hospital for the baby's arrival, did you enjoy your stay in hospital?

CATHY (very definitely): No, I didn't, no (absolutely not!) (208)

(Teresa laughs at her definiteness)

CATHY (laughing in response): On no - well, I went in before, because she were three week overdue (209); and they couldn't make up their minds what date I were due on (210); and I'd been in (hospital) all Thursday and they says, "Oh, if yer - if yer haven't started in labour (soon) we're gonna set yer off" (211). Well, I wanted to get it all over and done with (212), 'cos, I mean, nine months is long enough, without nine month and another month on top of that (213), so I thought "Great!" (214). And they never tell you nowt at hospital (215), because they'd got me on the side monitor machine and what I thought were tightenings, <u>they</u> were contractions (216) - I'd been in

slow labour for two days and they'd said nowt to me (217). And then they were rushing about on Sunday (218) and they'd to...they had to put me on a six-hour drip and rush me or I'd have lost her (219) - but they never said nowt (to me) (220); they just kept comin' tearing strips off (the monitor readout), running back, bringing t'doctors looking at t'chart, bringing...tearing more strips off, you know (221). And I, I were really shittin' mese'n...

TERESA: I'll bet!

CATHY: ... thinking, well, I wonder what's going off (happening) here? (222); 'cos normally they don't set anybody off (induce labour) on a Sunday (223), they wait while (until) Monday, while t'consultants come (224): and I thought, well, I wonder what they're doing here? (225) Anyway, it were quart' to twelve, and for (by) half-past twelve (226) they'd got...they'd broke me watters (waters) (227), they'd got me on t'drip and t'whole lot (228) - so I thought well, they must be doin' summat here (laughs) (229) (winding down); but they set me off on Sunday (230)

TERESA (acknowledging her harrowing experience): That's terrible... Right, em, how long were you in for - just the week?

CATHY: I were supposed to be, aye (231). I went in on Thursday, I were in a week and me ninth day was due - (informative) you know how you've got to keep babbies in for nine days? - it were due t'day after, so I were in (hospital) roughly a week and a day, you could say (232)

TERESA: Had you ever been in hospital before for any reason?

CATHY: No, I'd only...well, stitches and bumps and things like that; but I'd never... that were t'first time I'd ever <u>stopped</u> in hospital (233)

TERESA: Yeh, yeh - so it was frightening?

CATHY: It was (234), 'cos everybody seemed to be coming and having their bairns and going home (235); and you see she, she were full of jaundice, so they kept me in longer with her (236); and I thought, well, this is bloody marvellous - I come in first and I'm going out last! (237) You know, I were beginning to (think like that). Now, eeh, when I look back, I'm glad really, becos' it were a break, you know what I mean? (238) I didn't feel as though I'd got a bairn, 'cos I mean t'only time you ever brought 'em out were when visiting-time (came) and they were... then you fed 'em; and then they were back in t'nursery for you to get a nap (239) - and it were great! In fact, I'm lookin' forward to goin' in this time (laughs) (240)

TERESA: You'll have to make the most of it (pause). When you were getting ready to leave the hospital, did you have arrangements at home to make things a bit easier for you when you got out - did you have some help?

CATHY: Well, B. offered to help (242); and, er, I'd got all t'stuff sorted out, and all it wanted was bringing downstairs and airing (243); and it was the first time he'd ever shown any interest in doing owt (anything) for me (244). And me Mam and Dad come down (245), and

me Mam's one of these that (say) "Oh, yer not doing <u>that</u> right" and "Yer not doing <u>this</u> right" and "She'll want <u>that</u> doing" (246) and he ended up swearing at her. Well, they had a big argument over it (247): so when we come out - well, I'm saying, it looked like a bomb had hit it (248). (whilst she was still in the hospital) everybody were coming and telling me how nice he'd kept t'house and (that) he'd got everything ready (249): and when I come out... (overcome by her memory of what occurred)... oh, it were bloody terrible, lass! - I sat down and roared (cried) (259). I were doing housework ten minutes after I'd got in t'house...

TERESA: Oh dear me (shocked)

CATHY: ...it were that bad (251). But, er, I think that's why I lost me milk, because I were at it (busy, distressed) (252). I'd have liked to have carried on breast-feeding (253), but I were just at it solid (continuously): it never, altered, you know. I were still doing housework and I weren't getting the rest. (254)

TERESA (sympathetically): Yeh

CATHY (somewhat defiantly): Min'st (mind) you though, I've learnt to cope with it now, so (255)

TERESA (agrees): Uhuh, uhuh - what about transport back from hospital - how did you get back?

CATHY: Er, one of his (husband's) mate's cars (256) - he, he brought me back by car 'cos...well, what it were, me Dad's car had gone off t'road (257A); and me husband had sellt our car while I were in hospital, because he knew I wouldn't part with it otherwise (257B) (takes out a cigarette). You see, we bought this little mini... (searches unsuccessfully for a match)

TERESA: Have you got a match, do you want...?

CATHY (accepts a light): I ain't got a light...we bought this little mini and, er, we couldn't...we sent off for t'log book for it and they couldn't...they'd got no, no note of it at t'motor place, like (257C); so we were beginning to think it were stolen, you know (257D) - so he got shot on it while I were in hospital (257E); and then he finds out that t'fellow he got shot on it to sent off and got t'log book as easy as pie! (257F)

TERESA: Really?

CATHY: ...and it were t'best car we'd ever had (257G); and it only cost us thirty pound and all - that were t'best thing about it (257G) (sighing wistfully).

TERESA: Oh dear... right, when you got home, how long was it before you were visited by the midwife?

CATHY: I can't...I think it were t'day after (258)

TERESA: Uhuh, and what was she like when she came?

CATHY: Well, she...they're all helpful; I mean they're...they try to

make you understand things (260). I mean, I have, I have got a bit of common sense like (261), but - I don't know, I think a babby causes more problems than owt - you know what I mean? It caused problems between me husband and me Mam and Dad, they were arguing (262). And they (i.e. professionals) look at it - well, let's say through rose-coloured glasses, let's say (263). They think it's all straightforward and easy (264); well, I suppose to them it <u>is</u> easy - but you've got to have money, same as I said (265)

TERESA (agreeing): That's right, yeh

CATHY: ...and I mean, I were fed up of them coming and causing arguments (266) ; and I were, I were in t'middle on it - I'd got to take sides between me husband and me Mam and Dad, and you can't do that, and then they come down (get angry) (267). And then I told her about it - t'midwife - (imitates midwife) "Oh, it'll be sorted out, once the baby's walkin' and talkin'" (268) - you know all the... but tht's it - it weren't getting sorted out, it were getting worse, in fact (269). I know, I know it's a callous thing to say, but I were beginning to wonder whether it were worth me having a bairn, you know what I mean? I were thinking to mese'n "Well, I wished she'd a-been born dead now" (270)

TERESA: Yeh, yeh, and you wouldn't have had half the trouble... (echoing C's sentiments)

CATHY: And...but I don't know - they, they expect you to cope, that's what it is... (271)

TERESA: Uhuh...expect you to get on with it. What, er how long was it before you were visited by your health visitor?

CATHY: Oh, er, about three or four days, summat like that (272)

TERESA: ...and what was she like when she came - like the midwife?

CATHY: No, she were okay (274). I mean, I've had, er, I've had marital problems since (275) and I've been able to go up and talk to her - she's been really good and understanding, and things that she's said to me has made complete sense to me (276)

TERESA (encouragingly): Mmm?

CATHY: ...but, me husband is one o'them that weren't (won't) listen to anybody, so, you see, it's not made us (our) problem any better (277) - but I can see it a lot clearer now (278)

TERESA (curious): Mmm...mm...what happened - what's been going on ?

cathy (seriously): Well, he used to, er, he used to beat me a lot (279)

TERESA (concern, dread): Oh dear...

CATHY (hastily): ...only after we were married - he never brayed (beat) me before we were married (280). And he brayed (beat) me when I were carrying' t'babby, and she's carried a mark on her stomach where he brayed me (281)

TERESA (sympathetic, concerned to find the reasons): What ...was it just arguments got out of control, or...?

CATHY: Well, he's...he's gypsy blood in him you see, and he's very quick-tempered and, you see, he flies off t'handle for t'least little... like, if he's had an argument at work he used to come home and take it out on me or owt like that, you know - 'cos I were t'only one (to take it out on) (283). And I used to try to talk to him, but he just couldn't...you couldn't get owt through to him (284). I ended up going to me own doctor in t'end, 'cos I were, I were bad with me nerves, and I thought "Well - twenty-one year old and a bag of nerves!" - and I were havin' to take sleeping tablets and this, that and the other (285) - and I thought "Well, it's no good, because I'm just gonna end up neglectin' me bairn" (286)

TERESA (encouragingly): Mmm?

CATHY: You see, it didn't make it too bad once I'd got her (indicating the baby) (287). (softly, almost to herself) 'Cos I know well, if I haven't got him, I've got part of him (288)

TERESA: Mmm?

CATHY: You know what I mean? So that made it a lot easier. Now, I mean, now they (these considerations) could make it a lot easier to say "I'm going" tomorrow (laughs). I wouldn't be bothered, I've got me bairn, you know what I mean? (289)

TERESA: Mmm - uhuh (Yes)

CATHY (indicates current pregnancy): I mean, this one were only 'cos he thought he were goin' down t'line (laughs) (290)

TERESA (curious): Why did he think he was going down t'line?

CATHY: 'Cos he's a bugger - it's t'lads that he mixes with - they're always trying to get him into pinching and that (291)

TERESA: Well, if you've got no bloody money, what are you supposed to do? (echoing first part of interview)

CATHY: Well, that's it - (confidentially) he's had, he's had to pinch coal and things like that - else we'd have been freezin' (293). We'd have been freezin' and all, up to her being about five month old. She were down here (in the living room) in t'cot; B. were sleepin' on t'floor and I were on t'sofa (294). And when I tell...when I telt them at t'Social Security (imitating the reply) "Oh, a lot of people are in your..." - well, I know they are...(exasperated) (295)

TERESA (pursuing her idea - righteously) ...but it doesn't make it right

CATHY: No, it doesn't. That's what I can't understand. I mean, fair enough, there's folk that's been on t'dole for years and years (297) - (snaps her fingers) they've only got to go like that and they get all they want (298). Me and my husband's always worked for a living, you know (299), and that's what I mean - I mean, I've had to sell me

telly; I've had to sell me bar; I've had to sell me rings, just to pay electric bill (300). And, I mean, I've worked for them - we've both worked! (301) (sadness here)

TERESA (supportive): I know

CATHY: ...and that's what makes me...it...you know, I think - I don't know... I wished he could get a job. I mean, he's been for hundreds, but there's no chance - and that's what makes it so...so bad, you know (303)

TERESA: Mmm...

CATHY: ...and it wouldn't be so bad, but now we've got a bairn to bring up as well (304)

TERESA: Mmm, I know, that's it - when you've got a baby it's worse, isn't it? So, where did he hit you - everywhere?

CATHY: Yeh, yeh, he used... I used to end up with black eyes and busted ribs and all sorts (305)

TERESA: Oh, you poor thing - it must have been awful.

CATHY: Well, it was...it was (pauses)

TERESA: Was it every night, or...?

CATHY: He doesn't ...no - but I could, I could guarantee that before t'week were out I'd got a good hidin' for summat or other (306)

TERESA: What - just anything?

CATHY: Well, I'll tell you what it were. He used to go out pinchin' (307), and up to (the time of) me havin' t'babby (308) he used to go out about eight o'clock at night and I wouldn't see him while (until) next day, and we didn't sleep together or owt like that (309). We couldn't sit down and have a talk like me and you are doing now (310)

TERESA: Mmm...

CATHY: ...and it were just all gettin' on top of me, and I found mese'n nagging at him (311). And then, when he started bringing these thieves in (312), and I were tryin' to tell him that they were just usin' him, see, he wouldn't listen to me (313). (ruefully) then, that's when he used to fly off t'handle - he thought I were talkin' a load of shit (314)

TERESA: Mmm... Does it still happen now, then, or...?

CATHY: No. He hasn't hit me for, it's about... he hasn't hit me since I've been carrying this one (i.e. about eight months) (315)

TERESA: Mmm... Could you defend yourself - did you hit him back or...?

CATHY (as if this is obvious): Oh, I used to hit him back, but I used...I used to get it twice as bad - (emphasises) - twice as bad. That's it, men are stronger. Yeh, I er, I mean, he changes, like into

t' (incredible) hulk when he's mad (angry); and he can throw me round this room like a toy (316)

TERESA: Mmm?

CATHY: You see, but... now we don't argue so much 'cos more often than not he's out of t'house (317)

TERESA: Mmm?

CATHY: I got him a load of fishing tackle, and that kept him out of trouble for a bit. You see, once he weren't in, we didn't argue (laughs) (318)

TERESA: Yeh...

CATHY:... and I thought, well, it's not fair on t'babby really...

TERESA: Yeh...

CATHY: ...bein' in the middle of arguments (319)

TERESA (recapitulating): Mmm... So it's mainly money that caused the arguments then, is it ?

CATHY: It is, yeh, that's, that's what it is - it's money that's done it (320). I mean, in a way he were right - if we had got money he wouldn't have to go out pinching (321). But he's never been caught (322), but he's always been split on (informed against). And it's always been his mates (with great irony) - you know what I mean, his good friends who would never split on him? (323) (using husbands naive phrases).

TERESA (knowingly): Oh, aye!

CATHY: ... and now, we're paying all t'fines off all t'time (324)

TERESA: Mind, he's got to watch folk, haven't you?

CATHY (agreeing): Mmmm...

TERESA (worldy-wise): If you're goin' to do any nickin' ...

CATHY (maternal, excusing): Well, you see, he's gullible, me husband (326)

TERESA (inviting her to continue): Mmm?

CATHY:...but I could see, right from t'beginning, that they were just using him (327). But I tried to tell him and, of course, I were wrong (328). But I... he's found out since that I were right. And, in fact, sometimes he's said to me "Eeeeh, Cathy, I wish I'd a-listened to yer" (329)

TERESA: Yeh, yeh...

CATHY: ...but it's too late now, 'cos I mean, now, I mean, we're payin' three pound a week on fines (330). (sadly) That three pound a

week could be gettin' me extra snap for me bairn, you know what I mean? (331) (with a faint hope) But he's probably learned his lesson now (332)

TERESA (warm and encouraging): Eeeh, I think you've done well to survive, I really do. I mean, how much must you be gettin' a week?

CATHY: Forty-seven pound

TERESA: For three people ?

CATHY: ... and then there's ten pound rent to come out of that

TERESA: So, you're living on thirty pound?

CATHY: Thirty-seven. There's ten pound bank loan a week (to be paid back); five pound (a week for the furniture) suite; three pound (a week) insurance. (calculates) We end up with about six pound a week for snap (food) and clothing and household stuff (333)

TERESA: Gosh, that's terrible (difficult)

CATHY: I know - and then I've got to get me coal out of that as well. I don't know, I don't know how we've...we've had to survive, I mean (333A), same as I pay two pound a week for a bag of 'tatties. We have chips, more often than not, which is all we can afford, and t'babby has Weetabix and chips. I ha'nt had, I ha'nt had a joint of meat for ...ooh, God knows, but it's over a year since I had a joint - we have to make do with sausage (laughs)

TERESA: Even sausage isn't cheap, though, is it? It's about sixty or seventy (pence) a pound now.

CATHY: No, it isn't no. I pay about fifty-eight (pence) a pound. I get a pound and a half, and it lasts us three or four good meals, you know (333B). (pulls strained expression).

TERESA: Yeh, yeh...eeeh, you poor thing, I just don't know how you manage.

CATHY: I just don't - I don't. I've got to - I've got to keep me will power up (334)

TERESA: Yes, you've just got to keep going (echoing)

CATHY: ...'cos if I don't, I know that t'next thing (is) I'll be having another nervous breakdown...

TERESA: Yeh...?

CATHY: ...and I couldn't, I couldn't go through all that again (335). I mean I were...I were pelletin' mese'n with, er, drugs and this, that and t'other, just to calm mese'n down (336). And I thought, "Well, Cathy, slowly but surely you're killin' yerse'n off" (337). And, luckily, I ain't had sleeping tablets or owt like that since I had her (338). But if things carry on t'way they are, I'm goin' to have to... I don't want to go... I don't want to start takin' drugs and that, but... (339) (looks hopeless)

TERESA: Well, they don't help anyway, do they really? I mean, what you need is money - you need some money to live on (echoes sentiments)

CATHY: That's it. But, I mean, we've trailed through to (neighbouring town), we've trailed through to (another neighbouring town), we've tried all over to get some money and you just can't - they're just not interested (341). I mean, I've got, I've got one pair of sheets and that's to do for three beds - so God knows how I'm goin' to do it (342). I've had to sell one of me beds and all (343). I ain't got no bed for our babby when t'other babby comes along. They've more or less told me that they've both got to share t'same cot (334)

TERESA: My goodness...

CATHY: ...and even that, that's broke, t'cot - it were second-hand when I got it (345)

TERESA: Mmm...Has the health visitor...does the health visitor know, 'cos she might be able to do something?

CATHY: I've been up to t'health visitor (346). She sent me t'Social Services at (a suburb of her home town) (347); and I went there, but they'd got nowt in (348). I mean...I mean I didn't like...I don't like begging...
TERESA: ...I know, but you've got to...

CATHY: ...that's...that's what I feel like I'm doing - begging (349). (doggedly) But I mean I've got a...I've got a bairn to think about now (350)

TERESA: I know - that's it, yeh...

CATHY: I mean, we've always worked for what we've wanted, - but there's no chance (351). I mean, that maternity allowance...I'd really built me hopes up 'cos they'd sent me a book on Friday (352); and I'd built me hopes up 'cos I'd seen a cheap tumble-drier (353), and I thought, "Right, with t'money I'm goin' to get that (354). On Saturday, they'd knocked it off his dole money (355) - they never said a word to us about it (356) - so we had to go through and see to it. "Oh well", they says, "we can't be giving you this and that as well" (356A). But I mean, I were goin' to get a bed and all sorts out of that money (357). I mean, this baby's due now in about a week to a fortnight, summat like that (358); and upstairs I've got a little pair of, like, plastics; a little blue vest; a little blue cardigan; a blue pair of mittens and a blue shawl and that's it - that's all I've got for this bairn (359), and I know it's goin' to be a lad this time 'cos I can tell, see (360) - if it had been a lass, I've got plenty of gear from her (indicates baby); but I've got nowt if it's a lad (361), and I'm just whittling mese'n to death now, 'cos I'm getting that near, you know, I, I can feel that I'm near t'end now (362)

TERESA (sympathetically): Oh dear me... Did you, em, did you know what sorts of things to get ready for your first baby ?

CATHY: No, I didn't (363)

TERESA: well, how did you find out?

CATHY: Well, I got one of them books from. from t'antental clinic; and it says, oh "Everything you Need for your Baby"; so I just followed that more or less (364) But I were getting stuff, I were getting stuff that I didn't need, like (365). Even when they packed me case up, they never said nowt that you didn't need to take t'baby's stuff through (366), so I packed this case full of t'babby's clothes and nappies and all sorts (367). Well, they supply nappies and vests (368) - and, well, I didn't know, - they never said nowt to me (369)

TERESA: You should have took a few of them... (laughs)

CATHY (laughs and replies in same tone): I did - I took a load, lass! (370)

TERESA (laughs) Good...!

CATHY: I'll tell yer, he (B.) come to pick me up, and he'd been late or summat - he were supposed to be comin' at one o'clock (371). Well, after five o'clock they wearn't let you go or summat (372), so it were getting on to four o'clock and they'd used my bed - (explaining) they'd got my bed made up for somebody else (373). So I thought, "Well, I can't go" (374) - and I were dressed all ready (to go) (375), and it were t'time for her feed and I were leaking (laughs) (376). So when he comes, I says "We'll have to go in here", I says; "We'll have to feed t'babby", I says, "because you're too late - 'cos her feed were (due) at three" (377). And this nurse says "Oh, get a few nappies while you're in there, love". Well, I'd got t'big case with all me stuff in, and I filled it - I packed it out. They lasted me about five week! (378)

TERESA: Yeh, you'll have to do the same thing next time, an' all! (laughs)

CATHY (decidedly): I'm going to do. I've told them - everybody that visits me's got to bring a little shopping bag (with them), and I'll put some in (379)

TERESA: You must try to get whatever you can, (laughs). Right - when you were coming home from the hospital with your baby, can you remember what you were worrying about - can you remember your immediate worries, what with being a first time mother and...

CATHY: Yeh, it were "How am I going to feed it?" (laughs) (380); you know, 'cos I were breast feeding like and I'd been told off (by) no end of folk that once you get out and get t'housework done, your milk goes (381); and I thought, with him not working, how am I going to get all t'proteins and that for t'babby...that a babby needs, y'know...'cos she were on solids, her, at four weeks old she were that fast - and I thought, well, I'm never, ever goin' to be able to feed her (382). And then (next) I thought, "Well, I wonder if t'house is goin' to be warm enough for her?"

TERESA: Yeh, yeh (go on)...

CATHY: ...'cos it's terrible cold in winter, this house; and I thought

"Well, has he got enough coal for..." - you know, for t'fires to keep 'em in and that (383). And then I thought, "Well, I wonder what t'house is goin' to be like when I get back?" (384)

TERESA: Yeh...

CATHY (laughs): Well, I sat down and roared, lass!

TERESA (laughs with her): Did you feel confident?

CATHY: I felt clumsy, I didn't feel confident at all (385); in fact, it took me three or four days before I got to love her. I know it sounds funny, with it being me first bairn and me wanting her so much, but I...I hadn't got that <u>bond</u> with her. It took days for it to grow on me, you know what I mean? (386). I just felt clumsy because, before, I'd never dream of picking a bairn up that small; (seriously) and I were always frightened to death of <u>dropping</u> her - you know what I mean?

TERESA: Yeh (encouragingly)

CATHY: I felt so clumsy with her (387), until me mother said "Well, they're a lot stronger than they look, you know!" But oh, I did feel clumsy, I felt inadequate (388). T'only thing that I felt good and proud and confident about were, when I were walking down the street (with the baby), and people were saying, "ooh, let's have a look!"

TERESA: Yeh...

CATHY: You know, you know I felt really great then, when people were saying "Oh isn't she lovely?" (389) (wryly) And she weren't really - she were ugly when she were born - she were really terrible! (laughs)

TERESA: (laughs with her)

CATHY: I think it were with bein' overdue and all, 'cos she were all...all patchy and blotchy and dry... you know, all dry skin and that (390)

TERESA: Mmm... Were you glad to get home ?

CATHY: Yeh, I was. (Mind you) I wearn't be this time, but... (laughs) (391)

TERESA: Right...if anything happened during the early weeks, where did you go for help and advice ?

CATHY: I used to go up and see t'baby doctor - (checking her meaning) - you mean if owt happened t'babby ?

TERESA: Mmm (affirmative)... You know, if anything was worrying you or...

CATHY: I used to go up and see t'baby doctor (392); but I found that he were a load of bull (393). Well, I mean, his, my husband's, mother suffers with T.B.; and although me husband isn't chesty, she is, me daughter (indicating baby) - and me mother's chesty as well and I'm

not (394). And, er, I went up because, well, I'm saying, there were that fear of the cot deaths going round - there was a little lad down here had died with it (395). But she were that chesty - I could always tell when she were asleep, you know I could really feel it, you know,on her chest, ruttlin' all t'time (396). And I went up to see t'baby doctor about it; and he said oh, it were t'cold in her nose - her nose were blocked (397). But she's ...she's gettin' worse and worse (398). She's had t'T.B. injection but she is very chesty and it does frighten me sometimes (399), because I know, sometimes when she's bad she wakens me up, she's that loud and that (400). (resuming her account) He reckoned it were her nose (scornfully) - and I wouldn't go to him now. If I've got any problems I'd go to me own doctor at (names group practice), 'cos he's ever so good, him (401).

TERESA: Uhuh...What sorts of things have worried you during this first year of being a mother - what things stand out as having been a big worry? (accounting for her last statement) There's <u>that</u> for a start...

CATHY: Well, dressing her has been... you know, providing clothes for her and that...because from being about six months old to being a year old, they seem to go through clothes like, like nowt... you know what I mean, they grow out... (402). One day you can put 'em on and they fit all right, and the next day - that's it, and you think "Well, that's a bloody waste of money, that" (402A). I mean, I got a hell of a lot of clothes for her when she were first born; and she seemed to grow out on 'em before I knew what were happening (402B)

TERESA (agrees and elaborates): Yeh, they do...they shoot up, don't they?

CATHY: But, er, t'main problem's been feeding her and dressing her, you know, with not having enough... (403). I mean, same as I said, me and me husband, we've starved so as that she could have summat (404). It's not...bothered us, like. I mean, I've always had me Mam - if we've been short of snap (food) I could always go up; but she's on t'dole as well, you see. You can't expect too much from them, but she's always made sure we've come away with a...with a meal inside us, you know (405). And when she got, when she got walking, that was t'worst problem, because you've got to have eyes up your arse to keep...you know (406). She keeps banging herse'n now; and I daren't take her up to t'clinic 'cos she...she's got a black eye now, where she fell against t'corner of t'bloody table...

TERESA: (reassuring): They're always doing it...

CATHY: ... and I daren't take her up to clinic, 'cos you've heard they...these things about women beating their bairns up and that - and I think, "Well, I wonder if they'll think I've done that?" (407)

TERESA (reassuring): Mmm... I know, it's a real worry, isn't it? But I think that's something they've all got at this age, 'cos a lot of mothers have said that one thing that's really worried them is the baby throwing itself around - they just...some of them just tearing across the room...

CATHY: Well, that's what I mean - since she got walking she's been on her arse more times... (408)

TERESA: I think it's 'cos they can't balance when they're that age.

CATHY (offering Teresa a cigarette): Do you want one of these?

TERESA: No thanks, they're too strong for (laughs) - I'll get the matches. (encouraging her to continue) Yeh?

CATHY: It's not that and all (not only that) - I got...I can't afford to get her proper shoes (lighting a cigarette). T'shoes that she <u>has</u> got, I got 'em from a jumble sale and they've got no tread on 'em - and she keeps sliding off that carpet there... (indicates carpet)

TERESA: Oh, yeh... (notes the spot)

CATHY: ... and going and flying (409). I mean, t'other day - I know it sounds callous - but she did t'splits. Now it hurt her poor little... but it were that, it were that comical I just couldn't, you know, I just couldn't help mese'n from laughing at her, you know - 'cos she went ...she were sort of getting' off that carpet and she...one foot went that way and one foot went that way and... (410). Mins'st you, though, I've always said this - if you make too much fuss over a bairn (after a 'spill') they roar (cry) all the more (411)

TERESA: Yeh, yeh...

CATHY: ...I mean, at one bit she'd only got to go like that and catch herse'n; and if she roared (cried) I used to... "Oh, me babby!" - (fly to her aid) you know all things like that (412). And folks say, "Oh no, you're makin' a rod for your back - just laugh at her!" So I laugh at her now if she does owt (413) If I know she's gone bad (fallen heavily), like when she hit her head I knew there was summat up then because she really screamed, and it come out more or less straight away - and then I did panic. But owt else (if any small accident occurs) I say, "Oh, get up, yer silly bugger!" and laugh at her. And then she's (all) right, you see - she has a laugh with us (414)

TERESA (laughs): Yeh...

CATHY: (still thinking of baby's behviour): It's amazing...kids - and she's very intelligent for her age (415) (thinking of an example) That's one thing I wouldn't like... - I got some new eye-shadow, and it were a screw-on top, and I thought "Well, a bairn her age'll not be able to take it off". So I give it her - walks in t'kitchen - comes back in - blue eye-shadow everywhere - she'd got it all over! (416) I'd only just got it from Avon, and I thought, "Well, I never thought that a bairn her age'd have t'intelligence to screw t'top off and take it all out". And...ooh, but they're a lot brainier, kids, than we think (417)

TERESA: Yeh, yeh, bright... (moving on) Right, the next bit's about, em, help and advice. Do you think you've ever suffered from lack of help and advice ?

CATHY: Yeh, I have. Yeh, when, when I were carrying her, I didn't know what I were lettin' mese'n in for or nowt. I mean, I found out - (wryly) - I found out by actually doin' it, d'you know what I mean?

(418)

TERESA: Yeh, that's what a lot say

CATHY: Like me mother and all these that's 'ad kids; they all used to say "It's the worst pain you can ever go through - but once you see t'baby, you forget all about t'pain" (419). Well, of course, nobody likes t'idea of havin' pain; so for t'last few week I were like this, you know (huddles in mock terror) - I were really shittin' mese'n. Well, (imitates) "T'worst pain you can ever have..." - you know (420). And then I thought to mese'n, "Well, you silly bugger - if it's t'worst pain you can ever have, how come they go in and have two and three kids", you know what I mean? "Well" I thought, "it can't be that bad or they wouldn't - they would only have one". And then there's me mother there with four, and she's saying it's t'worst pain you can ever have! (421) But to be honest, I think it's just like tryin' to have a good shit when you're constipated - that's t'only pain I can liken it to. Yeh, that's all it is, really (422). But now I'm gettin' to t'latter end with this one, I'm remembering t'pain from t'last one, you know what I mean ? (423)

TERESA (moving on): Right, the next bit's, em, do you think your husband's adapted to being a father quite well, or...

CATHY (decidedly): Do you want my honest opinion ? I don't think (that) bringing a bairn up changes (affects) a man at all - that's my opinion from B. I mean, he can still say "Oh, I'm going so-and-so" - "I'm goin' to do so-and-so today" (424) (contrasting her own lot) If I want to go anywhere, I've either got to take t'babby with me or find a babby-sitter now. I mean, I'm stuck in t'house from one day to the next (425). I mean, I've only been...it's only 'cos I've been really badly (ill) for t'past couple of days that me Mam's got (looked after) t'babby - otherwise I'd have been wi'her, you know what I mean? (426) And I sleep with her, and she waits (stays awake waiting) for me to go to the bed on a night, so I get no break from her...

TERESA: It's twenty-four hours a day, is it?

CATHY: Yeh, I have her through t'day and through t'night (427). He says "Oh, I'm goin' to so-and-so's for an hour" - I can't. You know I don't think it (parenthood) changes (affects) a man at all (428). T'only time it changes (affects) a man is if his wife pisses off and has to bring 'em up hisse'n - <u>then</u> they understand how we feel (429). But, apart from that, they can just say, "Oh, I've got a daughter - I've got a son" (and) that's it - that's t'end of it, for them (430). I mean, even if...he don't have to worry about "Is she gettin' enough snap (food)?" - you know, things like that. He don't like to let nowt worry him; and (whereas) I've got to think to mese'n, "Now, have I got enough clothes for her for winter?" - "Have I got enough this?" - "Have I got enough that?". I do all t'worrying (431). Plus, they're on about evicting us from this house and all, and... (432)

THERESA: Really?

CATHY: Yeh, there's been a mistake with t'rent. Now (recently) t'rent man comes when he feels like it (irregularly), so it got us about three week behind with us (our) rent. Well, at head office they've got us about six week behind, and they're on about evicting us - well

(quotes) "take possession of t'house" (432A). You see, with it being a pit house, they're not forced to find me another house, see? If it were t'Council, they'd have to, but with it bein' a pit house they're not forced to, you see (432B). So, I have all these worries, plus bringing a bairn up, and he...he don't...it don't bother him at all - he's not bothered (433)

TERESA: Mmm, dear me... (moving on) Has the baby been ill at all this year ?

CATHY: Well, apart from her being chesty - she's had a lot of colds and that, you know (434)...but that's only, that's only expected with t'house - I mean, you can feel it as soon as you walk up them stairs, cold and damp... (435)

THERESA: Yeh, yeh - but other than that she's been... ?

CATHY: She's been pretty fit (436). In fact, it's me what's been badly (ill) more, you know, since I had her, than she's been (437) But she's a good babby - well I'm saying, when she's good she's really good - but when she's bad I could kill her! (438) (laughs)

TERESA: Yeh, yeh - what about feeding? You said you breast-fed (her) at first?

CATHY: Yeh, I did, yeh (439)

TERESA: How did you find that?

CATHY: That were painful - very painful. I mean, it felt like they'd got a moughful of teeth (440). But I thought, "Well, if it's t'only way I'm goin' to get me figure back, I'm goin' to keep on" (441); and (eventually) I got enjoyment out of it. And I thought...well, you know I used to love to just watch her, and it used to...(too difficult to describe her pleasure)... I don't know (442). It were just t'same as when he were bringin' all of his mates in - I used to think to mese'n "Well, I'm not goin' upstairs to t'cold bedrooms to feed her!" So I just used to get it out and feed her - I didn't give a chuff who were in because...well I'm not lettin' me bairn starve (443)

TERESA: Yeh, just for other people...(echoes)

CATHY: ...and with her bein' overdue and all she were right hungry, 'cos t'cord or summat weren't feeding her - you know, it had started disintegrating. But with her being greedy it were painful at first (444). But after t'first couple of week, Oh it were lovely...a lovely sensation (445). I'd do it again but, er, I've got a bike and that, and I want to, I want to get me figure back, 'cos it's a bigger babby, this one (446)

TERESA: Yeh...and then at what stage did you start bottle-feeding?

CATHY: I started bottle-feeding her when she were about four week old, 'cos me milk had gone. But (later) she were off t'bottle for four month - she don't even know what t'bottle is! (447)

TERESA (following this up): And did you manage to get your milk and everything alright?

CATHY: Yeh, I got me milk okay (448)

TERESA: Em, who would you say has been most helpful in bolstering your self-confidence in looking after her?

CATHY (thinking): Well, I can't...nobody really. I've had to do it mese'n, you know what I mean? I've had to think, "Well, Cathy if you don't look after her, nobody else will!" And me mother's badly (ill) herse'n and me father does everything for me mother, so I couldn't really put it on them. And I've got nobody around here and his (husband's) family's too far away so I've had to do it mese'n, I've had to - you know what I mean? I've had to cope (by) mese'n (449), and I've thought - well t'same as that doctor (her own G.P.) said "If you start neglecting t'bairn with the way your husband's been treating yer and this, that and t'other - it's just no good". I mean, he could've given me the drugs and tablets for me nerves and that months since. "But", he says, "It's goin' to be no good", he says, "yer just goin' to neglect yer bairn". So I've done without and I've, er, I've overthrown it mese'n, you know what I mean? (450)

TERESA (affirmative): Uhuh (referring to schedule) Right, the next bit's about your first visit to the clinic with the baby. Were you apprehensive about going?

CATHY: Yeh, I were - I, I felt terrible (451). I didn't want to go because I felt all...well, t'women round here (in the neighbourhood), they're right bitchy, and I thought, "Well, they'll be on about me bairn and this, that and t'other" (452). 'Cos, I mean, I couldn't afford to buy brand new for her, and I used to - still do - go to Dr. Barnardo's and jumble sales t'first chance I get. And when I went up there (to the child health clinic), there were all these women with babbies with lovely pink outfits...and I <u>tried</u> to dress her nice, you know what I mean? (453) But I just couldn't compete with them and I did feel a bit funny (out of place) (454). And when I got back I says to B. I says, "I'm not going up there again", I says, "it's shown me up, you know!" (455)

TERESA: A lot of them use second hand stuff, you know, though...

CATHY: Oh I know - you ought to see 'em at t'jumble sales, lass, with big fur coats on 'em and that, going <u>scrounging</u> (456)

TERESA: Yeh, I got this from a jumble sale (laughs)

CATHY (indicating her own clothes): I've got <u>all</u> these from a jumble sale! (laughs)

TERESA: ...'cos I don't get much you know, with still studying...

CATHY: Yeh ? (feels coat)

TERESA: I mean, it was only two quid

CATHY: Yeh, you'll have your books and all that lot to pay for, wouldn't you, as well? (457)

TERESA: Yeh, but, you know what I mean, they can look as good, I

think, if you just...

CATHY: Of course they can, yeh... You ought to see t'young 'uns now, at t'jumble sales. I mean, at one time it were all these old fogies and that, you know; but now, you se t'young 'uns going up - and they come away with some beautiful stuff (458)

TERESA: Yeh, yeh

CATHY: Mind, you see, I don't like buying stuff, you see, when I'm pregnant, 'cos you never know what size you're goin' to go back to (459)

TERESA: Yeh...yeh, wait 'till you've had it and...

CATHY (returning to subject): but, er, I did feel a bit shown up at t'clinic (460)

TERESA: (probes): ...and, er, so did you go back ?

CATHY: I did; but I don't go, I don't go very often (461). I mean, like (names health visitor at child health clinic), she says, er, she says, "Oh", she says, "if you're ever short on clothes", she says, "We have a couple of boxes behind, behind t'counter where they serve tea and that" (462). So I went up about three month back and got her some clothes - some good, decent clothes and all (463). And I went up last week and I says to her, "Have you got any more clothes I can look at?"

She says, "Aye, love", she says, "go and help yerself". So I went, and this woman put two boxes out like; and they'd only got a bit of stuff (464). And I says to this woman, I says, er, "Have you got a carrier bag, love, for these clothes?", "Have you paid for 'em?" she says. "Paid for 'em?" I says, "Why, have you got to pay for 'em?", "Yes, you've got to pay for 'em; it all goes in the Christmas fund for the kid's party". Well, I didn't know; and she were right snotty about it (465). So I says, "Oh, I'll put 'em back then, love", I says, "I ain't no money to pay for 'em". She says, "Well, you know you've got to" (466). So I says, "Oh, I'll go and see (names health visitor), then about it", I says, "because she told me I could have them". "Oh, it doesn't matter - if (names health visitor) says it's all right, then it's all right" (467). I thought, "Yeh - she's either fiddling or being a bit...", 'cos I'd never seen here there before, you know.

TERESA: I don't know who it is...

CATHY: She were an old woman with grey hair and glasses

TERESA: I don't know...

CATHY: I've never seen her before (questioning) (468)

TERESA: Oh, take no notice of her, oh dear... Right, the next bit is, is it possible to have a private talk to staff at clinic if you need to?

CATHY: Yeh, it is (469)

TERESA: It is, okay, right. Do you like the system whereby you just pop in when you want to, or would you rather have appointments?

CATHY: Oh no, I like...I can never keep appointments, that's t'only thing (470). I...'cos I mean, like going to t'doctor's. If I want to go to t'doctor's, I've got to get up right early in t'morning (and) get t'babby dressed, washed, changed, fed before I can go anywhere, you see. And then by that time it's too late for t'doctor's. I find mese'n getting up right early, (but) I can never keep appointments (471), so...but, er, I just like to be able to pop in when I, when I want to (472)

TERESA: Uhuh...have you ever preferred not to go for any reason?

CATHY: Only when, like I say, when I first found out that she were chesty; and I went up and told t'doctor, and he said it were a cold in her nose. Well, I knew it weren't, and I thought, "Well, if these are what you call baby doctors, then I don't want to see 'em no more" - and I wouldn't go up and see him every time I had a problem, then (473)

TERESA: Did you ever think it was just a waste of time when you did go?

CATHY: Yes, sometimes I do, yeh, 'cos, I mean, they just pop 'em on t'scales and that's it. You're just sat callin' (talking) and having a cup of tea and that (474)

TERESA: Why do you think some people never go?

CATHY: I don't know, (475)...I think...well, I'm saying, in my, in my view, it's probably because they're t'same as me (476) - they don't like being shown up or owt like that (477) (pause) Or sometimes they just can't manage it (478)

TERESA: Yeh, yeh if they've got a heavy day.. Right - the checks that she's had done at the clinic by the health visitor and the doctor - has the doctor looked her over?

CATHY: Yeh, when she was... (uncertainly) I think it were when she were twelve week old (479)

TERESA: Has he only done it once, then?

CATHY: Yeh (480)

TERESA: And were you happy with that - the check, what was that like?

CATHY: Yeh, (486); but one thing I find with her being me first. They (staff) seem to think that a lass whose first bairn it is goes with every little problem - you know what I mean? (487) (describing the stereotype) They're very... I've forgotten t'word for it, but t'slightest little problem and they're at t'doctor's (488): and I found that t'same with t'doctors at (names health centre) (imitates doctors) "Oh, it's nowt to worry about" - and they...they think you're just being overactive about it, you know (489). But I mean, when it's your first bairn, you don't want owt up with them (anything wrong with them) - you want to find out that they're all right (490). I mean, at t'hospital they said that all t'first-time mothers, they're all like

hens, every time there's owt up wi' t'babby...! (491) (exasperated)

TERESA: But so you should be, though, I mean, what do they expect? They'd be complaining if it was the other way! (echoing sentiment).

CATHY: Yeh

TERESA: What...er, how often did you go to clinic at first, would you say?

CATHY: I used to go every fortnight - every two week like (492)

TERESA: And when did you start tailing off?

CATHY (slightly confused): Well, when I could...when I were...I don't know, really (493). (recovering herself) When I found out mese'n that she were getting everything that she should, and gaining weight properly, and doing things that she should at her age, you know (494). And I thought, "Well, it's a waste of time havin' someody tellin' me what I already know", you know (495), so I... it just dropped off (496). I...I don't know, I think...I like to take her out more and that now, you know, instead of nipping up t'clinic (497); and usually on a Thursday, anyway, I'm up at me Mam's all day (498), so...

TEREBA: Yeh, uhuh, right. The next bit's about immunisations. Has she had them done at the clinic?

CATHY: Yeh, she has, yeh (499)

TERESA: And they explained to you what the immunisations are for?

CATHY: No, no they ain't (laughs) (500). They just come or send a letter; and they'll say to me "Oh, she's due for a so-and-so" (501). But, t'same with that - what were it, now? - whoop cough (whooping cough immunisation). I didn't...didn't let her have that. I think it were because I didn't...I'd heard that much about it, you know what I mean?...So I...the bad side effects and this, that and t'other (502). But nobody ever explains what they do (503). I mean, she's been having jabs (injections) now, and half on (of) (em I don't... (504). Even when I were in hospital, they give her...they took some blood out of her groin. Well, I know they do t'Guthrie test on t'heel for jaundice and that; but I didn't know what this needle...'cos she were in right agony, t'babby (505). And I'd (had) to go and ask what they'd done it for, 'cos I were worried, you know (506). One of t'nurses said, "Well, I've never known 'em do that, love" - and it were because she'd got two sections of her cord instead of three (sic) (507), but it weren't nowt to worry about (508). But there again, it was because they hadn't told me (that she worried) (509)

TEREBA: Right, yeh...if they'd told you, you wouldn't have worried? (echoes)

CATHY: Yeh (509)

TERESA: Have you had any problem with the immunisations?

CATHY: No, none...none at all (510)

TERESA (confirmatory): ...she's been all right. Did your Mam have yours done?

CATHY: Yeh, yeh - I think she did, yeh. I've had all t'necessary jabs and that (511)

TERESA: Right...do you still think the health visitor wants you to go to clinic now?

CATHY: I think...once they get over a year old I think...I don't know (512). I think...now, I only use t'clinic when I've problems or owt, you know what I mean? (513). Or when I want somebody to talk to, 'cos I can talk to (names health visitor) okay (514). Min'st you though, they all give yer the same advice, "Go out and enjoy yerse'n" and...you know. But (laughs), but I can't afford to go (out). I mean, we've only been out three times, I think, since last Christmas, and that's it - and one of them were me sister's wedding, we really had to go to that one (515). But sometimes I just...I get that used to being stuck in t'house (that) I'm scared to go out ...it sounds a bit stupid, yeh...(516)?

TERESA: Yeh, I know what you mean...

CATHY: (hesitantly: I, I feel as though people are laughing at me and talkin' about me when I go out; so nine times out of ten I end up stuck in t'house (517). That's...what...another reason why I don't like 'buses either, I'd rather walk it to me Mam's, (although) what with a pushchair and a bag and a babby and that, it's a bit much (laughs (518) miserably).

TERESA: Oh them - I don't know why you worry. Who are these people, anyway? I mean, does it matter what they think? It doesn't matter really, does it? (attempts to encourage her)

CATHY (struggling to express her feelings): It...you know what I mean....

TERESA: (recalling her own similar experience): I know how you feel - it's a horrible feeling. I got like that when I was ill.

CATHY: I know. But since I've had...since I've had her, I 'ave dropped off (taken less care of herself), you know what I mean? I have...I've spent more time seeing to her propertly (so) that I ain't had enough time to see to meself (520)

TERESA: Uhuh, uhuh.

CATHY: ...you know what I mean? I mean, when we were first married, you'd never catch me like this (indicating her dress) - I'd be always dressed up with make up on, and I'd look nice. (sadly) But I can tell that I've let meself go with (due to) looking after her (521)

TERESA: (empathic) You haven't got time, have you?

CATHY: That's it...I ain't got time and half of t'time I just can't be bothered to (522), 'cos I find mese'n spending that much time looking after her (that) I ain't got time to see to mese'n right (523)

TERESA: Yeh...

CATHY: ...and I feel that other people notice it as well (524), because me Mam's always saying to me, "Oooh, Cathy, you haven't half let yerse'n go" - you see? (525) and that gives me that guilt complex, then; so that I'm like this (indicating her present mood), looking at mese'n (526)

TERESA. (attempting to cheer her): I was goin' to say, your hair looks really nice - it's a gorgeous colour

CATHY (deprecatingly): Oh, it isn't (she has just coloured it)

TERESA: It's in good condition, though - look at the shine on it

CATHY (playing with her hair): It gets on me nerves

TERESA (persists): ...but I mean, obviously your hair's really nice when you've done it - dead shiny

CATHY (agreeing): It is, but... I mean now...that I just don't see any reason to do it. I don't see any reason to put make-up on 'cos I never go anywhere (528)

TERESA: Yeh...

CATHY: You know what I mean? There's only sometimes that I...I'm sat in t'house, and I think, "Oh, Cathy, tha' does look a mess!"; and I get t'make-up out, and...you know...

TERESA: Yeh...

CATHY: ...doll meself (up)...pretend I'm going somewhere...and it makes me feel a lot better (529). But then, when he (her husband) walks in, he never notices anyway, so I mean...I could walk round t'house stark naked and he'd never notice (laughs)

TERESA: (laughs)

CATHY: ...in fact, I have done, once or twice! (530)

TERESA (laughs): ...in summer, I hope, when it wasn't too cold!

CATHY (thoughtfully): "I can imagine mese'n now", I says ..."I can imagine mese'n now", I says to him the other day, I says: "no wonder you don't fancy me any more". He says, "Why not, love?" I says, "Well, all t'blue veins that you get, and I've got stretch marks and all", I says. I just look like a piece of that cheese with blue veins in it, you know; and I thought, "Well, if I were thee, B. I wouldn't fancy me, either!" (531)

TERESA: And what did he say?

CATHY (continues her account): But he's...I'll tell yer, he seems to be ashamed of me when I'm like this, you know. He doesn't...he don't say nowt but it's the way he acts... Reluctant to take me out. And if he does take me out, he leaves me, you know, and stuff like that (532). But as soon as I get me figure back, that's it - he's back to

his jealous, possessive se'n (self) again

TERESA: Uhuh

CATHY (bitterly): I can't understand men, me (533)

TERESA: ...nor me neither. Can you remember when you first had to go to clinic...did you feel you had to go, did you feel obliged to go?

CATHY: Well, same as I said, they never said nowt to me (534). I thought I were expected to go and I thought I had to go every week; 'cos t'first week (that) I missed, I half expected somebody coming down and saying, "Why haven't you been down this week?", you know. And I thought you were expected to go, because they never said nowt to yer (535)

TERESA: Mmm...Did you make any friends at clinic?

CATHY: Not really, no (536)I...there's a couple...well, I'm saying, there's one woman up there that I know to talk to; (thinking) and another one, because I've known her from before I come down here, you know what I mean? So I know her to talk to (537). But, apart from that, if them two didn't come in, I'm sat by mese'n usually, you know (538). So, that's another reason why I don't go up (539).

TERESA (agrees and elaborates): Yeh, it's horrible isn't it...I hate sitting where I don't know anybody...

CATHY: I tried to get along with everybody, though - but round here they just seem as though they're all zombies, you know. They keep their se'ns to their se'ns, and you just...(540).

TERESA:...Yeh, yeh... Right, em did you first meet your health visitor after you'd had your baby...was that when you first met her or did you meet her before your baby was born?

CATHY (thinking hard): Oh, now wait a minute...er, yeh, I did meet her before. I think it was one of t'times...(pauses)...it were about four or five week before I had t'babby (541). I can remember her coming to t'house and introducing herse'n and this, that and t'other (542); and, you know, she said that...like, they keep a check on t'babby, and as they grow up (543)

TERESA: Uhuh, does she visit you very often?

CATHY: No, not really (544). Er, she always asks me when I go up if (whether) I've any problems or owt (545): 'cos, same as I said, I'd had a good talk with her and told her all me problems and that (546). But I like somebody...somebody who'se neutral (uninvolved), like her

TERESA: Yeh...

CATHY: You know what I mean? If, like, say, I were talkin' to me mother, then me mother'd be all on my side; and if I spoke to his (her husband's) mother, (then) his mother'd be on my side, you know what I mean? I wanted somebody who'd got nowt to do with it, but could give me advice, like (547). That's why I started going to me doctor; but I found out after a bit that he were siding with me, because he were

saying to me "Now, if I come and see yer, will yer husband be in?" - you know what I mean? Or, er, like if I used to send for him, he used to say "Is your husband in?"; and I used to say, "No"; and he used to say, "Oh, I, I want to ask yer if ye're all right?"... you know (548). But I wanted somebody to talk it out with <u>both</u> on us... (549)

TERESA: Yeh...has (names health visitor) seen B. then?

CATHY:... which she did, yes, yes, she's seen B. (559). But all he says when she walked... he says he were listening to her; but, soon as she walked out of t'door, he just turned round and he says, "I don't want you going up there anymore (551A); I don't want anybody interfering with us" (551B)

TERESA: It's difficult, though...

CATHY (continuing her narrative): He says, er, "If we've got any problems, we'll sort 'em out ourse'ns" (552); but he's not willing to try. I mean, I've tried and tried (553). I mean, me Mam and Dad's asked me to go home more times than owt; and I've, I've always stuck by him, you know what I mean? I've turned round and said, "No, Ma, I'm not coming back"; and I've stopped with him (554). But it's just not...I don't know, he's very much like a child - it's like I'm bringing two on 'em up instead of one, you know what I mean? (555A). He hadn't had much education (555B); and, well, t'way he were brought up, I thought it were wrong, 'cos his parents neglected him (555C), and he ended up being brought up with his grandparents, who were really too old to care, you know what I mean? (555D). He could do what he wanted; go where he wanted; and no authority were used on him, you see (555E); and I think he's trying to do that now with us (me) (555F).

TERESA: Yeh, yeh...

CATHY: He's trying to show... I mean, their family - it were nowt for t'fellow to beat t'wife up; (with great irony) it were <u>good</u> that, you know what I mean? They all did it - so, of course, he did it to me 'cos he thought it were good; and he thought, well, it were proper to (appropriate for) him (555G). I mean, I were brought up proper; I weren't brought up spoilt or owt like that. I got, I got more or less everything I wanted; but not, not quite everything (555H). But 'cos they weren't bothered about him - his normal parents, I mean (555I) - <u>my</u> parents have tried to take over where <u>his</u> parents left off. They've treat(ed) him t'same as me (555J); but he's not grateful for it (555K). He, you know...he wants to be by hisse'n, and (able to go) off, and to say, "I'm t'boss" - and that's it. (555L)

TERESA: What...em, after you've had a fight, does he apologise or anything?

CATHY: Yeh, he...that's, that's what made it so bad. I mean, he used to say, "Oh, I'm sorry love; I'll never do it again" - and some times he'd cry; and if there's owt I hate to see, it's a man crying. And then I used to think, "Well, he really means it this time". But then after a bit I got to thinking - and it's just an act, this...you know, this crying and "Oh, I'm sorry, I'll never do it again" (556), when I know damn' well he's goin' to do it again (557)

TERESA: Yeh, it's funny isn't it...

CATHY: But, he'd only got to say a couple of words to me and I used to melt (558).

TERESA (empathic): Yeh, yeh...and it (his previous behaviour) doesn't matter...

CATHY: You know, sometimes...sometimes he could just say summat to me, and I could pick a knife up and I could just ram it through him. And then, two minutes after, he'd say summat else and I'd think, "Well, I don't know", you know, "I don't know how I could have picked that knife up"; and...(at a loss)...I don't know...(559)

TERESA (elaborating Cathy's previous statement): I think you're right - I think it's 'cos a lot of men just don't grow up...

CATHY (agreeing vehemently): They don't, they don't...

TERESA: ...they stay kids all their lives

CATHY: That's it (560). I mean, I thought that having t'responsibility of a child'd...you know, evrybody says, "Oh, he'll grow up once you get t'bairn". But he ain't - he ain't altered (561). (pensively) It's...it's funny, that...I don't know, he seems to be growing up now that she's growing up, you know what I mean? Now that she's talkin' and walkin' and that, he seems to be...I don't know, takin' more notice on her and that (562)

TERESA: Uhuh, uhuh...

CATHY: But before, he never let her change his life a bit (563)

TERESA: Eeeh, it's strange isn't it...

CATHY: I can't...I don't know...I'm never goin' to get to understand them, me. (very seriously) I'll tell you summat - I'd never get married again - never! (looks at Teresa and laughs, amused by her own vehemence)

TERESA: (laughs with her)

CATHY (emphatically): Never!

TERESA (returning to schedule): When, er...have you ever found...rang the health visitor up?

CATHY: No, I hadn't no. I've got her 'phone number, but I just...I don't know, I'd sooner see her when she's up at t'clinic - you know what I mean? - wait to see her then...

TERES: ...(rather) than ring her up?

CATHY: Yeh, because I...I don't think you can say t'same thing over a 'phone as you can...

TERESA: face-to-face...?

CATHY: Yeh. It's...it's...I think it has more impact when you talk face-to-face (565)

TERESA (agreeing): Yeh, yeh, I do (too). What...do you like her (the health visitor)?

CATHY: Yeh, she's okay (566)

TERESA: Do you think you know her quite well?

CATHY (pondering this): Not quite well - I mean, I know if I've got a problem...I know that she's there...let's put it that way.

TERESA: Uhuh - you know her well enough, you would say, for (that) ?

CATHY: Yeh, yeh (567)

TERESA: Do you think she knows you quite well?

CATHY: Well, she would do, yeh (i.e..'I suppose so, yes') (568)

TERESA: Well enough. Right, em, how long have you had your doctor - all your life?

CATHY: No (569). Er, there's five to choose from at (names group practice), up like where I go (570). But since me husband started hitting me and that, I found that I stuck to this one doctor, you know what I mean? 'Cos I can really...I can really sit down and talk to him; and I can really...well, I'm saying, he's t'only one that gets through to me - let's put it that way (571). (returns to general question) But I've always had them doctors up there - but, I mean, they...they change. I mean, once one makes a bit of money, they go and retire and...you know what I mean? - buy a new car and that (572)

TERESA: Have you ever asked for a home visit from your doctor?

CATHY: Yeh, yeh I did (573)

TRERESA: Has he been all right (accommodating) about it - about coming out?

CATHY: Well, it's not so much t'doctors up there - it's t'receptionists (574). I mean, like I said, when I were badly...when I were carrying her...I'd found out I were pregnant and they wouldn't send a doctor out to see me - because that doctor had said it were wind, you see. So they wouldn't send anyone to see me (575). In fact, I ended up getting one of me mates to go and 'phone up to make an appointment, 'cos I were that badly (576). And they wouldn't send a doctor out - but that's t'receptionists - they think they own t'place (577). (illustrating her point) I mean, you can go up now and you can say, "I want to see a doctor". (imitates receptionist) "Why, what's up with you?" I mean, if you knew what were up with you, you wouldn't bother going to see t'doctor, would you? (578)

TERESA: (laughs) Er, no

CATHY: ...and then they...then they... (trying to remember) Oh aye, what were it now I went up for? (remembers) Oh, I tried for pain

killers - I'd got bad migraine or summit and...oh, it were me sinuses, they were all blocked, and it had given me toothache and earache and me eyes were going runny, the whole lot. And I 'phoned up to make an appointment (579). And she says, "Oh, come up and see us, love" (580). So I went up. I says, "Can I see a doctor" (581) (imitates receptionist) "Why, what's up with yer?" (582). I says, "I want to see the doctor". You know what I mean - it isn't her place to just prescribe. But they do - they think they own it up there (583). (pauses) Next question? (584)

TERESA: Right...looking back, where would you say you learned most about looking after your baby from? I think you said (from what Cathy has already said) that it's yourself, isn't it?

CATHY: From meself (585); and, with (due to) me mother being badly (ill), me and me sister brought up t'youngest two (of her own brothers and sisters). We did all t'nappy washing and changing and feeding and that, you know, with (due to me mother being badly - so I knew a lot through (as a result of) that. And housekeeping and that - I mean, me mother were always one of them sort as - when you tidied up - she used to go shhh like this (imitates mother testing surfaces for dust) and go round t'room with (her) fingers - you know what I mean - she were a bugger for that! And, with her being badly and all, we had to bring up t'youngest two by us se'ns (ourselves) (586)

TERESA: Uhuh...and what about baby books - what would you say about them?

CATHY: They're okay - but they give you all t'good side

TERESA (inviting her to continue): Yeh?

CATHY: I mean, it's like one of these bloody romantic films where you see 'em walking off in t'sunset together - you know what I mean? It's not like that - life isn't like that (587)! (pensive) I don't think they could put it down in words, what it's like - you know what I mean? (588) They try, (let's) put it this (way): they ease yer mind a lot, but they give yer t'good side, not t'bad (589)

TERESA: ...yeh and they should give you the bad (side) as well...?

CATHY: I mean, they're...(looking for examples)...like, now, t'symptoms you can get when you're pregnant: they just say, "Oh, you can get swelling of t'feet", so-and-so; but they never go on to say that t'swelling of t'feet could stop you from walking; that it were very painful; how often you might get it - you know what I mean? (590)

TERESA: Yeh...not all the details...

CATHY: That's it. Like morning sickness - they never tell you what it's like, having morning sickness - I mean, it's chuffing terrible, that! I wouldn't, I wouldn't like any lass to go through that - no chance! (591)

TERESA (laughs): Right, em...what does the baby's father think of the clinic, the health visitors and others you've had contact with in the care of your baby?

CATHY: He don't reckon much to 'em (593) - I mean, he thinks that you have a bairn and you bring it up and that's ...that's t'end on (of) it, as far as I can gather from him (594). He thinks that they're just a set of interfering people, you know, who like to stick their noses in your business (595). And he reckons that health visitors and this, that and t'other only come to see yer bairn if they think you've been braying (hitting) it and whatever, so... (596)

CATHY: Well, I know he has t'wrong...he's got t'wrong idea about life, you see... (597)

TERESA: Mind - they (husbands) take some convincing...

CATHY: They do, yeh

TERESA: ...if you try and you know...(pauses - changes the subject) Right, em, would you personally advise other new mothers to go to clinic?

CATHY: Well, er, I suppose it's up to them (598). I mean, I can't see as it's done me and t'babby any good, really (599). I mean all...t'only time it's done her good is when she's had to go up for her injections (600); but apart from that you're still not gaining anything (601)

TERESA: (encouraging her to continue): Uhuh...uhuh?

CATHY: It's just a place...as far as I can gather, it's just a place where women go...take the kids so t'kids can play together...so (that) they can have a cup of tea and a call (chat)...

TERESA: Yeh...

CATHY: It's just, like, a break from t'twenty-four-hour routine, you know what I mean? (602). I suppose it's...it's a good thing in a way, because, I mean, you can get...

TERESA: You need to get away...

CATHY: You do. You need that break. I mean, at least...if not once a day (then) once a week, you need that break from rout... (603) min'st yer though, if they're owt like <u>my</u> bairn, you've still got to keep yer eye on her once they're walking about, 'cos she's a bugger! (604) (thinking it through) But I would, I'd advise 'em to go, yeh - if they thought they could mix in with t'company and that, you know (605)

TERESA: Uhuh...looking back, have you enjoyed this year?

CATHY: (thoughtfully): Yeh...yeh, I have
TERESA: Overall...you could say (that) you have?

CATHY: Yeh (606)

THERESA: What have you enjoyed most about it?

CATHY (without hesitation): Being independent and knowing, now, that I'm grown up...I've got a bairn of me own - you know what I mean?

(607)

TERESA: Uhuh...right - if anything, what would you rather be doing with your life?

CATHY: I don't know (laughs). I've always fancied being a model (608) (dismissing this) - but, er, no, er, I'd got a good career. I wish I'd have stopped at t'first sewing factory (609), instead of movin' on and going and living with him (her husband) and that (609A), 'cos I were earning some good money, you see, and I'd have probably been a supervisor or summat now (609)

TERESA: Uhuh, uhuh...

CATHY: But I mean...I know lasses have dreams (610), but I always said, "Well, I'll never go in a factory!" - but, I mean, factory work is t'only work you can get...

TERESA: That's right, yeh...

CATHY: ...and sometimes it's higher paid than owt else, you know what I mean? (611) (realistically) But I...I'd have probably been where I am now, that's what...er, if I could go over it again I'd be where I am now (612). (adds decisively) But I don't think I'd be married this time...

TERESA: Yeh?

CATHY: I think I'd be single! (laughs) (613)

TERESA (laughs with her): Right - what have you personally missed most since having your baby?

CATHY: (promptly): Going out and socialising - er, being able to be one of t'lasses, you know what I mean? It's...you're tied down - I mean, you're tied down when you're married; but you're tied down even more when you've got a bairn around yer (614). I know...I know, fair enough, it's <u>your</u> fault in t'fist place that you've 'got (conceived) a bairn (615); but, you know, I miss going out and enjoying mese'n (616A); and I miss being able to work for a living (616B). Being stuck in t'house and all, t'only work I do is housework, which, you know, you don't get paid for anyway (616C). So..but that's what I miss most...I think it's with me being young and all. Now, if I were in me thirties it wouldn't bother me so much (617)

TERESA: Yeh, yeh...but at this age you want sort of...

CATHY: Mmm...

THERESA (returning to schedule): What, em...is there anyone you can rely on to look after the baby if you do want to get out - have you got anyone you can leave her with?

CATHY: Well, same as I said, I could leave her with me Mam and Dad (618) - but me Mam's badly (ill), and I don't like putting (imposing) on me Dad; so I think (that) before (I'd) put on them I'd sooner stop in (619). In fact, I find mese'n...I mean, I've had t'chance to go out, and I've found mese'n stopping in, because - same as I said -

I've...it's like what do they call it?

TERESA (referring to Cathy's previous account): Agrophobia?

CATHY: That's it...agrophobia. I feel as though everybody is looking at me and talkin' about me when I go out...

TERESA: Yeh...

CATHY: ...so I'm getting that scared to go out (620)...in fact I'm t'same when I go shopping (621). I enjoy shopping usually (621A); but - since we've both lost us (our) jobs, I mean (621B) - now it's, oh, go in t'shop - tin of beans from here - and you know...and I know exactly what I've got to get every week, 'cos I ain't got enough money to get owt different (621CD). So it's just like a...I can go in three shops, get a few things from each shop and that's it (621E) - that's me...that's like, me outing over and done with (621F). Whereas, he's out at all times, you see (621G)

THERESA (sympathetically): Oh, it's terrible...(pauses)...are there any changes you'd like to see in the services... I mean, you've mentioned a lot so far...is there anaything we've missed that you think is important?

CATHY: Well, I think they should tell you more about t'injections and that for your babbies (623). I think that that is definite - because, I mean, a lot of women...they wearn't (won't) let the bairns have injections simply because they don't know what they're going to do t'bairn (624)

THERESA: Yeh...

CATHY: You know what I mean? And...(pauses, thinking)...they shouldn't rely on yer to know everything (625). They should try and help you more to understand what yer goin' to go through (626). I think that's t'main...t'main things - instead of yer having to pick a book up and finding fairly tale stories on how to have a bairn (627). I think they should tell yer, you know, what you need to know (628); and not keep owt back from you. I think that's t'main thing (629)

THERESA: (pursuing her thought): ...'cos some mothers have said they wish that there'd ...there'd been mothers there who'd had a baby, who could say, "It's not all roses, it's like this..."- you know, yeh, like you could tell someone else now, couldn't you, what it's like...?

CATHY: Well, put it this way - when I get this bairn, it'll be like bringing twins up really: because I mean, she's still a babby herse'n (631). I'll have more idea, with this one, how to bring it up, than I did with her (632). Because, I mean, you tend to ask questions, like, off yer mother - you know what I mean? You tend to ask yer mother things more than owt (anybody else) (633): and yer mother or yer father, they always go with their way - (the way) they've brought you up - do you know what I mean? They expect you to stick to that rule - like there's many a time I can go up (to her mother's) now, and me mother'll say, "You know, you shouldn't be doing that with t'bairn"; and "You shouldn't be letting her do this" - you know what I mean? (634). And I think "Well, who'se bloody bairn is it - is it mine or is it me mother's?" - you know what I mean? - and I turn round and

tell her, "Look, it's my bairn - (and) I bring it up t'way I see fit to" (635). I mean, you've got to learn (636); but I don't think people should expect you to learn all by yerse'n (637). they should give yer advice, fair enough (638); but not (just) from their (own) experience (639); (but) from known fact, if you know what I mean... (640)

TERESA: ...sort of objective like...

CATHY: Like all this about "Oh, it's t'worst pain you can get" - like I were telling you - they shouldn't say that. They should say, "Well, fair enough, it's a pain - it's a bad pain (but) you get over it..." - you know what I mean? - "...when you see t'babby, you're all right": but not "Oh its's t'worst pain you'll ever get" - you know what I mean? It sounds as though...that you're ready to go on t'cross or summat like that (641)

TERESA (laughs)

CATHY: ...'cos they're going through (by) their experience, you see, instead of...I mean, every woman knows that parting with a bairn is goin' to be painful - which it is - but it's over and done with once t'bairn's there (642A). But I know they frightened me stiff when I come to having her. In fact, I were ready for...for shovin' a cork up me to hold it back a bit longer, 'cos I were that scared! (642)

TERESA: (laughs): What would you do differently next time round?

CATHY: I don't know. I think I'd end up doing same - exactly t'same (643). Because, I mean, she seems to be thriving on what I've done for her, so I'll...probably this one'll thrive just as much, with (by) using t'same method (644).

TERESA: Will you go up to clinic?

CATHY: I don't know. I doubt it. I don't...I think...same as I said, it's all right (for) the first time mothers and t'babby being up to about six month old. But after that it's just for a call (talk) and a (cup of tea)...

END OF INTERVIEW

4.4. STAGE 2. RESTATEMENT OF TEXT AND INITIAL LABELLING OF MAIN TOPIC AREAS

(corresponding to step 4 in the procedural outline).

The meaning units identified in stage 1 are restated in the third person, preserving the central meaning as intended by the interviewee. Some obvious irrelevancies can be identified and omitted at this point, which in concert with the more succint summary statements reduces the text for further analysis. As a preliminary stage in organising the text, the main topic of each section of text is noted in a purely identificatory heading, e.g. where an incident, or a complaint about a specific matter is told, the section is given a brief title. The meaning units identification numbers are included to show where the statements occurred in the interview..

PLANNING FOR A CHILD

Cathy and B did not plan to have a child at this particular time (3)

They had tried for two years previously to have one. (4)

Having suffered three miscarriages, Cathy thought herself unable to have a successful pregnancy. (5)

Resolved sadly to accept childlessness (6)

When Cathy stopped actively trying to have a child, she was successful. She now believes 'trying too hard' actually prevented conception; but whether due to mental or physical factors or to 'fate' is unclear (8)

It just happened (9)

Cathy believed one needed to take 'special' care when pregnant (10a)

For her, this was disproved to some extent by events... (11)

... when, despite not being 'careful', she carried the child well (12)

She expected to have problems in view of her previous miscarriages (13)

Now the opposite is the case - she is 'breeding like a rabbit' and 'can't stop'. She is proud and pleased to be fertile. However, she feels the process is outside her control... She laughs, but is mildly exasperated at the unpredictability of life (14)

In retrospect, Cathy did not want to wait to have a child (15)

She wanted a child whilst still young herself (16)

Cathy has formed definite views on 'older' parenting. She sees child-rearing as a long, hard slog requiring youth to succeed. Also the resulting 'age gap' is considered to be bad. Being young herself, the difficulty is reduced; and mother and child can 'grow up together' (17)

SEXUAL ASSAULT

At sixteen, Cathy suffered a miscarriage following a sexual assault which occurred shortly after she had left school. She had intended to abort the baby in any case (20)

Cathy dared not tell the police because she thought her attacker was likely to seek violent revenge. She ought to have reported it, and in retrospect this would have been the right course of action (possibly compliant with values ascribed to interviewer) (23,24,25)

Frightening aspects of the assualt led to a long delay in telling her parents, with feelings of personal guilt and implied fear of recrimination (29)

Shortly after telling her parents, she lost the child (30)

She feels this was due to the nature of her work. The event occurred at work and was painful (31)

The repercussions did not stop at the damage of the assault itself, but led to loss of her job, which was important to her. She resents this, feeling that her employers have written her off as worthless, and are punishing her for miscarriage and illness, both of which are outside her control. (33)

She feels she was unfairly treated, but has accepted her lot, whilst remaining resentful and sore in consequence. (33)

SEX EDUCATION AND THE REALITIES OF SEXUAL EXPERIENCE

Cathy found a used contraceptive at thirteen; and was informed almost incidentally about contraception by a school friend (35)

Her mother told her when she was a year older, and already knew (37)

Cathy feels she was ill-prepared for the realities of sex. She feels she was given a biased view; told simply that it was 'a good thing' (39)

Miscarriages and possibilities of pain and disapointment were not mentioned (40)

The simplistic picture given led to inadequate preparation for the often routine and mundane features of 'sex' (42)

Earlier in her relationship with B she had enjoyed sex far more because of its vaguely illicit quality. Now the reality is less appealing. She resents the information which she feels was witheld, feeling disappointed and in some way cheated. (44)

CONTRACEPTION

Cathy took oral contraceptives from age fifteen for approximately one year(47, 48, 49)

Her first miscarriage resulted from sexual assault only two days after stopping the 'pill'. The timing of events was unfortunate. (50, 50a)

Back on the 'pill' until age seventeen and a half... (51)

....she discontinued taking it when she met B (52)

Unable to use the 'pill' whilst breast-feeding baby (53)

...they resorted to a simple technique (54)

It was failure of the withdrawal technique which resulted in her second (ill-timed) pregnancy (55)

She would have preferred to wait before having a second child (57)

She feels she needed some time to 'get used' to her first child before

becoming pregnant again. (58)

REALISATION OF PREGNANCY - INITIAL ENCOUNTER WITH SERVICES

Weight gain in spite of her diet and morning sickness were seen by Cathy as clear, unambiguous indications of her pregnancy (60, 62)

The doctor dismissed her symptoms as 'wind'. Cathy felt rebuked and foolish - felt as if she were thought to be lying or soliciting undue attention (63)

Her pregnancy was denied in spite of informing the doctor that her pregnancy test was positive (64, 64a)

She persisted with the doctor by reference to her persistent symptoms; and to the instructions she received to acquaint her doctor with the results of the test. She was only following instructions. (64b)

Her husband was outraged at the doctor's 'unreasonable' behaviour... especially in view of her continued state of being unwell... (66)

... and her previous history of miscarriages (68)

Even on this further visit the doctor was unconvinced (70)

Only when irrefutable physical evidence became apparent did the doctor agree that her pregnancy was 'real' (71)

She is very aware of the serious consequences which could have resulted: and displays considerable antagonism to the doctor concerned. She feels that he treated her in an unreasonable, dismissive manner, making light of her very real concern. She feels the incongruity of official attitudes; for the behaviour which was 'proper' according to instructions on the pregnancy test kit was branded as 'improper' by the doctor. (75, 76)

With some satisfaction, Cathy recalls that the doctor had to change his mind. She won the 'battle', but still feels aggrieved about it. Her word alone is felt to be regarded as valueless by the official world of 'them'. She is very antagonistic and would have held the doctor culpable for the possible loss of the child. There is much use of 'they' and then' in these passages. (72)

Cathy sees doctors as 'they' - an abstract totality distanced from her. 'they' - the abriters of truth, the legitimisers - may make complete mistakes due to 'their' dismissive attitudes. She questions their authority as experts on the basis of her experience.

HUSBAND'S REACTION TO HER PREGNANCY

B. was with her when the result of her pregnancy test was given to her (77)

He was very calm about it, in contrast to Cathy, who was delighted (78)

ADVICE FROM DOCTORS REGARDING HER PREGNANCY

Cathy did not receive any advice from her doctor regarding pregnancy. However, she expected none; and finds the notion of a doctor offering advice amusing. For her the 'way of being' with a doctor does not include his giving her advice this is too egalitarian a concept. (78)

She thought feeling ill might be due to her pregnancy (83, 84)

She went back to her doctor for help and was rebuked for her ignorance (86)

She remembers the phrase used to send her away (87)

She was refused a sick note on these grounds. Rebuked for soliciting time off work regardless of how ill she felt in virtue of an authoritarian dictum reflecting the 'word' rather than the 'spirit' of the law. (88)

Still unwell, she continued to take time off work and nearly lost her job. She felt ill, pregnancy was experienced as an illness. The doctor's dismissal, added to pressure from work, made her feel as if she was accused of improper behaviour, as 'stupid' and 'wrong'. (89)

Doctors are not a source of advice (90)

Medical advice is not freely offered, but has to be extracted by dint of much effort and pleading. She is exasperated by 'their' attitude, an unwillingness or refusal to take her seriously, and her own powerlessness to help herself. 'They' can help. These things can be dealt with, as eventually they are. But it is a struggle to convince 'them' of your needs. 'They' seem to act on the assumption that her needs are not real or worthy; and are only convinced by unremitting persistence on her part. There is a blurring of the 'they' of the doctors with the 'they' of the social services - both are seen as unyielding, dismissive, powerful agencies. (91)

PROBLEMS AT WORK

Working in a sewing factory, Cathy was taken off machine work as soon as it became known that she was pregnant and given a standing-up job. Standing up gave her fainting, dizzy spells. (92)

She was treated in a punitive, unfair and cruel manner by her employers, who gave her inappropriate and unpleasant jobs, and refused her any help in her tasks (she wasn't allowed a chair or to wear slippers when her feet pained her as a result of eight hour's standing at work). Her own attempts at retaliation only made things worse; and when she took time off work she was threatened with the sack. Faced with the choice between this and unpleasant work, she decided not to let them upset her. Wanting to be shown some concern and care, she encountered only coldness, cruelty and entire lack of sympathy. Feeling under threat and 'hard done by' by those in authority and in control of her life chances. Now she vows that she would never return to work there. (98,99,100,101,103,105,106,102,107)

HELP AND ADVICE

Cathy had no idea where to go for help or advice regarding her pregnancy. (109)

She was totally unfamiliar with the procedure - although she expected that there would be one (110)

On her first contact with the midwife, she felt she was expected to know more than she in fact did. She felt ignorant and 'put down' (111)

There is arcane knowledge which those professionals inside the 'system' take it for granted that the public should know. (112)

Having been through the process once, she is now expected to know all about it. (113)

She has more 'idea' this time; but feels that 'their' expectations remain unrealistic. She is aware of the existance of the 'system' but not sure what it is. She feels belittled by the midwife, who expects her to 'know'. (116)

This illustrates her problem Not knowing what to do, she feels foolish, confused and anxious about being belittled. But there is no escape - she must have contact in this case. She is ambivalent towards the helping agency. She knows that the exemption certificate exists and that she was entitled to, and received one during her previous pregnancy. This time she is not sure if she qualifies; and since no-one has mentioned it, she dare not mention it herself. Her need struggles with fear of recriminiation and labelling as a 'scrounger' if she asks for something to which she is not entitled. (117)

She feels that she is in some way outside the 'system'. In her case, she is obliged to ask or beg for help which is normally freely given to others. She is perpetually over-looked or ignored. The 'system' is unfair to her, since the onus is on her to initiate help all the time. She cannot understand why help is not offered to her in an acceptable fashion. (1178)

EXPERIENCES OF ANTENATAL CARE

During her first pregnancy, Cathy was able to attend clinic at her local health centre, under the care of her own doctor. This was a convenient journey for her. However, during her current pregnancy. She must continue to attend the (more distant) hospital clinic. This is a long and tedious journey, exacerbated by her very early appointments, which cause her to set off at an unreasonably early hour. She finds this very exasperating indeed, regarding it as an enforced and (probably malicious) change of venue. Again, no-one has explained to her why it is better for her to attend at the hospital clinic. (120,121,122,123,124,125)

Cathy is anxious to be accepted and approved of, but uncertain how to achieve this (128)

Her initial impressions are of an interminable first visit, during

which she is subjected to a barrage of relatively impersonal questioning, followed by a physical (internal) examination. (129,130,131)

Cathy is disappointed when she cannot see her own doctor for antenatal care (132)

...especially since she felt he was personally interested in her, and she could talk to him. (136)

The woman doctor she saw (in common with other women doctors) was less sympathetic towards, and rougher with, other women. (137)

She thinks maybe women are less sympathetic towards other women than a man is towards women in this situation.
(137a)

She feels that she is passed on like an inanimate object to another doctor in a totally impersonal fashion. An uncaring, impersonal ethos prevails. (137b)

CONTINUANCE OF HOSPITAL ANTENATAL CARE

She is in the ludicrous situation of being compelled to dash from hospital to health centre to attend two antenatal appointments on the same day(138, 139)

Even when the situation was pointed out repeatedly, the unnecessary duplication was ignored... (140)

...though staff behaviour showed that they recognised the superfluity of the second visit (142)

The superfluous second visit involved loss of time at work and caused her problems with her employers. This is another example of her not being taken seriously; as a result of which the inconvenient arrangement persisted in spite of her protests. In retrospect she is amused at the 'silliness' displayed and its persistence - but it was a very uncomfortable experience at the time. (143)

NATURE OF HOSPITAL ANTENATAL

In strong animal imagery she recalls her impression of being one of a lage, regimented, de-humanised group. 'Slaughter' evokes the fear and threat which existed in the situation. (145)

She recalls prolonged periods of waiting, which served to increase the anxiety and tension which she experienced. (146, 147)

Her impression was of a largely uncaring attitude on the part of the medical staff, leading to a feeling of worthlessness, being treated like an object. (148)

Doctors in that situation are largely uncaring, and treat mothers-to-be like insignificant, worthless objects devoid of human dignity. Her humiliation was complete when, having finished with her, she was compelled to walk naked across the room before she could cover herself - no-one brought her gown across. (149)

She now tries to cope with such situations by telling herself that she is no more than an object to a doctor; and that normal human relationships and feelings like shame and embarassment are out of place in this context. (153)

ASKING QUESTIONS AT THE HOSPITAL

Cathy sees asking questions at the hospital clinic as covertly impermissable. Seeking for increased confidence and control and aware of her inadequate procedural knowledge, she would ask questions, but these were treated in dismissive mannner. She was no better informed. (163)

Cathy felt 'put down' - she was in some way expected to know without being told; and not to know was in some way culpable. Either the staff had somewhat unrealistic expectations of her; or the reverse and she was simply not expected to want to collaborate actively (164)

Even when she stresses the distress and difficulty which the rash is causing her, no-one cares, and her request is insensitively brushed aside as inappropriate - she must see her own doctor. At the same time, what constitutes an appropriate request at the antenatal clinic is not clearly defined. Her insensitive dismissal leads Cathy to feel that 'they' think she is behaving improperly, making too much of it. (164 -179)

ANTENATAL CLASSES

Cathy went to one such class and never went back (180)

She reasons (retrospectively) that this was her intention; she only wanted guidance on breathing in childbirth. (181)

She did not go to take part fully. She rationalises the rest as a 'waste of time' with ludicrous excercises on offer. (182)

The class seemed 'okay' but for her it was experienced as largely irrelevant, inappropriate and not applying to her own situation. (188-192)

Her visit to the antenatal class made her feel more than ever 'different', isolated and not a 'mainstream' mother-to be. She knows what her baby should be getting but is unable to provide it. She can never afford to do things 'their' way - she is base, poor, different. The total irrelevance of this generalised approach and advice to her own condition and needs distresses her when she considers the child's needs. (193-197)

HUSBAND'S ATTITUDE TO HER PREGNANCY

Cathy's joy and pleasure in her pregnancy can be contrasted with her husband's incredible calmness and uninvolvement. Desperately wanting to share her pleasure with B, she is hurt and saddened by his lack of interest. She is isolated and alone, cheated of the emotional and practical help which she feels she should be getting from him. (199-207)

CHILDBIRTH - HER EXPERIENCES IN HOSPITAL

In hospital Cathy was the subject of an emergency induction procedure, during which the only message conveyed to her by the staff was that of alarm - 'something' unspecific was wrong, obviously - but what it was she had no idea. During this very alarming sequence, every procedure was done to her, or took place around her. There was no direct communication with her, explaining what was to happen - or indeed what was already happening. She was 'out of control', passive - an object rather than an active agent. (209-233)

The exceptional circumstances surrounding Cathy's delivery singled her out as 'different' from the other, 'normal' mothers, who went home after their deliveries much more quickly than she did. (235,236)

In retrospect, Cathy enjoyed the rest in hsoptial, in comparison with her stressful, demanding life back home. The full weight of responsibility did not 'hit' her until her return home. (239)

CATHY'S RETURN HOME WITH THE BABY

Right from the start, the new child is seen to be Cathy's sole responsibility. Even B's supposed preparation of the baby's things in readiness for Cathy's homecoming is described as '...doin' things for me...' (244)

Despite her husband's supposed preparations and her own careful planning, her homecoming was a 'disaster' due to the chaotic state of the house and her family's bitter arguments. A passive victim of these events. Her plans disrupted, she broke down and cried. (242-251)

These events were instrumental in producing a further disappointment - that of losing her milk and being unable to breast-feed her child. (252)

Her expectations dashed, her life has not altered as she has anticipated - for the better. She simply returned to the accustomed 'grind'... (254)

... and learned to cope. Cathy and her husband are the sports of a malign fate which favours others - not them (256-257)

ENCOUNTERS WITH THE MIDWIFE

'They' appear to 'mean well' - they present themselves in a helpful manner... (260)

... whilst underrating Cathy's capacity for common sense (she is treated as if she had none) (261)

The experience of motherhood has caused more problems than joy, with family feuding. (262)

'They' have no conception of the gravity of the problems Cathy is facing, assuming that life is as straightforward for her as for others. From 'their' standpoint it may be easy; but it is not so from

hers. (263)

The main problem is money or the lack of it. 'They' are different and apart from Cathy. 'They' have money; and because of this they cannot understand that Cathy is different and cannot 'fit in'. The advice offered belongs to a different world entirely to the one she inhabits. (264)

The midwife made light of her predicament at the centre of the family feud, by offering the pat solution that 'time will heal'. (268)

The reality was very different from the midwife's glossy solution. (269)

The midwife expected her to cope better than she was doing. The midwife's unrealistic expectations made her feel once more a failure: she could not live up to the midwife's implicit assumptions concerning the nature of motherhood, with which she felt herself to be constantly compared. This idealised view placed her, outside the mainstream of advice which the midwife could offer. (271)

The weight of events led her to extreme reflections. (270)

ENCOUNTERS WITH THE HEALTH VISITOR

The health visitor got closer to 'reality' than did the midwife; Cathy felt able to discuss her 'marital problems' with her. The health visitor is valued because she accepts her. (276)

The health visitor's help and advice was to no avail due to her husband's intransigent attitude... (277)

... but she has benefitted by being less confused about it all (278)

CONNECTION BETWEEN THEFT AND FAMILY VIOLENCE

B's excursions for theft and persistent lack of communication led to arguments followed by his beating her violently, resulting in actual bodily harm. She sees the theft and violence as closely related. When she tried to warn him, he would lose control, accusing her of lying. This occurred regularly even during her first pregnancy, though he has not 'touched' her since her current pregnancy started. Things got especially bad when he brought his 'thieving' companions home and she tried to warn him that he was just being 'used'. Trying to fight back simply led to more violence. (305-309)

Cathy feels ineffectual and 'toylike' in these encounters - she is unable to defend herself in any real sense. (316)

More recently, Cathy has hit on a strategy for 'containing' the arguments. Buying B some fishing gear has limited arguments by taking him out of the house. She hopes it will also keep him out of trouble. However inadequate this strategy, it deals with the problem and reduces tension for the sake of her child. (317, 318)

MOTIVATION FOR THEFT

The root of the problem lies in the lack of money (320)

B. is forced to steal because of their lack of money; and by implication poverty is responsible for his violence also. (321)

Betrayal by friends leaves her bitter at B's being 'split on' by his supposed good friends. This emphasises how right she was to warn him against them (323)

The result of B's gullible behaviour has been a series of fines, which they can ill afford to pay since the money is badly needed for food and clothes for the baby. She emphasises how she knew all along that B. was being 'used' by his 'friends' but he would not heed her. Since being convicted B. now agrees that Cathy was right and has even said as much - but this realisation though well and good, has happened too late in the day. She hopes (but not with much conviction) that B. has now learned his lesson. (324-331)

Now she vaguely hopes that he will heed her future warnings. She resignedly accepts what has occurred and what may possibly occur again. (332)

THE FAMILY'S FINANCES

Every penny is exactly accounted for. It is very hard; but they have no choice. (333)

Their diet is very poor, with meat a rare occurrence. Cathy sometimes wonders how she's managed - but she has no choice; she mustkeep going and 'keep her willpower up'. The only alternative is a nervous collapse which she could not face again. (333-335)

At one time she was taking an excessive and punishing amount of drugs to stay calm. Since the birth of her child she has fortunately been able to manage without these but a recurring fear is that she may be driven back to that frightening state by the pressure of events if no improvement occurs in her lot. She has had to struggle to survive; and the fear of personal collapse is an ever present strain. (336-339)

ENCOUNTERS WITH THE SOCIAL SERVICES

Her present resources for meeting the needs of the new baby are alarmingly inadequate. She has been forced to dispose even of a much needed bed by poverty. She has met with indifference on the part of the social services in all the contexts tried. 'They' don't care; 'they' expect the two children to share one cot; 'they' have nothing that is useful to Cathy and no money to offer her. She hates having to request resources from the social services, which she regards as 'begging'. But she has no choice, she must do what she can for her child. She is forced to demean herself by begging from the uncaring for the sake of her child. (341-350)

The injustice of a system which enforces 'begging' from those who have worked and would work again if there were any hope of gaining

employment galls her. (351)

The futility of trying to struggle against a malign fate. Her plans for disposal of the maternity allowance to improve her family's lot are thwarted by an uncaring system, which claws back with one hand what it gives with the other. She questions this, only to be rebuked for expecting too much. Once more her hopes are dashed by a punitive and uncaring system. (352-357)

PERCEPTION OF HER PRESENT NEEDS

The birth of Cathy's second child is imminent (358)

So far, she has only managed to get together a few inconsequential items for the baby (359)

... which fatalistically she is convinced will be the worse economic alternative - a boy. If it had been another girl she could have coped better from existing resources used for her first baby. (360)

Cathy feels powerless to complete her preparations, a prisoner of circumstance. Very ill-prepared, she feels close to despair of ever coping in time. (361)

PREPARATION FOR HER FIRST CHILD

Not knowing what she needed for her first child, Cathy had sought authorative guidance from a book available at the antenatal clinic... (364)

... but this she felt turned out to give faulty guidance, irrelevant to her own situation and causing her to buy items which, with hindsight she didn't really need (365)

This was compounded by the total lack of guidance about what to take in when she went to hospital for her confinement. Again wrongfooted and unaware of what to bring, she felt foolishly uninformed and in a sense betrayed by the hospital, quick to reprimand but not to inform. (366-369)

Once, circumstances worked in her favour, in the shape of her husband's late arrival, resulting in the need to feed her baby and an opportunity to obtain some free nappies and vests from the linen room. The nurse's casual sanction gave her a rare opportunity to help herself - something she is now planning ahead to do again when the chance arises. (371-379)

IMMEDIATE WORRIES AND CONCERNS

Her immediate worries were fundamental concerns regarding the baby's basic needs to be properly fed and warm and to be returned to a reasonably looked-after home. She feared she would 'lose her milk' due to necessary overwork on her return home. She feared lack of money with which to obtain coal and other necessities, due to B's unemployment. She feared returning to a chaotic house - a fear which was all too well justified. With all this went a sense of crushing responsibility, and also a guilty sense that she <u>should</u> have known how to cope (380, 382, 383, 384)

Cathy felt herself to be an inadequate, clumsy mother... (385)

... with surprisingly inappropriate, feelings towards a previously much wanted baby (386)

The whole experience was new and extremely frightening (387)

Some much needed reassurance came from her mother. The only time Cathy felt 'good and proud and confident' was when her baby was being admired during trips out in the pram. She deeply appreciated the effects on herself of this approval and acceptance. (389-390)

MEDICAL HELP AND ADVICE

She was grossly dissatisfied with the advice received from the doctor at clinic. She was well aware of the potential importance of family predisposition to certain illnesses, e.g. 'chest trouble' and frightened by the phenomenon of 'cot death' and anxious to protect her new baby from this risk. Her baby's symptoms were severe and alarming, but the 'baby doctor' dismissed her worries by pronouncing the child's persistent chest infection as due to a 'stuffed nose'. Cathy was disturbed by his dismissal of her real concern, and in doing so lost all credibility for her. She would now refuse to see him. (392-400)

Cathy would now consult her own GP who she feels she can talk to and who knows his job. (401)

WORRIES DURING THE CHILD'S FIRST YEAR

Basic necessities are the ever present problem, there is chronic lack of money to dress the baby, coupled with the frustratingly short life of baby clothes, since Cathy cannot control the rate of the baby's growth but must struggle to keep up with it. It is equally a struggle to feed her adequately, both parents 'go without' for her sake, and have been forced to seek help from Cathy's mother who, though also out of work, sees that they never go home unfed. She feels out of control, being unable to ensure adequate provision, and a reluctant dependance on her mother. (402-404)

When the baby started to walk, she began to bump herself, and Cathy worried firstly, in case she should hurt herself, and secondly, lest she should be thought by 'the clinic' to be beating her child, especially as she has told the health visitor about family violence. She does not trust 'the clinic' and expects to be suspected there, it's policing function is more in evidence than its caring function. (406-407)

Feeling guilty in case the child's inadequate footwear causes her an accident, she fears the worst yet cannot do anything about it. She has to watch the child taking unnecessary risks with worn out soles on second hand shoes. (409)

MOTHERING AND THE 'LOCAL WISDOM'

She gained more confidence in dealing with her child's mishaps by heeding other mothers' wisdom. This taught her that learning to care

for a child involves control of her spontaneous reactions, and discriminating 'serious' fron 'non-serious' occurrences. (410-414)

She is thrilled and gratified by her child's behaviour which illustrates how intelligent she is (i.e. by contriving to unscrew a bottle, with consequent mess). She has been fascinated by her child's development, learning and re-examining her own beliefs regarding children's abilities. (415-417)

LACK OF ADVICE AND ALARMIST TALES

Cathy feels she has suffered from a chronic lack of help and advice. When she became pregnant, she had no idea what a trial motherhood would be. The harsh reality only became known to her through experience. (418)

Her own mother's account of childbirth was misleading and frightening (419-421)
Her own experience was very different from that of their accounts. She has not forgotten the pain and discomfort from the previous birth as she approaches this second one. (422)

HER HUSBAND'S RESPONSE TO FATHERHOOD

Men are unaffected by fatherhood, B. still runs his life as usual with freedom to do as he pleases (424)

She contrasts this ruefully with her own lot, she is mostly restricted to the house (425)

Only in very exceptional circumstances is it possible for her to have a break. (426)

The need for care is continuous and unremitting, both day and night (427)

Her husband can leave to visit friends or otherwise do as he pleases (428)

Only if deserted would a man understand the total responsibility felt by a mother (429)

For a man, fatherhood amounts to no more than a bland formal statement (430)

B. doesn't even take the child's provision into account. He prefers to avoid all worry and concern, leaving it all to Cathy. (431)

Cathy deeply resents B's non-involvement in any aspect of child care, or indeed in any other problematic issue with which she has to contend.

At present there is an unjustified threat of eviction, which B. ignores. B. will not take responsibility for anything; typical of 'men' in general. She is alone, troubled and unfairly beset with every worry. There is no sharing of concerns equally, as there should be. (432-433)

BABY ILLNESS

Baby has had a number of colds. (434)

This is to be expected dur to their cold and damp living conditions. She is not unduly alarmed by the child's persistent colds, as she can see a clear reason for them, albeit beyond her control. She accepts this stoically. (435)

Overall the child has been reasonably fit (surprisingly, she herself has had more illnesses since the birth of her child.) (436-438)

FEEDING PROBLEMS

Breast feeding proved to be painful. (440)
... but she was prepared to suffer to get her figure back (441)

... finding to her surprise that she got a lot of pleasure out of it. (442)

This pleasure was marred to some extent by B. inconsiderately having his 'mates' around. Since there was no where warm for Cathy to go for privacy, she resolved to overcome her personal embarassment, reasoning that the priority was to feed her baby. (443)

Her overdue child was exceptionally 'greedy' because of the disintegration of the 'cord', making feeding painful. (444)

Later, breast feeding became a treasured experience (445)

Cathy would like to breast feed her new baby and has worked out a strategy to help retain her figure. (446)

She was compelled to give up breast feeding. (447)

HELP IN GAINING/MAINTAINING SELF-CONFIDENCE

Nobody has been in a position to offer sustained help. She is forced by circumstances to cope alone. (449)

She fears her GP's warning that she may start neglecting her child. (His analysis:- it is either drugs and child neglect on the one hand; or individual perseverance on the other), seems to sum up her situation so she has pulled all her strength together to survive. (450)

FIRST VISIT TO CHILD HEALTH CLINIC

She was very apprehensive about going to clinic (451)

She did not want to go, fearing that others would disparage her child and herself, fearing their hostility and 'not fitting in'. (452) Cathy felt ashamed of her child's second-hand clothing. She tried; but couldn't compete with the 'lovely pink outfits'; and felt put down. (453)

Clinic visits were experiences of acute shame, her appearance and that of her baby provoke 'nasty' comments. Others treat her as of no account because she is poor and unable to 'look nice'. She desperately wishes she could fit in but must remain an 'outsider'. (455)

Cathy is forced to participate unwholesome 'scrounging' which is demeaning even though changing trends make it less reproachable/more fashionable to attend jumble sales. Attending clinic poorly turned out accentuates her worthlessness in others' eyes. (456-460)

She attended clinic infrequently, not
least because she was publicly disgraced and rebuked by clinic staff for 'improper' conduct. Even when despite her own reservations she went along with her health visitors suggestion, she was made to suffer the indignity of public degradation. (462-468)

CLINIC SYSTEMS

Keeping appointments is a stress she prefers to avoid, self directed visits are to be preferred. (470-472)

LACK OF RELEVANCE

Cathy discovered the lack of 'expertise of the doctor and refused to see him again. (473)

Often visits were a waste of time. Weighing and a talk with other mothers were insufficient justification for a visit. The socialising opportunity was not one she could take up. (474)

REASONS FOR NON-ATTENDANCE

Others may have valid reasons for not attending, they may feel as she does, wishing to avoid degrading situations, or they may simply be too busy. (475-478)

MEDICAL EXAMINATION OF CHILD

The paediatrician's superficial knowledge was shown by his omissions. Now he is held in very low esteem. (480-484)

There are calm areas of her life e.g. her child is doing well in development. Nurses and doctors set themselves up as arbiters of a child's progress, with mothers as 'clients' needing access to their arcane skills and knowledge. (A) to ensure there is nothing obscurely wrong with their child; (B) to 'legitimise' their own child care ('Am I doing alright?'). There must be some need for legitimation and approval of mothers but they make unjustifiable assumptions about mothers, belittling their genuine concerns. There is a paradoxical situation in which on the one hand, mothers must learn when (and when not) to involve health professionals, which inevitably makes for mistakes, e.g. consulting doctors for 'petty' reasons and getting labelled/stereotyped disparagingly as a 'fussy hen'. On the other hand there is the fact that the clinic is there to detect what she supposedly cannot. Having and caring for a child is thus simultaneously construed as 'easy' and 'natural' on the one hand; and

as fraught with pitfalls and sources of potential error on the other. A 'good' mother must show concern - yet doing so can make her 'wrong' too! she can't win. (485-491)

Initially she attended clinic fortnightly... (492)

... tailing off when the clinic lost its original function of confirmation regarding elements of baby care; weight gain; and the achievement of 'milestones'. (494)

Now there is no point in going. (495)

She has better things to do. (498)

Cathy has taken her child to the clinic for immunisations. (499)

It is unheard of for 'them' to offer explanations for what they do or why they do it. They merely send a formal note stating that the child is due for something. She remains unsure concerning her refusal of pertussis immunisation for her baby, as she made the decision on unsure grounds. Ignorance encourages anxiety. There is a desire for more control over decision making, which could result from better information. On the one hand, the mother is expected to know and considered ignorant if she doesn't. On the other hand, if she inquires she is considered 'too nosey' - it is tacitly 'beyond' her and not her concern. An 'act of faith' in the staff is required. (500-509)

There have been no adverse effects from the baby's immunisations. (510)

CLINIC ADVICE

Cathy is not sure if the health visitor still wishes her to go regularly to clinic. (512-513)

She sees the clinic as occasionally useful: e.g. for advice on 'problems', and for a talk with someone. (514)

Advice given (to go out and enjoy herself) trivialises her deeply-felt sense of isolation and fear. Afraid of the contempt and ridicule of the wider social world, she can't take part, she is singled out as shameful and 'unworthy'. (515-516)

There is no understanding of her predicament by others which makes her feel even more of a freak. Understanding and acceptance by others is not a feature of her life. (517)

SELF IMAGE

There is a reason for people's rejection of her, since her standards of self-care have deteriorated since early marriage. Now she seems to have neither time nor motivation to 'look after' herself, whilst feeling guilty and alarmed at her appearance. She has been forced to reconsider her own personal attractiveness: and to conclude that she has 'failed'. Even B. and her mother - have scorned her; and there

seems to be no source of approval left. When she looks at herself with a cold critical eye it seems all insults are justified; she is not worth caring about, to be scorned and ignored is appropriate for her. Pregnancy is an ugly condition which calls for abuse. Sad, isolated and frightened, yet anxious to take part in life, she has to resort to make-believe - the only safe way of 'being attractive' without fear of a rebuff. (529, 530, 531, 532)

B. 'abandons' Cathy whilst she is pregnant. She is bewildered by his attitude, which she regards as typical of men generally, resuming interest in her when her figure is back to normal. (533)

CLINIC ATTENDANCE: MORAL IMPERATIVE

In the absence of guidance, Cathy at first assumed that attendance was obligatory and enforced. She thought the unspoken assumption of the 'authorities' was that it was there - therefore it had to be used. She did what she felt to be 'expected' of her out of fear of a reprimand. (534, 535)

ISOLATION IN THE CLINIC

Cathy's social contacts at the clinic are very limited. (537)

... and their non-arrival would leave her feeling extremely isolated... (538)

... the discomfort of which discourages her attendance (539)

Cathy feels isolated/rebuffed/turned away by the other mothers. She would like to fit in, but they will not allow her to do so. (540)

RELATIONSHIP WITH HEALTH VISITOR

The health visitor is there to keep a check on the baby's welfare. (543)

The health visitor is available when Cathy takes the initiative and goes to seek her. Cathy appreciates her as an uninvolved yet sympathetic advisor. (545-547)

Her approach can be contrasted with that of her doctor who tried to become her ally against B. She wanted both B. and herself to work out a solution not to be supported in rejecting him. (548-549)

The health visitor did see B. for a discussion: to no avail as this angered him, since he does not himself acknowledge any problem; and ended in his forbidding her to go to clinic. For him, the family and its affairs are not a valid concern for 'outsiders'. (550-552)

Though she tries, repeatedly resisting her parents' advice to leave B. he himself will not 'try'. She has no-one else; her efforts to improve things all come to nothing, it's hopeless. (553-554)

REASONS FOR B's BEHAVIOUR

When one contrasts B's undisciplined childhood with her own, she sees in it the roots of his present irresponsibility. He continually wants

to be 'the boss' yet untrammelled and able to be 'away' on his own. She feels as if she has two children (one an adult) to look after. (555)

EMOTIONAL TURMOIL

Cath's emotions towards B. include a bewildering mixture of love, hate, protectiveness and compassion. Their problems are deep and complex: she sees no easy solutions - they must be lived with. (556-558)

Although she has thought long and hard about this, there are no solutions, it is to be lived with. Her optimistic expectations of marriage and motherhood have been dashed. (559-564)

RELATIONSHIPS WITH/ATTITUDES TO HEALTH CARE STAFF

Cathy prefers face-to-face contact with her health visitor, it being difficult to express oneself on the phone. (565)

The health visitor accepts Cathy as a worthwhile person to be listened to, and she can be relied on to be there, and to be interested. (567)

Cathy prefers to 'stick with' the one doctor who she feels has shown understanding of her problems; and with whom she feels she can communicate. She puts little faith in the genuine reciprocity of such relationships, since doctors 'move on' - they are 'in it for the money'. She cynically accepts its impermanence. (570-572)

She resents what she sees as the improper barriers put between doctor and patient by over-zealous receptionists, who also diagnose and prescribe. (574-578)

True help is hard to secure; there are many barriers; and even when these are negotiated, the doctor's 'caring' is as a patient rather than as a person. He will suffer involvement as a means to make money. (579-583)

ROLE OF EARLY EXPERIENCE

As her own mother was ill, Cathy and her sister were involved in bringing up two young siblings, keeping house and conforming to exacting standards. This experience taught her a great deal. (586)

BABY BOOKS

The idealised picture conveyed by much baby literature, gives in her opinion a totally false picture of life. (587)

It would be difficult to 'put down in words' the total reality. (589)

She gives two examples of the gloss on harsh reality provided by literature. Her world is nothing like the cosy world of the baby books. (590-591)

B's OPINION OF THE CLINIC

B. is suspicious of 'do-gooders', whom he perceives as nosey, interfering, policing and punitive. He cannot conceive that they may genuinely wish to help. He sees the family as totally responsible for child-rearing; and is suspicious of the authorities who try to get involved. (593, 595-596)

Cathy understands his harsh view of life. B. is not subject to the sme conflicts as she is: to him, the dichotomy of 'us' and 'them' is a clear reality. 'They' must be after something.

ADVICE TO NEW MOTHERS CONCERNING CLINIC

Whilst acknowledging that it is 'up to them', Cathy feels tht the only practical benefit to her child from the clinic has been immunisation. Otherwise it has not made any appreciable difference. (599-601)

She recognises its value as a socialising 'break' for some mothers though not for herself. Although it may suit 'main-stream' mothers, it is not for her - she does not 'fit in'. (602-605)

EXPERIENCE OF MOTHERHOOD

Cathy has enjoyed having her own child with its symbolic implication of her own maturity and independence.

AMBITIONS AND REGRETS

She had hopes of a glamorous life. Though not fond of factory work, it offered a realistic option, and with part of herself she regrets not having stayed on rather than taking up with B. (608-609)

Dreams are irrelevant - real life is hard, and dreams are never realised. She regrets some decisions but recognises that there are limited choices in life which constrained her. It might have been better had she remained single. (610-613)

One major regret is her loss of freedom; though she accepts moral responsibility for her predicament, she would love to have a life outside the house once more. She realises that her youth makes her feel 'cheated' in this repsect. She also greatly misses both the intrinsic interest of having a job outside the house, and the economic independence which such a job brings. (614-617)

Although Cathy knows that she could leave the baby with her parents, conscience compels her to stay in rather than impose on her already overburdened father. (618-619)

Even when the chance to go out is there, the opportunity is not taken up due to her agrophobic condition; a product of her 'incarceration'. Limited, repetitive shopping expeditions emphasise the mechanical nature of her 'survival routine'. For her the world has become a prison - her freedom is limited not only by lack of money, but also by cumulative fear and self-isolation. Even shopping is no longer enjoyable; a mere mechanical operation rather than an expressive and exciting event, since she is not able to exercise any genuine choice of items. (620, 621)

SUGGESTED IMPROVEMENTS IN THE SERVICES

There is a need for mothers to be better informed if they are to take part in genuine decisions regarding take up of services. Lack of such information definitely leads to non-takeup, or rejection of, critical services such as immunisation in some cases. (623, 624)

Health care staff should not entertain unrealistic expectations regarding what mothers know about the services. (625)

More realistic preparation for childbirth, should be provided. (626)

... instead of the glamourised and unrealistic glosses on reality which are the focus of much 'baby' literature. (627)

Mothers-to-be should not be cheated by withholding information. (628-629)

It would be very useful if first-time mothers-to-be could have the benefit of realistic accounts and advice from experienced mothers at the clinic. (630)

The experienced mother becomes more self-determined, less dependent on the accounts of others. (631-632)

For many girls, their mother acts as the principle source of information and advice... (633)

... but mothers tend to expect daughters to rigidly adhere to their 'rules'. This leads to resentment, re-assertion by the daughter of her right to bring up her own child as she thinks fit. (634-635)

New mothers need to learn, but not alone. (636-637)

Others (both professionals and experienced mothers) should offer more factual advice, not idealised or idiosynchratic ones. (638-640)

Her plea is for 'known fact' unflavoured by either romanticism or drama reflecting the idiosyncracies of individual women. She was herself terrified by lurid tales of childbirth. There is certainly pain - which goes once the child is born. New young mothers-to-be should be protected from this type of alarmism. (641-642)

FUTURE PERSONAL CARE OF CHILD(REN)

Cathy has gained more confidence with which to approach the care of her second child ... (643)

... since her daughter seems to be doing quite well on her present regime. (644)

The clinic has a very limited usefulness as far as the welfare of the child is concerned. She does not think she will use it again... since apart from its limited practical use, she sees its functions as mainly social ones from which she feels herself to be substantially excluded. (645)

4.5. STAGE 3: Identification of the Central Themes of Relevance to the Research Interest

(corresponding to steps 5, 6 and 7 in the procedural outline).

The text is interrogated for it's relevance to an understanding of the interviewees experience, and organised around a summary central theme, which is regarded as of relevance to an understanding of her relations with health care provision, or becoming a mother. These themes, so identified, are regarded as the end product (the results) of the analysis for this interviewee.

First of all the larger area of the research interest to which the themes relate is noted; this is either to do with becoming a mother, or views of service provision. A main theme identified in the transcripts of relevance to this area of interest is then offered, supported by its constituent dimensions which show the ways in which the main theme was arrived at in the analysis, e.g;

In this case study, when talking about becoming a mother, one main theme discovered in the text, was the respondents descriptions of the CRUSHING RESPONSIBILITY she had felt. The constituent dimensions of this these were the SOLE RESPONSIBILITY for the childs welfare she felt forced to take on, the WORRYFUL nature of this task and the IMPACT OF THE REALISATION that she was expected to cope with it all. The constituents are then labelled with meaning unit identification numbers, to indicate their location in the text.

These are laid out in the following way:-

The larger area of the research interest to which the themes relate e.g. MOTHERHOOD.

A main theme identified as of relevance to becoming a mother e.g. CRUSHING RESPONSIBILITY.

All constituent dimensions of this main theme are then presented e.g. SOLE RESPONSIBILITY, WORRYFUL, IMPACT OF REALISATION, which represent each time in the interview the interviewee talked of the heavy responsibilities she felt she had undertaken. The constitutive dimensions of the main theme are the ways in which this theme was identified as of central relevance to the interviewee. They serve as evidence for the identified theme, which for some main themes were many and in others few.

MOTHERHOOD is characterised by:-

CRUSHING RESPONSIBILITY

IMPACT FELT

The stressful, demanding job of mothering is easily ignored in hospital.

When one comes home one really feels it then. (238)

SOLE RESPONSIBILITY

From the start, the child is regarded as A's responsibility solely.

The preparation for homecoming is described as a favour for A. (244-249)

B. (husband) seemed unconcerned (200-206)

She felt like a one parent family

WORRYFULL

All the worry about providing for the child is her responsibility. (631)

A LONG HARD SLOG

DEMANDING

Aged parents can't manage it.
The age gap is a bad thing. (13-17)

One can never keep appointments.
There is so much to organise and prepare.
Better just to pop in to clinic when ready (670-672)

NEVER ENDING DEMANDS

24 hour a day job, no break possible.
Even night time is not sacred. (624-629)

INJURIOUS TO THE SELF

FEAR OF THE SOCIAL WORLD

Confinement leads to a fear of going out (713-719)

SELF SACRIFICE IS REQUIRED

There is no time to see to oneself adequately, so ugliness is unavoidable (719-726)

DISFIGUREMENT

One ends up looking just like a lump of cheese (728-733)

A TIME OF HARDSHIP

CONFINED TO THE HOME

One is restricted to the house, only exceptional circumstances allow for a break from the 24 hour routine, day and night, with no respite. (624-629)

All the worry is her responsibility (631)

CUT OFF FROM THE WORLD

She is so used to being stuck in the house, that now she is afraid to go out (713-719)

Anxious to take part in life, she has to resort to make believe, as the only safe way (728-733)

"Fair enough" though it's her own fault in the first place, she must take responsibility (815)

THERE IS A SENSE OF LOSS

MISSED CHANCES AT WORK

If she'd stayed working, she could have been a supervisor by now, earning good money (809)

LOST FREEDOM TO TAKE PART IN LIFE

She is no longer able to be "one of the lasses" and misses going out and socialising (814).

LOSS OF SOCIAL CONTACT

She is stuck in the house, and sees no-one (816)

LOSS OF EARNINGS

She is no longer able to work for a living (816)

LOSS OF EXPRESSIVE CHOICES

She used to enjoy e.g. shopping, but now its just a boring routine, she can't exercise choice becuase she has no spare money and so is restricted to very limited options (821ff)

NEW AND FRIGHTENING EXPERIENCE

LACK IN CONFIDENCE

She felt inadequate, clumsy and had no confidence, experienced unexpected emotions (589-590)

APPROVAL WAS IMPORTANT

The only time she felt proud and confident was when passers by admired her achievement, treated her as a success (589-590)

INEXPERTISE

She was rebuked for her ignorance (87), Doctors and others dismissed her real concerns as petty, foolish, worrying; they typified her concerns as that of a 'mother hen'. She feels though, that a first-time mother needs to "find out that they're alright" (babies) (679-691)

A TIME FOR ALTROUISM

CHILD MUST COME FIRST

Apparently ludicrous arrangements were made to keep her husband out of trouble, but this must be endured for the sake of the child (318-319)

DEGRADE AND DENY SELF

Hated activities like begging become unavoidable when the childs welfare is at stake (350)
All major worries revolve around the childs welfare, and the ability to provide for the child sharpens the normal day to day worry about survival (580-585)
Doctors reinforce this view, as when he warned her to improve herself, overthrow her problems or neglect the child. Problems must not be dwelled upon, one can't feel self pity as the childs welfare is most important (649-650)

EXPERIENCE ITSELF IS THE REAL SITE OF LEARNING

NEW INSIGHT

When the child hurt herself, A. laughed which seems callous, but was not, as fussing a child leads to more crying. At one time she would fuss over the slightest event, and had heard others warning her about spoiling the child. She heeded this and found it works, the child laughs the hurt away. (610-614)

A FASCINATING/PLEASUREABLE TIME

SURPRISING CAPACITIES OF CHILD

Children are surprisingly bright, e.g. hers was able to remove the caps of an eyeshadow box which led her to re-examine her beliefs about a childs abilities. "They're a lot brainier than we think" (615-617)

UNEXPECTED PLEASURE
Surprisingly, A. enjoyed breast feeding, she "loved to just watch her" (639)
which became a lovely experience (645)

PLEASURE OF ACHIEVEMENT

She has enjoyed having this child, being independent, and knowing she now has a bairn of her own (806-807)
The child has been pretty fit, a good child, who can be endearingly naughty (634-638)

LIFE IS UNFAIR AND DETRIMENTAL

HARD DONE BY

She was raped when younger, which resulted in a miscarriage, and was unable to see justice done. She was reluctant to tell her parents, feared recriminations from her attacker, and afraid to go to the police (18-33)

She was punished by her employers, for what was outside of her control, and did not warrant that sort of treatment. (98, 101)

HARSH TREATMENT COMES HER WAY

There was a total lack of sympathy shown at her work place, when she was pregnant, (98), she was unfairly treated, given unsuitable tasks and even punitive ones like cleaning the toilets out. (92-107)

UNREASONABLE TREATMENT

Social Security officers treated her as an unworthy person but she has worked hard. (295-303)

SHE IS PRONE TO BAD LUCK

UNFORTUNATE

The futile attempts she made to control her own fertility, came to nothing, as she was raped only 2 days after stopping the pill. (47-51)

Her housing position does not assure rehousing (632)

PLANS FLOUTED

Events are largely outside her control, the 2nd pregnancy was ill timed, due to failure of the withdrawal method. (51-58)

UNLUCKY

The only car they had ever had, they believed to be stolen, but later found the new owner had no problem getting hold of legal documentation, a loss she regrets. (257)

Due to her rent collectors sloppiness, they appear to be behind with the rent, and are threatened with eviction, unluckily this type of housing does not assure rehousing. (632)

INADEQUATE PREPARATION FOR THE HARSH REALITIES OF LIFE (CHEATED)

CHEATED

She feels cheated by those who 'know' things, information is deliberately withheld, e.g., "sex is not just a 'good thing', that's too simple a view, which overlooks the pain and disappointment of miscarriages. It becomes boring in any case. (34-44)

Antenatal literature gives false information, requiring one to buy unecessary stuff. (563-569)

MISINFORMED

She was totally unprepared for the trials of motherhood, and only found out when it was too late. (618)

Advice in general is not very useful or true e.g. with giving birth, the pain was not as bad as she had been led to believe. Her own experience was much less harrowing. (619-623)

Baby books only tell the good side, which is not like real life, which would be difficult to put into words. It seems they try to ease one's mind by glossing over problems. (787-791)

UNACKNOWLEDGED NEEDS

People should not expect one to be well informed, they should try to help one understand what is to come, instead of "fairy stories". They should not withhold information. (826-832)

One needs to learn, but not alone, advice should be given, not from personal experience, but known fact, as otherwise it's too dramatic or falsely idealistic and leads to uneccessary worry. (836-842)

EXCLUDED FROM THE MAINSTREAM OF LIFE

VICTIMISED

Normally, certificates of need are given freely to all who need them, but she was not, no-one even mentioned it to her. She was overlooked, the onus being on her to initiate help, putting her in the awkward position of having to persist to get her entitlements, with the ever present fear of recrimination. (117ff)

EXCEPTIONAL PROBLEMS

Her jaundiced child, necessitated an extra long stay in hospital, which was unusual, so she was singled out as abnormal. (235)

SHE IS UNCARED FOR AND ABANDONED

TREATED FLIPPANTLY

On realisation of her pregnancy, she feared losing the child, and was unable to keep up with work demands. Despite her pleas for care, doctors flippantly change their minds. (60-75)

COLDLY DISMISSED

Doctors refuse to see her problems as real, saw her as trying to cheat, so that the resultant threat to her job security was their doing. (89)

The hardships caused by an uneccessary duplication of visits to antenatal care were ignored (142), and no concern was shown for the spreading rash she developed. (170)

Social service staff don't care about her forthcoming childs needs. (340-350)

She was given cold and cruel treatment at work when her pregnancy was confirmed and threatened with the sack. (101-103)

NO-ONE CARES

Cynical doctors change frequently, once they've made a bit of money, regardless of her wishes, they have no commitment to care. (770-772)

Now that she is ugly and misshapen, her husband doesn't fancy her anymore, for which she does not blame him. (728-733)

COMPLETELY ALONE

Her husband is not interested in child care, or family life. (200-206), (623-633) Now she anticipates the total loss of her husband; which before the advent of her child would have been unthinkable. (287-289)

DISSAPOINTMENT WITH LIFE

LET DOWN

Her husband was unmoved by the news of her pregnancy, which she found unbelievable as she was 'over the moon'. (77-78, (200).

Even when she liked a doctor, he moved on; and she never saw him again. (132)

The total lack of involvement on her husbands part; his refusal to make it his concern, spoilt her dreams, as she wanted to share it all with him. (624-633)

On coming home, despite preparations it was a disaster, all her plans were destroyed, she just sat down and cried. (250)

She was enjoying breast feeding, but lost her milk almost immediately. (253)

Her life did not alter in any way, as within minutes of arriving home, she was back to the old grind. (254)

Her maternity allowance held out hope for the betterment of her conditions, but all hopes were dashed, when the money was deducted from the dole. (351-356)

All her efforts to resolve her marital problems, which even involved the health visitor were to no avail (749-755) leaving her hopeless.

Her painful dreams are now all spoiled, she fancied becoming a model at one time, but girls all dream such things, and she once vowed she'd never do factory work, but one has to, to survive. (806-813)

UNDER THREAT OF COLLAPSE.

FEAR OF PERSONAL COLLAPSE

The unreasoned violence of her husband, made her nerves so bad, she was driven to see the doctor, she was terrified at the bizarre situation she had found herself in; only 21 years old and dependent on tranquilisers. (279-286)

The responsibility of a child makes everything much more threatening. (304)

It has been very hard to manage with little money, but she must keep her willpower going, otherwise she may collapse again and recovery seems unlikely. The excessive and punishing use of drugs to keep calm is terrifying. (333-339)

She is troubled by the worry of threatened eviction (632-633), and fears hostile disparagement from others, e.g. 'bitchy' women at clinic who may laugh at her childs poor clothes, which makes her ashamed. (651-655)

This makes her scared to venture out, so she avoids public transport. (713-719)

HOPELESSNESS

All of her hard earned possessions have already had to go, and her husband has tried for hundreds of jobs to no avail. (295-303)

She fears he may be imprisoned for pinching, he is so irresponsible and easily led, but on the other hand, has had to steal coal. (290-293)

She feels helpless to change things, e.g. when she tried to stop him pinching by nagging, this led to severe beatings, he becomes uncontrollable and she is unable to defend herself. (305-319)

With hopeless resignation she accepts her lot (326-330)

Her impossible circumstances revolve around lack of money, (340-350) despite all her efforts to secure more.

Now her 2nd child is on its way and her panic increases as the delivery date looms closer. (358-362)

It's a losing battle trying to provide for her child, the frustratingly short life of clothes, and expense of food. (602-605)

Her husband won't even try to resolve their marriage problem

(740-755), as his problems stem from a poor childhood, which leaves her with a confused turmoil of emotions towards him, so that she now regrets marrying him. (755-764)

LACK OF PRESENTABLENESS

REJECTED

Others have good reason to reject her as she has allowed herself to go downhill, she feels guilty when others notice her failure. (719-732)

SELF DISGUST

When first married she would never be seen so ugly, she has allowed herself to go downhill (719-733), which others notice and make her feel ashamed (720), and it's not surprising that her husband no longer finds her attractive, as her disfigurement is all too obvious. (720-732)

DESPISED

She is forced to take part in despised activities like scrounging in jumble sales; even though today it may be almost fashionable to do so. (656-660)

Her shameful appearance provokes nasty treatment, and the disapproval and ridicule are unbearable. (651-655)

She was publicly disgraced at clinic (661-668) and now anticipates ridicule should she go out (713-719), as others despise and avoid contact with her. (737-740)

SERVICE PROVISION was seen as:-

DISTANT ABSTRACT TOTALITY

STAFF HAVE AUTHORITY AND POWER

Those in authority share the same attitudes (71); they can condemn one and withhold help e.g. by declaring that 'pregnancy is not an illness' (86)

Advice is not freely offered, it has to be extracted through persistence and pleading. One must convince them of ones needs before they will yield (90-91) (117ff)

They have access to priveledged information. (109)

As judges of ones behaviour, they can hand out or withhold approval, without any consideration of how a mother may need to 'find out' that all is going well (686-691)

It is unheard of for them to offer explanations for what they do, she was kept in ignorance of hospital procedures and immunisations and so was worried (700-711)

They can demand certain conduct, e.g. the first time she missed

clinic, she anticipated swift retribution; thinking attendance was enforceable. (734-736)

Her husband thinks little of them; that they are merely nosy and out to get you for child beating (793-797)

STAFF ACT IN SOCIALLY/MORALLY SUPERIOR WAY

Doctors don't give advice; this is an amusing idea, they merely order one around (80).

She was anxious to gain their approval; to do the right thing in their eyes (112)

Her doctor was right to moralise; and she invests in his view that she could neglect her child if she does not persevere. (649-650)

They laugh at ones concerns, thinking mothers make too much of it all; like "silly hens". (686-691)

THEY HAVE HIDDEN/INSIDE INFORMATION

They possess inside information, which she suffered for the lack of, e.g. the start of her pregnancy she knew there must be a procedure, she was just not sure what it might be (110); but the midwife expected her to know and treated her as foolishly uninformed. (111)

The implicit rules are all too obvious when the unenlightened transgress them e.g. questions were not allowed at hospital (163-165), where one was often put down as ignorant.

This was the same at clinic, when she was belittled by her lack of know how, e.g. when a problem which seemed pertinent to her (skin rash) was dismissed as not appropriate there. (170-178)

The ignorance of such matters, leads to one being wrongfooted e.g. on admission to hospital she did not know what to bring, she had no idea of what was expected (563-569), but was anxious to do the right thing. (112)

<u>SHE FELT ILL DEMEANED IN THE EYES OF "SUPERIORS", APART AND BASE</u>

SHE WAS BASE AND DIFFERENT

She did not expect to fit in antenatally and chose selective and limited contact (180-198), as she had nothing in common with 'their way' as revealed in the film shown on child rearing which was totally innappropriate to her life circumstances. (190-196)

Her unbearable predicament with family in-fighting was glossed over with off pat solutions like "time will heal", which was a nonsense and implied she should be coping. She felt a failure in their eyes, as they seemed to be looking through "rose coloured glasses" and could never appreciate her perspective. (260-269)

She is ashamed of the obvious differences between her and them; would like to do it their way, but cannot hope for this. (198)

She feels guilty and anxious about her poverty, especially the meagre diet she is able to offer her child, which seems alarmingly poor, and reflects on her as a mother. (196-200)

The advice offered simply cannot apply to her (263) "to go out and enjoy yourself" is a ridiculous notion, as she can't afford to go out and moreover is now afraid to try, being ashamed of her appearance. (713-719)

Baby books only give the good side, but life isn't like that for her. (787-791)

SHE WAS IGNORED AND DESPISED...

She feels base and poor in comparison to others (196-200), having to act in shameful and degrading ways e.g. she detests begging social services for help but has no choice. (348-350)

As judged from their world, her problems do not seem so serious, so she is seen to be failing in their eyes; these expectations are unfair, and based on an idealised view of the world. (271).

Conact with clinic was a shameful experience; she feared disparagement by others and was ashamed to be seen in second-hand clothing as all the others were very respectable. She could not compete, felt put down and vowed she could never endure it again. (651-655)

Socialising there is impossible for her, she could not join in, (673-674) she felt ignored and despised, usually had to sit alone and even though she tried to get along with the others she was ignored and avoided. (737-740)

As the clinic is used mainly for such socialising (which is a good thing as mothers need a break), it is not the place for her to frequent, only for those who can mix. (798-805)

<u>SHE SUFFERED MORAL CONDEMNATION</u>

SHE FELT REBUKED AND BELITTLED...

The doctor treated her concern about being pregnant as foolishly soliciting undue attention; which made her feel she was acting improperly, even though she was sure she was doing the right thing, as the instructions on her testing kit had said. (66-75)

She was rebuked for soliciting time off work; something the doctor would not condone, as if she was lying and couldn't be ill. (80-89)

Her skin rash was brushed aside as a ridiculous request, which was none of their concern. (170-178)

Social Security staff reprimanded her for soliciting help, as only one of many in need, even though she has worked (is respectable) and feels entitled to some help. (295-303)

She was publicly disgraced at clinic, as she was not aware that one had to pay for second hand clothing there, rebuked for not offering payment, she was forced to admit to having no money to pay and return

the clothes. (661-668)

They also think mothers make too much of their concers, and accuse one of hen-like pestering (686-691) which is shameful.

SHE FEARS BAD PRESS

She was anxious to be seen as an informed 'proper' person (109-115), fearing their judgements on her. Apprehension about her first visit to clinic was because she was unsure what was expected of her and did not want to be made to look a fool. (28-29)

When her child damaged her head, she anticipated them thinking badly of her, but she could do nothing about it as it was her poor footwear which caused the slip (606-609). There is no help available to her, as requests are transformed into threats e.g. the doctor frightened her into self improvement. (649-650)

All those who don't use the clinic, like her, are afraid of disparagement, and avoid the threat by staying away. (675-678)

DEHUMANISING CONTACT WITH STAFF

TREATED AS OF NO CONSEQUENCE

Impersonal interrogations are the order of the day (129) whereby one is regimented through the service as one of many (145), passed on from one doctor to another, "like a bag of flour" (129)

Staff treated her as if she was not worth caring about; the doctor, "didn't give a chuff" (148) and acted as if she was a little box in the corner of the room. (149)

Just like an object, she was subject to emergency and highly technical treatment in hospital, with no explanations or direct communication to her even though she was confused agitated and alarmed. (209-231)

RIDICULED AND HUMILIATED

She was treated as an exhibit; where there was no need for human emotions; as with doctors in general such matters are not applicable e.g. when she was forced to walk naked across a room full of medical students; who did not care how she felt. (149-153)

FELT WORTHLESS IN THE EYES OF STAFF

PROTESTS ARE IGNORED

She was outraged at the unwarranted dismissal by her doctor of her symptoms (60-75), and in general has to struggle to be heard; problems are not taken seriously, and one has to plead to get anywhere. This forces one to act in an undignified way. (90-91)

Social security dismiss intolerable living conditions as one of many, even though she has worked. (197)

Her elaborate description of her childs 'chestiness' symptoms were dismissed as 'cold in her nose', which is too simple to be true. (598)

Ridiculous clinic arrangements which caused her hardship; were never changed even though she kept telling them what was happening (140).

She was never listened to respectfully (170-178) and often treated as not having any sense. (260-2262).

Grave problems were made light of (263ff) which leads to incorrect diagnoses (679-684) and inadequate care.

CRITICAL ANTAGONISM TOWARDS STAFF

CULPABLE NEGLIGENCE/INEXPERTISE OF STAFF

On occasions, they have been forced to agree with her, they were wrong all along, and could be held responsible for the possible death of her child. (75)

They acted improperly and are not always correct. They make the wrong diagnoses (592-561) and so she refused to see this doctor again. The doctor at clinic proved himself to be no good when he mistakenly dismissed a bad chest as 'cold in her nose', (673) and often they do not conduct a very thorough examination e.g. they do not get the stethoscope out and check internally. (679-682)

They only tell one what is already known (693-698) in any case, and cause worry, making problems worse by withholding information. (700-711)

They are unreliable (770-772) and act improperly e.g. when receptionists refuse to send a doctor out when one is ill, and even prescribe medication. (773-784)

Contact with them brings no appreciable benefit, it's all just for socialising really (798-805) e.g. clinic visits make no real difference.

RIDICULOUS AND IRRELEVANT SERVICES

- They are not always correct in their assessments (71-75), and can place ridiculous demands on mothers, e.g. when the changed venue of the clinic necessitated 2 bus rides (20-25). Even when the problems are pointed out to them, they persist in their idiocy. (138-142)

The activities at the antenatal classes were ludicrous "stretching yer ankles and this lot" and seemed a complete waste of time (182), whilst the clinic "only weighs 'em". (675)

The services are difficult to make use of because they make the wrong assumptions about mothers e.g. that their concerns are merely overactive mothering. (686-691)

APPRECIATION OF CARE

APPRECIATION OF CARE.

FELT ACCEPTANCE

The health visitors concern about her marital problems was much appreciated, especially so, since she was allowed to talk. Even though, the problems are not resolved, she ended up feeling less confused about it all. (274-278)

REASSURANCE

The developmental checks, have been reassuring, as they mean she has one less thing to worry about. (685)

As someone to talk to, the health visitor proved accessible, even though the advice was irrelevant. (714)

ACTIVE INVOLVEMENT

The health visitor tried to intervene in her problems, was prepared to get involved, but ended up seeing the problem in a one sided way. (752-755)

REMAINING DATA (meaning units not already included in the thematic summary)

A. reluctantly depended on her mother for food (605)

She justifies her behaviour at each stage (639ff) e.g. breast feeding. Some questions elicited well told stories e.g. A's analysis of her husbands problems (279-319)

The stoical acceptance of the hard facts of life; e.g. the child will never be very healthy in such a damp house (634-638), as a mother she must cope alone (649), and this predicament is seen as all her own fault. (815)

Her conception and pregnancy were seen as perilous and precarious (1-13), as was her lack of control over, life events (13), information (823) and the future.

N.B. All category systems are inadequate to the task of covering every aspect of the topic they refer to c.f. "etcetera" H. Garfinkel 1967, Studies in Ethnomethodology. New Jersey: Prentice-Hall.

APPENDIX 5

SELECTION OF STUDY CASELOADS.

Referred to in text 4.1.

Contents

Profile of HV caseloads (N=39) 1980

0 - 1 years caseloads

Cases No	HV fr
40-160	6
60-80	7
80-100	10
100-120	12
120-140	1
140-160	2
160-180	1
	39

range = 50-168 for full-time staff
44-106 for part-time staff

1-5 years caseloads

Cases No	HV fr
110-150	2
150-200	0
200-250	6
250-300	8
300-350	7
350-400	9
400-450	3
450-500	1
500-550	3
	39

range = 110-532

Schools caseloads

Cases No	HV fr
o	2
1	5
2	10
3	8
4	4
5	1
6	3
7	3
8	2
9	1
	39

range 0 - 11

Non-accidental injury caseloads

Cases No	HV fr	range = 0-13
0	7	
1	4	
2	5	
3	6	
4	4	
5	5	
6	3	
7	1	
8	1	
8	1	
10	0	
11	0	
12	0	
13	1	
	39	

Elderly persons caseloads 60-75 years

Cases No	HV fr	range = 0-29
0-5	21	
5-10	6	
10-15	4	
15-20	1	
20-25	3	
25-30	3	
	39.	

Elderly persons caseloads 75+ years

Cases No	HV fr	range = 0-50
0-10	26	
10-20	5	
20-30	3	
30-40	2	
40-50	2	
	39	

Number of child health clinics per month

No of clinics	HV fr
0-2	3
2-4	1
4-6	16
6-8	3
8-10	9
10-12	1
12-14	5
	39

range = 0-14

Developmental assessment sessions per month

No of sessions	HV fr
0	7
1	6
2	11
3	1
4	10
'as required'	1
	39

range = 0-4

Health education sessions in schools per month

No of sessions	HV fr
0-10	24
10-20	4
20-30	2
30-40	4
40-50	1
50-60	1
	39

range = 0-60

Number of 'problem families' caseloads

No of cases	HV fr
0-5	15
6-10	8
11-15	8
16-20	6
21-25	1
26-30	1
	39

range = 0-30

The tabulated summaries above allow for a comparison of the Health Visitor caseloads and give an overall impression of the locality in which the study was to take place. On each of the indicators outlined above, the HV chosen for inclusion in the study fell within the modal or higher than modal caseload bracket. Of the 39 HV's working in the study area there were 12 who had higher or modal caseloads, e.g. over 100 charges in the 0-1 year old section and over 300 in the 1-5 year old section. Three of these HV's were excluded owing to the considerations outlined in the text (4.1) and the remaining 9 caseloads comprised the study population. Comparative data outlined in the table below indicate that they were not untypical of the study area.

5.2. Comparison of Health Visitor Caseloads (1980 summary)

HV	0-1 yrs	1-5 yrs	Not reg	Problem families	Elderly	CHC per month	HT per month	DA per month	GP's atta ched
1	114	366	1	6		36	8	1	2	3
2	103	368	4	9		40	9	1	2	3
3	87	291	1	9		13	4	1	1	3
4	62	269	8	20		8	4	2	1	3
5	113	425	6	16		39	4	0	0	4
6	101	400	13	14		2	8	1	0	3
7	88	287	2	0		0	12	2	2	4
8	106	362	0	0		17	12	1	1	3
9	78	304	9	0		0	4	1	1	3
Modal frequency										
	100-120	300-350	3-4	0-5		0-10	4-6	2	2	3
Range N=39										
	50-168	110-532	0-13	0-30		0-50	0-14	0-4	0-4	3-4

*HV are referred to by number only to preserve anonymity

There were 4 major care settings covered by the 9 HVs which again were not untypical in any way from the rest.

5.3. Table of Comparison of Chosen Care Settings

	1	2	3	4	5	6	7	8	9	10	11	12	13
A	2	100-120	300-350	5-10	20-30	1	1	8-10	2	GP	6	AHA (C)	15
B	3	100-120	250-300	0-5	0-10	7	8	4-6	1	CMO	10	AHA (C)	60
C	2	160-170	300-350	25-30	40-50	3	4	4-6	4	CMO	7	AHA (HC)	5
D	2	100-200	300-350	5-10	10-20	3	1	12-14	N/S	CMO	6	AHA (C)	8
Modal freq		100-120	350-400	0-5	0-10	2	3	4-6	2				
Range N=39		40-180	110-550	0-29	0-50	0-11	0-13	0-14	0-4				

Key

Column 1 Number of health visitors based in specific settings

Column 2 Caseload of health visitors (children under 1 year of age) expressed as an average range for the care setting

Column 3 Caseload of health visitors (children aged 1-5 years) expressed as an average range for the care setting

Column 4 Caseload of health visitors (elderly persons aged 60-75 years) expressed as an average range for the care setting

Column 5 Caseload of health visitors (elderly persons aged over 75 years) expressed as an average range for the care setting

Column 6 Number of schools served by health visitors and school nurses within care setting

Column 7 Number of children appearing on the register for non-accidental injury

Column 8 Number of child health clinics held during one month (usually advisory sessions dealing mainly with infants)

Column 9 Number of developmental assessment clinics held during one month (usually specifically for developmental surveillance by doctor and HV) NB: Setting does not use specific sessions for this purpose and number is included with general child health clinics in column 8

Column 10 clinic attended either by a GP from the care setting or by an AHA Clinic Medical Officer

Column 11 Number of GPs in the appropriate general medical practice for the setting

Column 12 Type of premises available for clinic sessions

Column 13 Age of premises (in years) used for clinic sessions

Modal frequency: Modal frequency of each characteristic feature amongst total available sample (N=39)

APPENDIX 6

TABULATED SUMMARIES OF SOCIO ECONOMIC DATA

Referred to in text 4.3.

Contents

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS - KEY TO CATEGORY CODES:

CATEGORY:	CODE:
1 Maternal age at birth:	*Refers to mother's age at the birth of her first child, to nearest year*
2 Type of schooling:	*1 secondary modern 2 comprehensive 3 secondary grammar*
3 Age left school:	*Refers to the age at which the mother herself left school, in years/decimals of a year*
4 Qualifications:	*0 none 1 CSE only 2 'O' level(s) or CSE and 'O' level(s) 3 'A' level(s) or 'O' level(s) and 'A' level(s) 4 professional examination(s)*
5 Health education:	*Refers to health education topics covered at the mother's school: 0 none 1 Human biolo 2 Human biology and domestic science 3 Huma biology, domestic science and sex education 4 Human biology, domestic science, sex education and baby care*
6 Previous occupation:	*Refers to the mother's occupation before the birth of her child:* *0 no occupation* *1 student* *2 primary industry (e.g. farming)* *3 factory work (e.g. seamer, line feeder, tracer, machine operator, machinist)* *4 service occupations (e.g. receptionist, market seller, hairdresser, shop assistant, supermarket worker, barmaid, waitress etc)* *5 professional or quasi-professional (e.g. social worker, nurse, teacher, child care worker, dispenser's assistant, lab technician)*
7 Present occupation:	*Refers to the mother's occupation since having her child. Categories as for item 6 (HW= housewife; PT = part-time)*
8 Partner's occupation:	*Refers to present occupation of partner:* *0 unemployed or no occupation* *1 student* *3 skilled industrial worker (e.g. miner, electrician, welder, fireman)* *2 unskilled or semi-skilled industrial worker (e.g. storeman, dustbin man, labourer)*

CATEGORY:	CODE:
8 *Partner's occupation (contd):*	*4 non-manual worker (e.g. security officer, policeman, accounts clerk)* *5 professional worker (e.g. teacher, optician, metallurgist)*
9 Length of time in present accommodation:	*Refers to the length of time during which the family has occupied current accommodation, expressed in years/decimals of a year)*
10 Residences since a child:	*This refers to the number of residences in which the mother has lived altogether since childhood*
11 Regular contacts in neighbourhood:	*Refers to the mother's current regular contacts in the neighbourhood:* *0 none at all* *1 family only* *2 family and friends* *3 family, friends, and neighbours with children*
12 Type of property lived in now:	*Refers to the type of property currently occupied by the family:* *1 private flat 2 private house* *3 council flat 4 council house* *5 tied housing (e.g. NCB house)*
13 Bedrooms:	*Refers to the number of bedrooms in present accommodation*
14 Number of people living there:	*Refers to the number of persons living in present accommodation (i.e. the first three would be mother, father and child)*
15 Condition of property (own assessment):	*Refers to mother's own assessment of current living accommodation:* *0 'poor'; 'disgusting'; 'terrible disrepair'; 'terrible'; 'rubbish' etc* *1 specific complaints (e.g. 'subsidence'; 'top flat'; 'chronic damp', etc)* *2 'moderate'; 'not bad'; 'quite good'; 'okay' 'fair' etc* *3 'good'; 'very good' etc*
16 Domestic facilities:	*Refers to current facilities possessed by mother:* *0 no hot water* *1 hotwater only 2 hot water and fixed bath* *3 hot water, fixed bath, inside toilet* *4 hot water, fixed bath, inside toilet, cooker*

CATEGORY:	CODE:
16 Domestic facilities (contd):	*5 hot water, fixed bath, inside toilet, cooker, washing machine* *6 hot water, fixed bath, inside toilet, cooker, washing machine, telephone* *7 hot water, fixed bath, inside toilet, cooker, washing machine, telephone, car*
17 Journey to clinic:	*Refers to the approximate time which it takes the mother to get to the child health clinic, in minutes suffixed by mode of travel (W = walking; B = by bus; C = by car)*
18 Journey to GP:	*Refers to the approximate time which it takes the mother to get to her GP's surgery, in minutes suffixed by mode of travel (W = walking; B = by bus; C = by car)*
19 Marital status:	*Refers to current marital status of the mother:* *0 single parent* *1 separated or divorced* *2 common law wife* *3 married*
20 Years known partner:	*Refers to the length of time for which the mother has known her present partner, in years/decimals of a year*
21 Years with partner:	*Refers to the length of the period during which the mother and her present partner have been living together, in years/decimals of a year*
22 Together before child:	*Refers to the length of time during which the mother and her partner were together before the child's arrival, in years/decimals of a year*
23 Position in own family:	*Refers to position of the mother in her own family (e.g. '2:3' means that she was the second child of three)*
24 Pregnancy planned?:	*0 no 1 yes*
25 Information type:	*Refers to the mode in which information was obtained from the mother:* *TI taped interview obtained*

CATEGORY:	CODE:
25 *Information type (contd):*	*I* an interview was obtained but not taped *R* refused to be interviewed, either directly or by not keeping repeated arrangements *NI* never in - i.e. the mother was never found at the premises in spite of repeated visits after notes and letters warning of the visit had been delivered *L* 'lost' - i.e. premises found to be empty on arrival *O* omitted from the sample due to removal from the area of study

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	FIRST DECILE (N= 15):									
	28	31	32	50	58	59	62	66	75	86
1 Maternal age at birth:		34	22			22				
2 Type of schooling:			3			2				
3 Age left school:			16			15				
4 Qualifications:			2			2				
5 Health education:			3			2				
6 Previous occupation:			5			3				
7 Present occupation:			HW			HW				
8 Partner's occupation:	0	3	5	0		0			2	4
9 Length of time in present accommodation:			1			1.5				
10 Residences since a child:			8			4				
11 Regular contacts in neighbourhood:			2			2				
12 Type of property lived in now:			4	3	2	4		4	2	
13 Bedrooms:	2	2	3	3	3	2		3	3	
14 Number of people living there:			3	3		3		8	3	
15 Condition of property (own assessment):			2			1				
16 Domestic facilities:			6			0				
17 Journey to clinic:			30W			5B				
18 Journey to GP:			15B			5B				
19 Marital status:	0	1	3			3		0		
20 Years known partner:			7			6				
21 Years with partner:			5			2				
22 Together before child:			3.5			0.5				
23 Position in own family:			3:3			1:1				
24 Pregnancy planned?:			1			0				
25 Information type:	NI	R	T	L	NI	T	O	NI	NI	R

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(First Decile ctd)						SECOND DECILE (N=14):			
	103	105	110	112	117		21	29	55	65
1 Maternal age at birth:	23		23	17			30	22		25
2 Type of schooling:	2		1	2			1	1		2
3 Age left school:	16		16	15			15	16		15
4 Qualifications:	1		0	0			0	0		0
5 Health education:	0		3	1			1	3		2
6 Previous occupation:	4		4	0			4	4		4
7 Present occupation:	HW		HW	HW			HW	HW		HW
8 Partner's occupation:	2		3	2			3	3	3	2
9 Length of time in present accommodation:	1.3		3	1.4			0.5	2		1.3
10 Residences since a child:	4		2	2			7	2		3
11 Regular contacts in neighbourhood:	3		3	3			2	2		2
12 Type of property lived in now:	4		2	4			4	5	2	4
13 Bedrooms:	2	3	2	3			3	3	3	2
14 Number of people living there:	3		3	3			3	3	3	3
15 Condition of property (own assessment):	1		3	0			3	2		2
16 Domestic facilities:	2		7	0			7	5		7
17 Journey to clinic:	5W		10W	10W			20W	10W		5W
18 Journey to GP:	15B		10W	15B			15B	10W		10B
19 Marital status:	0	0	3	3			3	3		2
20 Years known partner:			7	2			14	3		4
21 Years with partner:			3	1.4			10	2		2.5
22 Together before child:	0.5		2	0			8	0.5		1
23 Position in own family:	1:2		1:7	3:3			3:4	1:4		3:4
24 Pregnancy planned?:	0		1	0			0	1		1
25 Information type:	I	NI	I	T	NI		T	T	NI	T

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Second Decile cont'd)									
	72	82	83	85	88	95	111	116	140	145
1 Maternal age at birth:	20					22	25		24	21
2 Type of schooling:	1					2	2		3	1
3 Age left school:	16					17	15		15	16.5
4 Qualifications:	0					2	0		0	2
5 Health education:	3					3	1		1	1
6 Previous occupation:	4					4	3		5	3
7 Present occupation:	HW					HW	HW		5	HW
8 Partner's occupation:	0	4	0	3	5	3	2		3	0
9 Length of time in present accommodation:	1.5					2.5	1		2	3.5
10 Residences since a child:	2					3	3		2	3
11 Regular contacts in neighbourhood:	3					3	3		2	1
12 Type of property lived in now:	4	3	4		2	2	2		2	5
13 Bedrooms:	3	2	3		3	2	2		2	2
14 Number of people living there:	10	3	3		3	3	3		3	3
15 Condition of property (own assessment):	0					3	3		3	0
16 Domestic facilities:	0					6	6		7	0
17 Journey to clinic:	20W					30W	20W		30W	5W
18 Journey to GP:	45B					B	10W		30W	20B
19 Marital status:	2					3	3		3	3
20 Years known partner:	6					13	2.5		4	4
21 Years with partner:	1.5					2.5	2		0.2	4
22 Together before child:	0					1	0.8		0	2
23 Position in own family:	1:6					7:7	3:4		1:3	1:4
24 Pregnancy planned?:	0					1	0			1
25 Information type:	T	NI	NI	L	L	I	T	R	T	T

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	THIRD DECILE (N=15):									
	12	16	33	39	44	45	60	79	80	84
1 Maternal age at birth:	18	22		23	23					
2 Type of schooling:	2	3		2	1					
3 Age left school:	15.5	15		16	16					
4 Qualifications:	2	2		2	0					
5 Health education:	1	3		3	2					
6 Previous occupation:	0	3		1	4					
7 Present occupation:	HW	HW		HW	HW					
8 Partner's occupation:	2	3	4	2	3	2	2	3	2	
9 Length of time in present accommodation:	2	2		3	1.6					
10 Residences since a child:	2	3		3	2					
11 Regular contacts in neighbourhood:	2	0		2	1					
12 Type of property lived in now:	4	5	2	2	4	4	4	4	3	
13 Bedrooms:	2	3	3	3	3	2	3	3	4	
14 Number of people living there:	3	3		3	3	3		8		
15 Condition of property (own assessment):	2	0		2	3					
16 Domestic facilities:	4	4		6	7					
17 Journey to clinic:	10W	20W		10W	10W					
18 Journey to GP:	10W	20W		10B	10B					
19 Marital status:	3	3		3	3			1	0	
20 Years known partner:	6	8		6	4					
21 Years with partner:	2	2		3	2					
22 Together before child:	0.2	1		1.5	0.3					
23 Position in own family:	4:6	1:4		2:4	4:4					
24 Pregnancy planned?:		0		1						
25 Information type:	T	T	NI	T	T	NI	NI	R	NI	NI

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Third Decile cont'd)						FOURTH DECILE (N= 8):			
	92	96	98	100	130		20	27	34	35
1 Maternal age at birth:		26			20					
2 Type of schooling:		2			2					
3 Age left school:		16								
4 Qualifications:		2								
5 Health education:		2								
6 Previous occupation:		5								
7 Present occupation:		HW								
8 Partner's occupation:		3	2	2	2				3	4
9 Length of time in present accommodation:										
10 Residences since a child:										
11 Regular contacts in neighbourhood:					1					
12 Type of property lived in now:									2	2
13 Bedrooms:	3				2		3	2	3	3
14 Number of people living there:							3			
15 Condition of property (own assessment):										
16 Domestic facilities:										
17 Journey to clinic:					2W					
18 Journey to GP:					2W					
19 Marital status:										
20 Years known partner:										
21 Years with partner:										
22 Together before child:										
23 Position in own family:										
24 Pregnancy planned?:										
25 Information type:	NI	T	NI	R	I		NI	NI	NI	NI

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Fourth Decile cont'd)									
	40	41	49	73	76	93	99	109	113	125
1 Maternal age at birth:	22	29		19	23	26		30	27	33
2 Type of schooling:	2	3		2	1	2		1	1	1
3 Age left school:	16	16		16	16	15		15	16	15
4 Qualifications:	0	2		2	1	0		0	1	0
5 Health education:	1	2		1	1	2		2	2	1
6 Previous occupation:	4	5		5	4	4		4	4	3
7 Present occupation:	HW	HW		HW	HW	HW		HW	HW	HW
8 Partner's occupation:	3	4	2	3	3	3		4	5	2
9 Length of time in present accommodation:	1.5	5		1.4	4	2		2	4	2
10 Residences since a child:	3	3		3	5	2		4	6	5
11 Regular contacts in neighbourhood:	2	0		2	3	3		3	1	1
12 Type of property lived in now:	4	2	4	4	2	3		2	2	2
13 Bedrooms:	3	3	3	3	2	2	2	2	2	3
14 Number of people living there:	3	3	3	3	3	3		3	3	3
15 Condition of property (own assessment):	0	3		0	3	3		2	2	3
16 Domestic facilities:	0	7		5	7	6		5	6	6
17 Journey to clinic:	3W	20W		15W	30W	10W		10W	10W	5W
18 Journey to GP:	20B	10C		B	B	5B		15W	15B	5W
19 Marital status:	3	3		3	3	3	0	3	3	3
20 Years known partner:	10	8		4.5	7	8		6.5	10	14
21 Years with partner:	2	5		1.5	4	2		5	4	12
22 Together before child:	0.2	3		0	3	0.2		3	3	11
23 Position in own family:	2:4	1:1		2:2	1:1	1:1		2:3	1:2	2:2
24 Pregnancy planned?:	0	1		0	1	0		1	1	
25 Information type:	T	I	NI	I	I	I	R	T	T	T

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Fourth Dec ctd)					FIFTH DECILE				
	126	129	131	156		(N= 9	20) 14	23	26	37
1 Maternal age at birth:	25	21	22	22					29	23
2 Type of schooling:	2	3	3	3					1	3
3 Age left school:	18	16	16	16					16	17
4 Qualifications:	2	2	2	2					0	2
5 Health education:	3	1	0	1					3	2
6 Previous occupation:	5	4	3	4					4	4
7 Present occupation:	HW	HW	HW	HW					HW	HW
8 Partner's occupation:	3	3	3	4			4		4	4
9 Length of time in present accommodation:	3	1.1	2	1					5	4
10 Residences since a child:	2	3	2	3					2	2
11 Regular contacts in neighbourhood:	1	3	1	2					2	3
12 Type of property lived in now:	2	4	2	3		2	2		2	2
13 Bedrooms:	3	3	2	3		3	3		3	3
14 Number of people living there:	3	3	3	3		3	3		3	3
15 Condition of property (own assessment):	3	3	2	2					3	3
16 Domestic facilities:	7	7	7	5					6	6
17 Journey to clinic:	10W	10W	15W	15W					10W	5W
18 Journey to GP:	10B	10W	15W	15C					10W	B
19 Marital status:	3	3	3	3					3	3
20 Years known partner:	11	6	7	15					10	8
21 Years with partner:	3	3	2	4					5	5
22 Together before child:	2	2	0.2	2					4	3.5
23 Position in own family:	1:2	1:2	3:3	1:3						1:2
24 Pregnancy planned?:				1					1	1
25 Information type:	T	T	T	I		NI	NI	NI	T	I

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Fifth Decile contd) 46	51	63	67	69	74	87	90	115	123
1 Maternal age at birth:	34	30		23	21	33	23		21	23
2 Type of schooling:	1	1		2	1	2	2			1
3 Age left school:	15	15		16	16	17	16		15	16
4 Qualifications:	0	0		2	1	2	0		2	1
5 Health education:	2	1		2	3	2	1		1	2
6 Previous occupation:	5	2		3	4	5	4		5	4
7 Present occupation:	HW	HW		HW	HW	HW	HW		HW	HW
8 Partner's occupation:	4	3	3		3	5	5	2	2	3
9 Length of time in present accommodation:	2	6		0.2	2	1	3.5		2	1.5
10 Residences since a child:	10	2		5	5	3	2		7	4
11 Regular contacts in neighbourhood:	3	3		2	2	3	3		1	3
12 Type of property lived in now:	2	2	2	4	2	2	2		4	4
13 Bedrooms:	3	3	3	2	3	3	3		2	3
14 Number of people living there:	3	3		5	3	3	3		3	3
15 Condition of property (own assessment):	3	3		2	2	3	3		0	3
16 Domestic facilities:	7	7		6	6	7	6		5	6
17 Journey to clinic:	15W	15C		5W	15W	5W	2W		10W	10W
18 Journey to GP:	15B	15C		10W	30B	B	2W		90B	10W
19 Marital status:	3	3		0	3	3	3		3	3
20 Years known partner:	12	15		3	4.5	16	8		3	6
21 Years with partner:	2	9			2	10	3.5		2	4
22 Together before child:	0.7	8			0.7	9	2		1	2
23 Position in own family:	7:8	1:1		2:2	2:4	1:3	3:4		3:5	3:7
24 Pregnancy planned?:	1			0	0	0	0		1	
25 Information type:	I	T	R	T	I	T	I	NI	T	T

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Fifth Decile cont'd)						SIXTH DECILE (N= 11):			
	124	128	132	135	136		10	11	15	22
1 Maternal age at birth:	21	26		21	18					
2 Type of schooling:	1	2		2	2					
3 Age left school:	16	16		18	16					
4 Qualifications:	2	0		3	1					
5 Health education:	2	2		0	2					
6 Previous occupation:	5	4		1	3					
7 Present occupation:	HW	HW		HW	HW					
8 Partner's occupation:	4	3	2	1	0			3	3	
9 Length of time in present accommodation:	2.5	5		1.1	1.1					
10 Residences since a child:	4	2		6	3					
11 Regular contacts in neighbourhood:	1	0		2	1					
12 Type of property lived in now:	2	2		4	4		4		2	
13 Bedrooms:	2	3	2	3	2		3	3	3	3
14 Number of people living there:	3	3		3	3		7	3	3	3
15 Condition of property (own assessment):	3	3		2	1					
16 Domestic facilities:	6	7		6	4					
17 Journey to clinic:	30B	10W		10W	15W					
18 Journey to GP:	30B	10W		15B	15B					
19 Marital status:	3	3		0	3					
20 Years known partner:	2.5	6		4	3					
21 Years with partner:	2	3			1.3					
22 Together before child:	0.5	2			0.1					
23 Position in own family:	1:3	1:2		3:4	9:10					
24 Pregnancy planned?:										
25 Information type:	T	T	L	T	T		NI	L	R	R

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Sixth Decile contd)								SEVENTH DECILE	
	25	52	70	102	106	118	151		3	6
1 Maternal age at birth:		35	29	28	23	27			24	
2 Type of schooling:		3	1	3	1	1			1	
3 Age left school:		18	18	17	16	14			16	
4 Qualifications:		3	3	3	1	1			0	
5 Health education:		2	3	1	1	3			3	
6 Previous occupation:		5	5	5	4	4			4	
7 Present occupation:		5	HW	HW	HW	HW			HW	
8 Partner's occupation:		2	5	3	2	2			4	4
9 Length of time in present accommodation:		3.5	7	3	3	4.5			4	
10 Residences since a child:		6	2	2	4	2			2	
11 Regular contacts in neighbourhood:		2	3	2	3	3			3	
12 Type of property lived in now:		2	2	2	2	2			2	4
13 Bedrooms:	3	3	2	2	2	2			3	3
14 Number of people living there:	3	3	3	3	3	3			3	3
15 Condition of property (own assessment):		3	3	3	3	3			3	
16 Domestic facilities:		7	7	5	6	6			7	
17 Journey to clinic:		20W	10W	20W	3W	20W			15B	
18 Journey to GP:		7W	30W	20B	5B	10W			15B	
19 Marital status:		3	3	3	3	3			3	
20 Years known partner:		5	10	6	7	5			7	
21 Years with partner:		4	7	3	3	4			4	
22 Together before child:		2.5	5	1.5	2	3			3.5	
23 Position in own family:		1:1	1:4	1:1	4:4	3:4			1:2	
24 Pregnancy planned?:		1	1	0		1			0	
25 Information type:	R	I	T	T	T	T	L		T	R

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Seventh Decile contd) 24	38	43	64	78	91	141	146	154	157
1 Maternal age at birth:		28	25		22	35	24		23	32
2 Type of schooling:		3	1		2	1	2		3	3
3 Age left school:		18	15		16	15	16		16	18
4 Qualifications:		2	0		0	0	1		3	3
5 Health education:		1	1		1	3	2		3	1
6 Previous occupation:		5	3		4	4	4		5	5
7 Present occupation:		5	HW		HW	HW	HW		5	5
8 Partner's occupation:		4	3	5	3	4	3	2	3	5
9 Length of time in present accommodation:		3.5	2		0.6	7	1.5		1.5	4
10 Residences since a child:		10	5		2	2	3		3	7
11 Regular contacts in neighbourhood:		0	3		2	3	2		3	0
12 Type of property lived in now:		2	2	2	4	2	4		2	2
13 Bedrooms:	2	3	3	3	3	3	3		3	3
14 Number of people living there:	3	3	4		5	3	3		3	3
15 Condition of property (own assessment):		2	3		3	3	3		3	3
16 Domestic facilities:		6	6		6	7	7		7	7
17 Journey to clinic:		10W	1W		2W	15W	2W		2W	20W
18 Journey to GP:		10W	1W		B	5W	2W		2W	20W
19 Marital status:		3	3		1	3	3		3	3
20 Years known partner:		11	5		3	17	4		9	10
21 Years with partner:		9	4		1.5	7	3		1.5	3
22 Together before child:		8	2		0.5	6	2		0.4	2
23 Position in own family:		2:5	2:5		2:4	1:1	1:1		1:2	3:3
24 Pregnancy planned?:		0	1			1			0	1
25 Information type:	NI	T	I	NI	T	I	T	R	T	I

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
			EIGHTH DECILE (N= 15):							
	158		2	7	8	17	30	36	47	48
1 Maternal age at birth:	21		28						18	36
2 Type of schooling:	3		3						1	3
3 Age left school:	16		18						16	16
4 Qualifications:	0		4						1	2
5 Health education:	1		2						2	2
6 Previous occupation:	4		5						4	5
7 Present occupation:	HW		HW						HW	5
8 Partner's occupation:	2		5	4	3	3		5	3	4
9 Length of time in present accommodation:	1.2		3						0.1	1.5
10 Residences since a child:	3		3						3	3
11 Regular contacts in neighbourhood:	3		3						3	3
12 Type of property lived in now:	2		2		2	2		2	4	2
13 Bedrooms:	3		3	3	3	2	3	3	3	4
14 Number of people living there:	3		3	3	3	3			3	3
15 Condition of property (own assessment):	3		3						0	3
16 Domestic facilities:	7		7						4	7
17 Journey to clinic:	2W		20B						5W	10W
18 Journey to GP:	2W		20B						10B	4C
19 Marital status:	3		3						3	3
20 Years known partner:			7						5	22
21 Years with partner:	3		6						2	17
22 Together before child:	2		4						0.4	16
23 Position in own family:	3:3								1:2	1:1
24 Pregnancy planned?:	0		1							0
25 Information type:	I		T	R	NI	NI	R	NI	T	T

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Eighth Decile contd)								*NINTH DECILE:*	
	56	*94*	*97*	*127*	*134*	*138*	*144*		*1*	*5*
1 Maternal age at birth:		*29*	*27*	*23*	*25*		*24*		*30*	*24*
2 Type of schooling:		*2*	*1*	*3*	*1*		*3*		*1*	*1*
3 Age left school:		*16*	*15*	*17*	*18*		*16*		*15*	*16*
4 Qualifications:		*2*	*0*	*2*	*2*		*0*		*1*	*1*
5 Health education:		*2*	*2*	*2*	*2*		*1*		*3*	*3*
6 Previous occupation:		*4*	*4*	*4*	*4*		*4*		*4*	*4*
7 Present occupation:		*4*	*HW*	*HW*	*HW*		*HW*		*HW*	*HW*
8 Partner's occupation:	*3*	*3*	*3*	*0*	*4*		*3*		*3*	*4*
9 Length of time in present accommodation:		*4*	*3*	*1*	*5*		*0.5*		*1*	*1*
10 Residences since a child:		*4*	*2*	*3*	*8*		*2*		*4*	*2*
11 Regular contacts in neighbourhood:		*3*	*2*	*2*	*3*		*3*		*2*	*3*
12 Type of property lived in now:	*2*	*2*	*2*	*4*	*2*		*4*		*2*	*2*
13 Bedrooms:	*3*	*3*	*2*	*2*	*2*		*3*		*3*	*2*
14 Number of people living there:		*3*	*3*	*3*	*3*		*3*		*3*	*3*
15 Condition of property (own assessment):		*3*	*3*	*3*	*2*		*2*		*2*	*2*
16 Domestic facilities:		*6*	*6*	*7*	*7*		*6*		*6*	*7*
17 Journey to clinic:		*10W*	*5W*	*10W*	*5W*				*20W*	*10W*
18 Journey to GP:		*10B*	*30B*	*10W*	*5W*				*10W*	*10W*
19 Marital status:		*3*	*3*	*3*	*3*	*0*	*3*		*3*	*3*
20 Years known partner:		*10.5*	*4*		*11*					*4*
21 Years with partner:		*8*	*3*		*5*		*3*			*2*
22 Together before child:		*7*	*1*		*4*		*2*			*1*
23 Position in own family:		*1:2*	*1:1*	*3:4*	*3:3*		*3:5*			*1:1*
24 Pregnancy planned?:		*1*	*1*	*1*			*1*		*0*	*1*
25 Information type:	*NI*	*I*	*T*	*I*	*T*	*R*	*T*		*T*	*T*

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Ninth Decile contd) 71	81	101	104	114	137	142	147	152	153
1 Maternal age at birth:	19	20	27		23		24			20
2 Type of schooling:	1	2	1		1		1			2
3 Age left school:	16	16	16		16		15			16
4 Qualifications:	2	0	0		2		0			1
5 Health education:	3	0	3		2		1			2
6 Previous occupation:	4	3	4		5		3			4
7 Present occupation:	HW	HW	HW		HW		HW			HW
8 Partner's occupation:	2	0	3		3	0	0	2		3
9 Length of time in present accommodation:	1.5	1.5	9		4		5.5			0.6
10 Residences since a child:	2	2	3		2		2			5
11 Regular contacts in neighbourhood:	0	3	0		1		3			2
12 Type of property lived in now:	4	3	2		4		3			2
13 Bedrooms:	3	1	3		3		2			2
14 Number of people living there:	3	3	6		3		3			3
15 Condition of property (own assessment):	1	3	3		3		3			
16 Domestic facilities:	6	5	6		6		7			6
17 Journey to clinic:	60W	10W	10W		10W		2W			10W
18 Journey to GP:	60B	10B	10W		20B		10B			10W
19 Marital status:	3	3	3		3		3			3
20 Years known partner:	9	5	3		5		9			2.5
21 Years with partner:	2	2	2		2		5.5			2
22 Together before child:	0.5	1	0.3		1		4			0.4
23 Position in own family:	4:5	1:1	1:1		1:3		6:6			2:3
24 Pregnancy planned?:		1	0		1					0
25 Information type:	T	I	T	R	T	NI	T	NI	R	T

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
				TENTH DECILE (N= 14):						
	155	159			4	13	18	19	61	68
1 Maternal age at birth:	20	20					30	21		23
2 Type of schooling:	3	2					3	2		2
3 Age left school:	16	16					18	16		15
4 Qualifications:	3	0					4	0		0
5 Health education:	2	2					3	3		1
6 Previous occupation:	3	4					5	3		4
7 Present occupation:	HW	HW					HW	HW		HW
8 Partner's occupation:	2	0				2	5	3	3	3
9 Length of time in present accommodation:	0.2	1					2	1.3		1
10 Residences since a child:	3	2					3	3		4
11 Regular contacts in neighbourhood:	1	2					3	2		3
12 Type of property lived in now:	4	4				3	2	2	1	3
13 Bedrooms:	3	3				2	3	3	2	2
14 Number of people living there:	3	3				3	3	3		5
15 Condition of property (own assessment):	3					1	3	3		3
16 Domestic facilities:	7	1					7	7		6
17 Journey to clinic:	10W	5W					10W	10W		15W
18 Journey to GP:	10W	10B					10W	10W		30W
19 Marital status:	0	3					3	3		2
20 Years known partner:	3	3					12	3.5		4
21 Years with partner:	1.5	1.2					4	2		3
22 Together before child:	1.3	0.1					2	0.3		2
23 Position in own family:	1:2	4:7					4:4	1:6		3:4
24 Pregnancy planned?:							1	0		0
25 Information type:	T	T			NI	NI	T	T	NI	T

MAIN MATERNAL SAMPLE: SOCIODEMOGRAPHIC DETAILS BY DECILES:

CATEGORY:	SUBJECT NUMBER:									
	(Tenth Decile contd)									
	77	89	108	133	139	143	149	150		
1 Maternal age at birth:	20		21	32	30	21	31	23		
2 Type of schooling:	1		1	3	1	3	1	1		
3 Age left school:	15		16	16	15	16	15	16		
4 Qualifications:	0		0	2	0	2	0	0		
5 Health education:	3		2	1	1	1	2	2		
6 Previous occupation:	3		3	1	3	4	3	3		
7 Present occupation:	HW		HW	HW	HW	HW	HW	HW		
8 Partner's occupation:	3	2	2	5	2	3	3	3		
9 Length of time in present accommodation:	4		1	5	6	2	8.5	1.5		
10 Residences since a child:	2		7	4	3	2	2	3		
11 Regular contacts in neighbourhood:	0		3	2	1	3	3	2		
12 Type of property lived in now:	2	1	4	2	2	2	2	4		
13 Bedrooms:	2		3	3	2	3	2	3		
14 Number of people living there:	4		3	3	3	3	3	3		
15 Condition of property (own assessment):	2		0	3	2	3	3	3		
16 Domestic facilities:	3		4	7	5	7	6	7		
17 Journey to clinic:	10B		5W	20B	10W	20W	10W	5W		
18 Journey to GP:	15B		5W	20B	10W	20W	10W	10B		
19 Marital status:	3		3	3	3	3	3	3		
20 Years known partner:	2		13	7	7.5	3.5	12	4		
21 Years with partner:	2		3	5	6	2	8	2		
22 Together before child:	0.7		1	3	5	1	7	0.2		
23 Position in own family:	3:6		1:2	1:3	2:3	1:1	3:6	1:2		
24 Pregnancy planned?:	0		1		1		1			
25 Information type:	I	O	I	T	T	T	T	T		

6.3. PROFILE OF MATERNAL SAMPLE ACCORDING TO SOCIODEMOGRAPHIC FEATURES

Table 1

Age of mother at birth of child

Age Group	FR	% of sub sample
17 - 21	23	26
22 - 26	38	43
27 - 31	18	20
32 - 36	9	10
	* 88	100

* Missing data N = 61
Mean age = 24.5 Range 17 - 36

Table 2

Type of school mother attended

School Type	FR	% of sub sample
Secondary	36	41%
Comprehensive	28	32%
Grammar	22	25%
	* 86	100

* Missing data N = 63

Table 3

Age mother left school

Age	FR	% of sub sample
16+	14	15
before 16	72	82
	* 86	100

* Missing data N = 63

Table 4

Mother's qualifications

Type of qualification	FR	% of sub sample
Professional	2	2
Some exams.	51	58
No qualifications	33	38
	* 86	100

* Missing data N = 63

Table 5

Health education topics studied by mother

Topic studied	FR	% of sub sample
None	4	4
Biology only	28	32
Biology, Domestic Science only	32	37
Biology, Domestic Science, Sex Education only	22	25
Biology, Domestic Science, Sex Education, Baby Care	0	0
	* 86	100

* Missing data N = 63

Table 6

Previous occupation of mother

Occupation Type	FR	% of sub sample
None	2	2
Student	3	3
Farming	1	1
Factory work	18	20
Service Industry	42	48
Professional/semi	20	23
	* 86	100

* Missing data N = 63

Table 7

Current occupation of mother

Occupation Type	FR	% of sub sample
Housewife	78	90
Professional	6	6
Service work	2	2
	* 86	100

* Missing data N = 63

Table 8

Partner/Father's Occupation

Occupation type	FR	% of sub sample
Unemployed	12	9
Unskilled/semi	30	24
Skilled manual	50	40
Non Manual	20	16
Student	1	-
Professional	12	9
	* 125	100

* Missing data N = 24

Table 9

Years spent in present accommodation

Years	FR	% of sub sample
Less than 2	37	43
Between 2 - 4	27	31
Between 4 - 6	15	17
Between 6 - 8	4	6
Between 8 - 10	2	2
	* 85	100

* Missing data N = 64

Table 10

Number of house moves since leaving parental home (mother)

Number of moves	FR	% of sub sample
Less than 3	58	67
4/5	16	18
6/7	7	7
8-10	4	4
	* 85	100

* Missing data N = 64

Table 11

Number of regular contacts mother has in her neighbourhood

Number of Contacts	FR	% of sub sample
0	8	9
1	13	15
2	27	31
3	38	44
	* 86	100

* Missing data N = 63

Table 12

Current property type occupied

Property Type	FR	% of sub sample
Private flat	2	1
Private house	65	56
Council flat	9	7.5
Council house	36	31
NCB house	3	2.5
	* 115	100

* Missing data N = 34

Table 13

Bedrooms available and number of residents

Number of bedrooms	FR	Number of residents						
		3	4	5	6	7	8	10
2	44	35	1x	2x				
3	82	63	1	1x	1x	1x	2x	1x
4		2						
	* 128	100	2	3	1	1	2	1

* Missing data N = 21
x overcrowded accommodation (i.e. more persons than bedrooms)

Table 14

Mothers assessment of property condition

Assessment	FR	% of sub sample
Poor	9	10
Major complaint	5	5
OK	19	22.5
Good	51	60
	* 84	100

* Missing data N = 65

Table 15

Domestic facilities available to mother

Facility	FR	% of sub sample
No HW	5	5
HW only	1	1
HW, FB	1	1
HW, FB, IT,	1	1
HW, FB, IT, C,	5	5
HW, FB, IT, C, WM,	8	9
HW, FB, IT, C, WM, T,	30	35
HW, FB, IT, C, WM, T, Car	34	40
	* 85	100

* Missing data N = 64

HW = Hot Water
FB = Fixed Bath
IT = Indoor Toilet
C = Cooker
WN = Washing Machine
T = Telephone
Car = Car

Table 16

Time taken to visit clinic

Mode of transport	Time taken in minutes: Less than 10	11-30	60+	Total	% of sub sample
Walk	54	23	1	78	91
Bus	2	4		6	7
Car	0	1		1	1
	56 (65%)	28 (32%)	1 (1%)	* 85	100

* Missing data N = 64

Table 17

Time taken to visit G.P.

Mode of transport	Time taken in minutes: Less than 10	15-20	25-30	45-90	Total	% of sub sample
Walk	32	5	3	0	40	50
Bus	13	16	3	3	35	44
Car	2	2	0	0	4	4
	47	23	6	3	79	100
	(59%)	(29%)	(7%)	(3%)		

* Missing data N = 70

Table 18

Marital status of mother

Status	FR	% of sub sample
Single	10	10
Separated/divorced	3	3
Married	80	85
	* 93	100

* Missing data N = 56

APPENDIX 7

ANALYSIS OF REVISED USER SCALE DATA

Referred to in text 4.4.

Contents

SCORES ON USER SCALE:

KEY TO NOTATION:

S = subject number

X1, X2, X3...X11 = the various items in the scale - i.e.:

X1 = Health Visitor assessments: X2 = takeup of immunisation

X3 = Hearing test

X4 = Clinic attendance

X5 = 'Gap score'

X6 = Age of baby at start of clinic attendance

X7 = Age of baby at end of clinic attendance

X8 = Duration of attendance

X9 = First medical examination

X10 = Non-routine contacts with HV

X11 = Non-routine contacts with medical officer in clinic

Y = Total score of combined items on the user scale

S:	X1:	X2:	X3:	X4:	X5:	X6:	X7:	X8:	X9:	X10:	X11:	Y:
1	6	4	0	4	13	15	14	14	4	17	0	91
2	8	4	4	2	12	15	15	15	4	2	1	82
3	8	4	4	1	10	15	13	13	4	5	0	77
4	6	4	4	3	12	15	15	15	4	14	0	92
5	8	4	4	3	12	14	15	14	4	9	0	87
6	4	4	4	3	10	13	15	13	4	7	0	77
7	4	4	0	3	10	13	15	13	4	19	0	85
8	8	4	4	3	9	15	15	15	4	8	0	85
9	8	4	4	2	9	12	15	12	4	3	0	73
10	8	4	0	1	10	15	15	15	4	2	0	74
11	8	4	4	2	9	14	15	14	4	1	1	76
12	6	4	0	1	6	12	15	12	4	1	0	61
13	8	4	4	5	12	14	15	14	4	18	0	98
14	6	4	0	1	8	14	15	14	4	7	0	73
15	8	4	4	2	10	14	15	14	4	0	1	76
16	0	4	0	1	6	14	15	14	4	4	0	62
17	8	4	4	3	9	14	15	14	4	9	0	84
18	6	4	4	4	12	14	15	14	4	16	0	93
19	6	4	4	5	13	14	15	14	4	22	0	101
20	4	2	4	2	8	14	12	11	4	7	0	68

S:	X1:	X2:	X3:	X4:	X5:	X6:	X7:	X8:	X9:	X10:	X11:	Y:
21	6	0	0	1	4	14	14	13	0	3	0	55
22	8	4	4	2	10	14	15	14	0	5	0	76
23	8	4	4	1	6	14	15	14	0	5	0	71
24	8	4	4	2	9	13	15	13	0	10	0	78
25	8	4	4	2	10	14	15	14	0	5	0	76
26	8	4	4	2	9	14	15	14	0	3	0	73
27	8	4	4	1	7	13	15	13	0	4	0	69
28	4	4	0	0	2	11	6	2	4	0	0	33
29	2	4	4	0	2	13	15	13	4	0	0	57
30	8	4	4	3	10	14	15	14	0	11	0	83
31	0	4	0	0	0	0	0	0	0	0	0	4
32	0	4	0	0	1	12	4	1	4	1	0	27
33	4	4	4	1	6	14	15	12	0	3	0	63
34	2	4	0	2	7	14	15	14	0	9	0	67
35	4	4	4	1	7	14	13	12	4	6	0	69
36	8	4	4	2	13	14	15	14	0	10	0	84
37	4	4	4	1	7	14	15	14	4	6	0	73
38	2	4	4	1	8	14	15	14	4	9	3	78
39	0	4	4	1	4	13	13	11	4	5	2	61
40	0	4	4	1	5	14	14	13	4	6	0	65
41	4	4	0	1	6	14	15	14	4	5	0	67
42	(omitted from sample)											
43	2	4	4	2	11	14	13	12	4	15	0	81
44	0	4	4	1	6	12	15	12	4	3	0	61
45	2	4	0	0	4	14	15	14	4	3	0	60
46	4	4	4	1	7	14	15	14	4	6	0	73
47	4	4	4	2	9	14	15	14	4	12	0	82
48	6	4	4	2	10	14	14	14	4	11	0	83
49	6	2	4	1	5	14	15	14	0	4	0	65
50	2	4	0	0	0	0	0	0	0	0	0	6
51	8	4	4	1	7	13	15	13	4	2	2	73
52	8	4	4	2	6	14	15	14	4	3	2	76
53	(omitted from sample)											
54	(omitted from sample)											
55	2	4	4	0	3	14	5	4	4	1	0	41
56	4	4	4	3	12	14	15	14	4	10	0	84
57	(omitted from sample)											

S:	X1:	X2:	X3:	X4:	X5:	X6:	X7:	X8:	X9:	X10:	X11:	Y:
58	0	4	0	0	2	7	11	3	4	2	0	33
59	0	2	0	0	2	13	4	2	4	2	0	29
60	0	4	4	1	6	14	10	9	4	7	0	59
61	8	4	4	6	13	14	15	14	4	28	1	111
62	6	4	4	0	1	4	12	0	0	0	0	31
63	0	4	4	4	10	14	13	12	4	8	0	73
64	0	4	4	3	10	14	12	11	4	17	0	79
65	0	4	4	0	4	13	11	9	4	3	0	52
66	0	4	0	0	0	0	0	0	4	0	0	8
67	0	2	4	2	10	15	13	15	4	6	0	71
68	8	2	4	3	12	15	15	15	4	15	0	93
69	0	4	4	2	11	14	15	14	4	4	0	72
70	2	4	4	4	9	13	13	11	4	11	0	75
71	8	4	4	3	12	13	15	13	4	13	0	89
72	0	4	0	1	3	12	15	12	4	3	0	54
73	2	4	4	3	8	11	15	11	4	5	0	67
74	4	4	4	3	8	14	15	14	4	2	0	72
75	0	0	0	0	1	13	3	13	0	2	0	32
76	0	4	4	3	8	14	15	14	4	4	0	70
77	6	4	4	7	14	15	15	15	4	41	0	125
78	0	4	4	3	7	15	15	15	4	10	0	77
79	0	4	4	0	4	13	15	13	4	3	0	60
80	2	2	4	0	4	15	15	15	4	3	0	64
81	0	4	4	4	13	14	15	14	4	19	0	91
82	0	4	4	1	3	11	15	11	4	2	0	55
83	2	2	4	0	4	14	10	9	4	0	0	49
84	2	4	4	0	4	14	15	14	4	3	0	64
85	2	4	4	0	3	14	4	3	0	2	0	36
86	0	4	4	0	1	14	2	1	0	1	0	27
87	0	4	4	1	9	14	15	14	4	8	0	73
88	0	4	4	0	3	12	15	12	0	2	0	52
89	2	4	4	4	12	14	15	14	4	22	0	95
90	0	4	4	2	9	14	15	14	4	7	0	73
91	0	4	4	3	12	14	15	14	4	10	0	80
92	0	4	4	1	9	13	15	13	0	4	0	63
93	2	4	4	1	6	13	15	13	4	7	0	69
94	0	4	4	3	12	14	15	14	4	15	0	85

S:	X1:	X2:	X3:	X4:	X5:	X6:	X7:	X8:	X9:	X10:	X11:	Y:
95	0	0	4	1	6	14	11	14	0	6	0	56
96	0	4	4	1	5	14	15	14	0	2	0	59
97	2	4	4	3	10	14	15	14	4	15	0	85
98	0	4	4	0	4	12	15	12	4	3	0	58
99	0	4	0	1	8	14	15	14	4	7	0	67
100	4	4	4	1	7	14	8	7	4	6	0	59
101	0	4	4	6	11	15	15	15	4	15	0	89
102	0	4	4	3	10	13	15	13	0	14	0	76
103	0	4	0	0	3	10	8	3	0	4	0	32
104	0	4	4	3	12	13	15	13	4	18	3	89
105	0	2	4	0	0	0	0	0	0	0	0	6
106	0	4	4	1	9	14	15	14	4	9	1	75
107	(omitted from sample)											
108	0	4	4	3	11	14	15	14	4	22	4	95
109	4	0	4	1	7	14	15	14	0	5	0	64
110	6	0	4	0	1	13	3	1	4	0	0	32
111	0	4	4	0	4	13	12	10	4	3	1	55
112	0	4	0	0	0	0	0	0	0	0	0	4
113	0	4	4	3	9	15	13	13	4	4	1	70
114	0	4	0	5	10	13	12	10	4	27	4	89
115	0	4	4	2	10	13	15	13	4	7	1	73
116	0	4	0	0	4	13	11	9	4	0	0	45
117	0	0	0	0	1	13	3	1	4	0	0	22
118	0	4	4	0	8	14	14	13	4	13	0	74
119	(omitted from sample)											
120	(omitted from sample)											
121	(omitted from sample)											
122	(omitted from sample)											
123	0	4	4	5	13	13	15	13	4	2	0	73
124	0	4	4	2	9	14	15	14	4	6	0	72
125	0	4	4	3	11	14	13	12	4	4	0	69
126	0	4	4	2	7	14	15	14	4	3	0	67
127	0	4	4	8	14	15	15	15	4	6	0	85
128	0	4	4	3	12	15	14	14	4	3	0	73
129	0	4	4	3	12	14	14	13	4	2	0	70

S:	X1:	X2:	X3:	X4:	X5:	X6:	X7:	X8:	X9:	X10:	X11:	Y:
130	0	4	4	1	8	14	15	14	4	0	0	64
131	0	4	4	2	10	15	15	15	4	1	0	70
132	0	4	4	3	11	15	15	15	4	2	0	73
133	8	4	4	7	13	15	15	15	4	20	0	105
134	8	4	4	2	9	14	15	14	4	7	1	82
135	8	4	4	1	6	14	15	14	4	3	0	73
136	8	4	4	1	9	13	15	13	4	2	0	73
137	8	4	4	3	10	15	15	15	4	9	0	87
138	6	2	4	3	11	15	15	15	4	10	0	85
139	8	4	4	9	14	8	15	15	4	22	0	103
140	6	2	4	0	2	8	13	6	4	1	0	46
141	8	4	4	2	8	14	15	14	4	7	0	80
142	8	4	4	3	12	14	15	14	4	8	0	86
143	8	4	4	6	14	15	15	15	4	12	0	97
144	8	4	4	3	10	15	15	15	4	5	0	83
145	4	4	4	0	3	13	12	10	4	3	0	57
146	8	4	4	2	8	15	15	15	4	5	0	80
147	8	4	4	4	13	15	15	15	4	9	0	91
148	(omitted from sample)											
149	8	4	4	4	13	14	15	14	4	11	1	92
150	8	4	4	6	13	14	15	14	4	16	1	99
151	6	4	4	2	10	15	13	13	4	3	0	74
152	8	4	4	3	12	15	15	15	4	8	2	90
153	8	4	4	2	11	15	15	15	4	10	2	90
154	8	4	4	2	9	14	15	14	4	7	0	81
155	8	4	4	3	13	14	15	14	4	7	1	87
156	6	4	4	0	6	14	13	12	4	2	0	65
157	8	4	4	0	10	14	15	14	4	8	0	81
158	8	4	4	0	8	15	15	15	4	5	0	78
159	8	4	4	0	13	15	15	15	4	8	0	86

7.2. Analysis of revised user scale in study proper

1. The minimum possible score = 0
   The maximum possible score = 134

i.e. item	1	max score 8
	2	4
	3	4
	4	9
	5	15
	6	15
	7	15
	8	15
	9	4
	10	41
	11	4

(For items 10 & 11 there was no upper limit to HV or CMO contact; in practice the range went up to 41 for item 10, and 4 for item 11 and these have been used to define the upper limit as found in the sample).

2. For the sample studied, the scores range was 4 - 125

3. When the scores on each item were correlated with those for all other items minus that one, significant associations were found indicating that each item was measuring a similar related trend to each other item.

Health Visitor Assessments

In order to discriminate between those who had attended for health visitor assessments at clinic and those who had to be followed up, the health visitor notes at clinic and her own records were scrutinised. Where a mother had not attended, and was followed up at home, this was not counted as an instance of usage, even though the assessment had

been done. For those mothers attending hospital as out patients to have their child monitored, each visit to hospital was counted as an instance of usage, the same as for clinic attendance. Some health visitors routinely preferred to carry out their assessments at the clients home, in which case only where there had been problems in doing this was non uptake counted. Health visitors in the study also pointed out that whenever they visited a client, they would informally check the childs developmental status. For the purposes of the study however, only specific records of assessments formally carried out and recorded as having been done were counted as uptake. These considerations cast some doubt on the validity of the scoring obtained, in that it remains possible that some mothers did have their child assessed for which there is no record, however, if they did so it was not an instance of voluntary uptake in the usual sense in which we are interested in this study.

Table 1, gives a summary of the uptake of health visitor assessments, which when compared with voluntary take up reveals a substantial degree of follow-up by health visitors.

The notion of voluntariness in uptake is very difficult to operationalise for the purpose of the study, but it was considered necessary to attempt to make this kind of distinction in order to separate client initiated from professional initiated uptake. Only when the researcher was satisfied that there had been a problem in uptake (either recorded non-attendance, issued reminders, refusals recorded etc.) was an instance of non-voluntary uptake decided on, in each case. This is not to imply that instances of voluntary uptake are to be regarded as those in which undue pressure or coercion was in

evidence, but simply that the initiative was a professional one rather than from the clients themselves.

From table 1, it can be seen that the majority 78.5% of the sample had 3 or 4 assessments carried out during the first 18 months post natally. Of these, 39% could be considered client initiated i.e. where the mother had been invited to attend and had done so, without any particular intervention on the health visitors part.

Table 1. Health visitor assessments

mothers could score 0, 2, 4, 6 or 8, corresponding to the number of assessments voluntarily taken up 0, 1, 2, 3 or 4 respectively.

Score on scale	No. of assessments	FR.	% of sample	no.voluntarily taken up	% of sample
8	4	83	55.7	44	29
6	3	34	22.8	16	10
4	2	19	12.7	15	10
2	1	7	4.5	16	10
0	0	6	3.9	58	38
		149		149	

The table requires further elaboration to clarify the differences in uptake, between those who voluntarily had assessments carried out, and those who required follow up.

Table 2. Comparison of voluntary and encouraged take up of HV assessments

No. of assessments done	Voluntary take up	% of sample	Encouraged take up	% of sample	T
4	44	29	39	26	83
3	8	5	26	17	34
2	3	2	16	10	19
1	3	2	4	2.6	7
	58	38	85	57	143
			0		
		6			
					149

85 members of the sample required follow up in order to reach the scores they did on uptake

The falling numbers who had assessments done, and the corresponding falling number of voluntary take up reveals that having had one or two assessments done is no guarantee of future take up.

Table 3. Fall in voluntary take up over time

	voluntary	encouraged
of the 143 who had 1 assessment done	91	52
of the 136 who had 2 assessment done	75	61
of the 117 who had 3 assesent done	60	57
of the 83 who had 4 assessment done	44	39

Only 44 members of the sample voluntarily had all 4 assessments done and could be considered ideal users of this service. The remainder all requiring encouragement to a greater or lesser degree, i.e. 29% VS 71%.

Item 2. Immunisation uptake

Immunisation uptake was scored similarly to health visitor assessments, according to voluntary uptake or not. Subjects were scored whether the injection took place or not if they attended for the purpose.

0 = no voluntary uptake
2 = 1 voluntary visit (and or injection)
4 = more than one visit for immunisation

Table 4 Uptake of Immunisations

score on scale	N	%
4	133	89%
2	10	7%
0	6	3%
	149	100

This table again requires a finer breakdown of the total sample
N = 149

129 had all immunisations done
14 had some done i.e. 2 or less
6 had none done

Those who had some done, had not finished the course and would be considered unsatisfactory. Of the 6 who had none done, only one child was considered unsuitable for immunisation due to health reasons, the remainder had no recorded immunisations or refused. The majority who attended for some or all sessions, N = 143 did so at clinic. (115 clinic and 28 general practitioner)

The avoidance of whooping cough vaccine

49 persons did not have the whooping cough vaccine.
42 had the rest but not whooping cough. (28% of sample)
6 had none done 4%
1 had attended for some .7%

The majority of the sample voluntarily attended clinic or their general practitioner to have their children satisfactorily immunised. However, a significant number refused the whooping cough vaccine, a feature which is further explored in the qualitative section of the study.

Item 3. Hearing test

Only two scores were possible here, 4 if the test had been carried out either at clinic or at home where the client had voluntarily complied or 0 where follow up was necessary.

Table 5 Uptake of hearing test

Hearing test done	146	voluntarily done	125	83%
hearing test not done	3	requiring encouragement	24	16%
	149			

A small percentage required encouragement in having the hearing test carried out i.e. 16% which is still significant in that it is higher than those requiring immunisation follow up, and priority is placed by health visitors on ensuring this is done, making it a major part of the service. In only 3 cases was it not carried out.

Item 4 Clinic attendance.

This was scored according to the percentage of possible attendances for the clinic in question.

Table 6 Attendance at clinic

Score	% of possible attendances	FR	% of sample
9	90-100	1	.4%
8	80-89	1	.4%
7	70-79	2	1.3%
6	60-69	4	2.6%
5	50-59	4	2.6%
4	40-49	8	5.3%
3	30-39	32	21.4%
2	20-29	28	18.7%
1	10-19	34	22.8%
0	0-9	35	23.4%
		149	100%

From the table it can be seen that very few made maximum use of the clinic, by attending each time they could go, or a session was held. In fact only approximately 8% attended for 50% or more of possible visits. The majority 92.6% went less than 50% of possible visits. There is a concentration of persons at the lower end of the scale

i.e. 46% of the sample attended for 19% or less of possible visits. For those attending a clinic where more sessions are offered this means a maximum of 11 visits possible, and for those attending those with fewer sessions this means a maximum of 5 visits possible.

Almost half the sample then attended clinic less than 5 or 11 times in 18 months, indicating that few visits are the norm. It was very unusual for mothers to attend more than 23 times in 18 months, and exceptionally rare for them to attend frequently i.e. attend over 75% of the sessions. It is far from clear what ideal attendance from the professionals view would be like, but this data gives a clear picture of what attendance actually took place in this locality.

Further more detailed information on clinic attendance was collected in order to clarify what patterns were like. The total number of attendances in table 6, gives an overall measure of usage and is a useful indicator of voluntary uptake by the sample. It does not show when the visits took place over the 18 months, or which periods of the childs development were covered by uptake. The following tables go some way towards a more detailed analysis of clinic usage over the 18 months.

Item 5. <u>The 'Gap Score'</u>

This reflects the number of months out of 15 during which the mother did not go to clinic or contact her health visitor. A high score e.g. 15 indicates monthly attendance, there were no months during which service was not used, and a non user would score 0.

Table 7 Continuity of contact with clinic/health visitor

Gap score	No.of missing months	FR	% of sample
15	0	0	0
14	1	4	2.6
13	2	12	8.5
12	3	16	10.7
11	4	8	5.3
		40	27.1
10	5	21	14.0
9	6	17	11.4
8	7	12	8.5
7	8	10	6.7
6	9	12	8.5
		72	49.1
5	10	3	1.9
4	11	11	7.1
3	12	7	4.5
2	13	5	3.2
1	14	6	3.9
0	15	5	3.2
		37	23.8
		149	100

Percentages have been combined to facilitate a clearer perception of the trends. Most members of the sample, approximately 73% had 4 or more months during which they did not make use of the clinic or health visitor. The major grouping (nearly half of the sample) missed between 5 and 9 months, making it less usual to have few (less than 4) or many (less than 9) missing months. For those at the bottom of the table, it can be seen that 23% of the sample did not make use of this service during 10 or more months of the first 15 months of the childs life. For the majority of the time then, the clinic was not attended in any consistent way. Those at the top of the table tended to visit clinic almost every month, and/or see their health visitor in a fairly regular consistent pattern.

Items 6, 7 and 8 Duration of attendance, document the ages at which clinic attendance starts and finishes and the duration of attendance. This means that a mother who attended clinic early and finished late in terms of her childs age at the time, would score more highly than one who came late and finished early.

Table 8 Duration of Attendance

Score	Item 6 age start attending months	FR	% of sample
15	1	29	19.4
14	2	74	49.6
13	3	26	17.4
12	4	7	4.6
11	5	3	2.0
10	6	1	.6
9	7	0	0
8	8	2	1.3
7	9	1	.6
6	10	0	0
5	11	0	0
4	12	1	.6
3	13	0	0
2	14	0	0
1	15	0	0
0	did not go	5	3.3
		149	100

Table 9 Duration of Attendance

Score	Item 7 age end attending months	FR	% of sample
15	15	103	69
14	14	7	4.6
13	13	11	7.3
12	12	6	4.0
11	11	4	2.6
10	10	2	1.3
9	9	0	0
8	8	2	1.3
7	7	0	0
6	6	1	.65
5	5	1	.65
4	4	3	1.9
3	3	3	1.9
2	2	1	.65
1	1	0	0

Table 10 Duration of Attendance

Score	Item 8 months in total	FR	% of sample
15	15	25	16.7
14	14	58	38.9
13	13	23	15.4
12	12	12	7.8
11	11	6	3.9
10	10	3	1.9
9	9	4	2.6
8	8	0	0
7	7	1	.6
6	6	1	.6
5	5	0	0
4	4	1	.6
3	3	3	1.9
2	2	2	1.3
1	1	4	2.6
0	0	6	3.9
		149	100

From the tables it can be seen that most people 86.4% (N = 129) brought their child to clinic for the first time in the first 3 months of its life. Only 5 never went at all and it was unusual to start coming later on, i.e. only 15 people came when their child was over 3 months old.

The majority were still attending when their child was 15 months old, i.e. 69% (103) were still attending whilst 45 had ceased to come. Again only 5 scored zero having never been. Those who preferred not to attend stopped at various points, the earliest was at 2 months and from then on small numbers of people dropped out until the age of 13 months when a more significant number cease attending. When this data is looked at in relation to the duration of attendance (i.e. how many months of the last 16 spanned attendance) the picture is fairly similar. Most people continue to attend for 12 or more months of

their childs life i.e. 78.8% (N = 118). Only 20% attended for less than 11 months duration. 15 people attended for part of the time between 6 and 11 months of their childs life, whilst 16 went for 4 months or less.

It was unusual then, not to make an appearance at clinic, at all, or to attend over only a short period of time. Taken together with table 7 and 6, it seems that it is common for women to attend clinic infrequently over a long period of time, there being long periods of time (between 5 months and 9 months) out of 15 during which they do not attend or see the health visitor. They do not attend every week, or month necessarily but call in every now and then up to the end of the first year, and beyond.

When we look closer at attendance in relation to the age of the child, there are some observable patterns.

Table 11 Pattern of attendance according to age of child

age of child in months

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
no.who attended one or more times at each age	32	95	112	124	104	101	90	86	76	64	67	88	75	46	40
no.who did not attend at each age	116	53	36	24	44	47	58	62	72	84	81	60	73	102	108

X2 = 270.100
df = 14
p< = .001

The distribution is not random, whereby at the beginning (apart from the first month when some may still be in hospital) the number who attend always exceeds those who did not attend up until about the age of 9 months when there are about equal numbers attending and not attending. After this point the figures are reversed, more do not attend than attend except for the 12th month where noticeably more attend. This would coincide with the 12 month assessments and developmental medical for which all would be asked to attend.

A breakdown of the numbers attending each at each month age again reveals a pattern.

Table 12 Frequency of attendance at each age/month

Age in months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
no. who attended once in each age /month	16	24	38	48	49	50	52	54	48	38	47	55	55	34	31
no. who did not attend in each age/month	116	53	36	24	44	47	58	62	72	84	81	60	73	102	108
no. who attended more than once in each age/month	16	71	74	76	55	51	38	32	28	26	20	33	20	12	9

Mothers then (from table 11) were more likely to attend up to their child becoming 9 months old, than thereafter when numbers begin to fall dramatically. When a breakdown of the type of attendance is made in terms of whether mothers attend once per age/month or more than once, an interesting pattern emerges.

In the first few months of the childs life, at ages 2, 3, 4 and 5 months, mothers are much more likely to attend clinic more than once in each age/month. At no other time does the figure for those attending more than once each age/month exceed those who attended only once. The differences in numbers are not great, but reveal a trend in attendance which favours those age/months. Mothers are very unlikely to continue visiting clinic often (i.e. more than one time in each age/month) after their child is 5 months old. The number who did not attend at all in each age month grows as the child gets older, particularly after the 4th month and the 12th month. Those who do attend in each age month are on the whole more likely to go only once. This would be consistent with the attendance figures shown in table 6. i.e. only 34% of the sample went to over 25% of possible visits. The majority 65% went to clinic less than 25% of the times they were on offer. Again table 7 confirms this pattern as it was unusual for a mother to go every month, i.e. only 27% of the sample missed going for 4 or less months, the majority 73% missed more than 4 months in attending. As most mothers continue attending over a period of 12 months, and their rate of visits is low (see table 8, 9, 10) i.e. 78% spread their visits over 12 months of their childs life, it appears that regular (i.e. monthly) attendance is not usual for this group. Rather attendance is concentrated in the early months of the childs life, when mothers are more likely to go more than once in each month and then tails off, there being relatively long periods of time between visits (5-9 months). The total number of visits made by those who attended in each age/month shows a similar pattern.

Table 13 Patterns of Attendance/Age of Child

Age of child/months..

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
total number of visits in each month by all mothers														
54	221	244	258	198	178	143	131	111	101	94	137	104	67	54

More visits were made at ages 2 months, 3 month, 4 month and 5 month and 12 month, as more people attended at these ages, and they visited clinic more than once at these ages, rather than at other ages.

When we look at the age at which attendance began and ended, it is possible to determine more precisely which sorts of patterns are preferred; for example it would be possible for those who come early to clinic (to score well on table 8) to ceease attending early (score badly on table 9). An arbitrary cut off point of 12 was taken on each score for tables 8 and 9, to see how many persons scored 12 or more on both tables, i.e. how many persons were early starters and late finishers. The trend was clear, (table 14). 121 people scored highly on both tables 8 and 9, showing that those who come early to clinic (i.e. at or before child is 4 months old) tend to carry on attending late (i.e. up to 12 months old). This was the most common pattern accounting for 81% of the sample. 16 people came early, but stopped attending early also. It was very unusual for a mother to start attendance after the child was 4 months old if she had not been before that date i.e. only 7 persons did in this study. However, having come to clinic late, 4 continued to attend at least up until

the child was 12 months old. To summarise then early starters tend to be late finishers, but the reverse is not true i.e. late starters are not early finishers.

Table 14 Patterns of Attendance

	Early Start Early Finish	Late Start Early Finish	Late Start Late Finish	Early Start Late Finish	T
FR	16	3	4	121	143
% of Sample	10	2	2.6	81	

Table 10 shows the duration of attendance for the sample as a whole. 118 people (79%) attended for a period in excess of 12 months. Only 10% attended for less than 4 months overall which includes those who never went. Attendance then is spread over a year for most members of the sample.

Item 9. First medical examination

It did not matter for the purposes of this study, when the examination took place, so that if it could be found anywhere in each clients records a score of 4 was given, otherwise (as this is not offered at home) a 0 was entered.

Table 15 Take up of Medicals

score	medical	FR	% of sample
4	recorded	122	81.8%
0	not "	27	18.1%

The majority had the medical examination at some point in their childs first year. Only 27 people had no record of this being carried out.

Item 10. Non-routine contacts with the health visitor

The total number of contacts with care recorded for each person was noted and all routine contacts omitted. These routine contacts did not constitute significant voluntary usage by the mother, or had already been accounted for in the index and they included; weigh only entries at clinic, assessment visits at home, the hearing test entry. Non-routine contacts would be those which could be considered active uptake on the clients part e.g. specific visits to clinic for advice noted on the record card, any routine contact which was accompanied by a consultation with the health visitor or phoning the health visitor with a problem.

Table 16 Non routine contacts with health visitor

No.of non routine contacts	FR	% of sample	
41	1	.6	
28	1	.6	
27	1	.6	
22	3	1.9	
20	1	.6	
19	2	1.3	
18	2	1.3	
17	2	1.3	
16	2	1.3	
15	5	3.2	
14	2	1.3	
13	1	.6	
12	2	1.3	
11	4	2.6	
10	7	4.5	
9	7	4.5	27.5% N=43
8	7	4.5	
7	12	7.8	
6	9	5.8	
5	11	7.1	52.7% N=82
4	9	5.8	
3	19	12.3	
2	16	10.4	
1	8	5.2	86.4% N=134
0	14	9.3	
	149	100	

The range was very wide, from no non-routine contacts at all to 41 where the mother was regularly and constantly visited at home at her request. Most of the interviewees had at least one non-routine contact with the health visitor i.e. 86.4% scored 1 or more. It was unusual for there to be more than 4 though, i.e. half of the sample scored above and below 4, and extremely rare for mothers to seek such a service on more than 9 occasions. .i.e. only 27% of the sample scored more than 9.

Most interviewees then were using the health visitor service in a non-routine way, but it was very uncommon for such contacts to be numerous. This table represents non-routine recorded contacts with the health visitor but cannot be considered as definitive in any way. There may well have been other contacts not considered significant enough for entry into the records by health visitors. In the records of home visits by health visitors, again the range is very wide. (These figures do not include inneffective visits.)

Table 17 Home visiting pattern

No.of home visits recorded	Fr.	% sample
1	2	1.3
2	10	6.7
3	18	12.0
4	24	16.1
5	15	10
6	20	30.4
7	8	5.2
8	19	12.3
9	7	4.5
10	7	4.5
11	2	1.3
13	4	2.6
14	2	1.3
15	1	.65
16	2	1.3
17	1	.65
18	1	.65
20	2	1.3
22	1	.65
24	1	.65
33	1	.65
40	1	.65
	149	100

All interviewees were visited at home at some point, but there are wide differences in the number of visits. It was unusual to be visited more than 5 times at home. Half of the sample received 5 or less visits and 78% received 8 or less. It was very unusual to be visited in excess of 15 times, over 91% of the sample fell below that figure. This table adds credence to that showing non-routine contacts with the health visitor, showing a similar pattern, of some extremes and the most common pattern.

Interviewees were even less likely to ring the health visitor at any time to ask for assistance.

Table 18 Number of recorded requests by telephone to Health Visitor

Number of calls	FR	% sample
0	111	74.4
1	18	12.0
2	10	6.7
3	9	6.0
5	1	.6

None rang more than 5 times during the first 18 months, and the vast majority, 74% did not ring at all. 24% rang between 1 and 3 times.

Item 11. Non-routine contacts with the CMO at clinic

These were documented for each interviewee whereby medical examinations and immunisations were omitted from the total number of contacts they had with the CMO.

Table 19 Non Routine Contact with CMO

No. of non routine contacts	FR	% sample
0	128	85.9
1	12	7.8
2	5	3.2
3	2	1.3
	149	100

Mothers were very unlikely to have any but routine contacts with the CMO at clinic, their contacts were limited to specific tasks or medical procedures. Only 12% had any non routine contacts, N = 21 and no one had more than 4. 85.9% had no non-routine contacts at all, showing this to be a rare source of non routine advice or usage by the interviewees.

Comparison of scores on user scale

In order to facilitate comparison between groups, the distribution was divided into deciles, each one reflecting low, medium or high usage.

range of scores = 4 - 125

mean score = 69.65.

The scores were ordered into deciles and compared with one another to see if the scoring patterns between each decile group were sufficiently distinct to be treated as separate groups. There were statistically significant differences found which was taken as sufficient justification for treating the decile groupings as distinct.

ITEM ANALYSIS OF ORIGINAL REVISED USER SCALE:

Item:	Section:	r:	t:	df:	p;
1	HV assessments	0.317	4.046	147	0.0002 (HS)
2	Self-initiated HV contact outside clinic	-0.005	0.054	147	0.977 (NS)
3	Immunisation takeup	0.265	3.326	147	0.001 (HS)
4	Hearing test	0.397	5.251	147	<0.0001 (HS)
5	Clinic attendance	0.684	11.369	147	<0.0001 (HS)
6	'Gap score'	0.854	19.937	147	<0.0001 (HS)
7	Baby's age at first attendance	0.593	8.927	147	<0.0001 (HS)
8	Baby's age when last attended clinic	0.732	13.032	147	<0.0001 (HS)
9	Duration of attend-ance	0.757	14.069	147	<0.0001 (HS)
10	Takeup of first medical examination	0.318	4.075	147	0.0002 (HS)
11	'Non-routine'contacts with HV in clinic	0.525	7.488	147	<0.0001 (HS)
12	'Non-routine' contacts with medical officer in clinic	0.215	2.673	147	0.0082 (HS)

(NB: NS = not significant; HS = highly significant. All probability values are two-tailed).

DECISION:

All scalar items correlate with a high significance, except for item 2, which is not significantly correlated and indeed displays a slight negative correlation to the total scale score. Therefore the final version of the user scale will consist of all the above items with the exception of item 2 (i.e. eleven items in all).

7.4

ITEM ANALYSIS OF FINAL REVISION OF USER SCALE:

X,Y scores of the main sample (N = 149) were item-analysed using a nonparametric correlation technique (Spearman, C., 1904,1906) and the equation $Y = Y - X_n$ (Oppenheim, A.N., 1966, p. 139) with appropriate correction for tied ranks (Siegel, S., 1956, pp 206--210).

ITEM:	SECTION OF SCALE:	rho;	rho_c:	t:	df:	p:
1	HV assessments	0.296	0.264	3.318	147	$<$0.01
2	Immunisation takeup	0.492	0.253	3.165	147	$<$0.01
3	Hearing test	0.499	0.322	4.128	147	$<$0.001
4	Clinic attendance	0.783	0.779	15.059	147	$<$0.001
5	'Gap score'	0.844	0.843	19.008	147	$<$0.001
6	Baby's age at first attendance	0.542	0.506	7.115	147	$<$0.001
7	Baby's age when last attended clinic	0.613	0.548	7.955	147	$<$0.001
8	Duration of attend-ance	0.659	0.647	10.297	147	$<$0.001
9	Takeup of first medical examination	0.454	0.264	3.314	147	$<$0.01
10	'Non-routine' contact with HV in clinic	0.616	0.615	9.447	147	$<$0.001
11	'Non-routine' contact with medical officer in clinic	0.457	0.230	2.871	147	$<$0.01

NB: All probability values are <u>two-tailed</u>

DECISION:

All scalar items in the final revision of the user scale correlate either significantly ($p<0.01$) or highly significantly ($p<0.001$) with the score obtained from the scale minus that of the item concerned. There is therefore statistical support for the proposition that each item score is predictive of the trend in other item scores.

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7.5

INDIVIDUAL SCORES ON REVISED USER SCALE:

SUBJECT:	SCORE:	SUBJECT:	SCORE:	SUBJECT:	SCORE:
FIRST DECILE: (Scores 0-33)					
28	33	59	29	103	32
31	4	62	31	105	6
32	27	66	8	110	32
50	6	75	32	112	4
58	33	86	27	117	22
SECOND DECILE: (Scores 34-57)					
21	55	83	49	116	45
55	41	85	36	140	46
65	52	88	52	145	57
72	54	95	56	29	57
82	55	111	55		
THIRD DECILE: (Scores 58-64)					
12	61	45	60	92	63
16	62	60	59	96	59
33	63	79	60	98	58
39	61	80	64	100	59
44	61	84	64	130	64
FOURTH DECILE: (Scores 65-70)					
20	68	49	65	113	70
27	69	73	67	125	69
34	67	76	70	126	67
35	69	93	69	129	70
40	65	99	67	131	70
41	67	109	64	156	65
FIFTH DECILE: (Scores 71-73)					
9	73	63	73	123	73
14	73	67	71	124	72
23	71	69	72	128	73
26	73	74	72	132	73
37	73	87	73	135	73
46	73	90	73	136	73
51	73	115	73		
SIXTH DECILE: (Scores 74-76)					
10	74	25	76	106	75
11	76	52	76	118	74
15	76	70	75	151	74
22	76	102	76		

SUBJECT:	SCORE:	SUBJECT:	SCORE:	SUBJECT:	SCORE:
SEVENTH DECILE:		(Scores 77-81)			
3	77	64	79	154	81
6	77	78	77	157	81
24	78	91	80	158	78
38	78	141	80		
43	81	146	80		
EIGHTH DECILE:		(Scores 82-85)			
2	82	36	84	97	85
7	85	47	82	127	85
8	85	48	83	134	82
17	84	56	84	138	85
30	83	94	85	144	83
NINTH DECILE:		(Scores 86-91)			
1	91	104	89	152	90
5	87	114	89	153	90
71	89	137	87	155	87
81	91	142	86	159	86
101	89	147	91		
TENTH DECILE:		(Scores 92-125)			
4	92	68	93	139	103
13	98	77	125	143	97
18	93	89	95	149	92
19	101	108	95	150	99
61	111	133	105		

7.6.

REVISED USER SCALE: STATISTICAL COMPARISON OF DECILES.

COMPARISON:	U:	n_1, n_2:	U_{crit}:	p:
1 Between first and second deciles:	3.5	15,14	36	<0.002 (HS)
2 Between second and third deciles:	0.0	14,15	36	<0.002 (HS)
3 Between third and fourth deciles:	1.5	15,18	51	<0.002 (HS)
4 Between fourth and fifth deciles:	0.0	18,20	76	<0.002 (HS)
5 Between fifth and sixth deciles:	0.0	20,11	37	<0.002 (HS)
6 Between sixth and seventh deciles:	0.0	11,13	20	<0.002 (HS)
7 Between seventh and eighth deciles:	0.0	13,15	32	<0.002 (HS)
8 Between eighth and ninth deciles:	0.0	15,14	36	<0.002 (HS)
9 Between ninth and tenth deciles:	0.0	14,14	32	<0.002 (HS)

NB: HS = highly significant. All significance levels are two-tailed.

COMMENT:

Having ordered a distribution of scores into deciles for descriptive purposes, it is necessary to ascertain whether the scoring differences between adjacent deciles are slight and probably chance-determined: or whether they represent altogether more substantial statistical differences, possibly indicative of critical variations within/between the groups. Accordingly, each decile of scores on the Revised User Scale was subjected to this type of comparison using the Mann-Whitney U test (cf. Mann, H.B. and Whitney, D.R., 1947; Siegel, S., 1956). It became obvious that there exist statistically highly significant differences between scoring patterns in each adjacent decile of scores; differences considerable enough to justify employing these discrete groups for purposes of further comparisons in the content-analytic phase of the study.

REFERENCES:

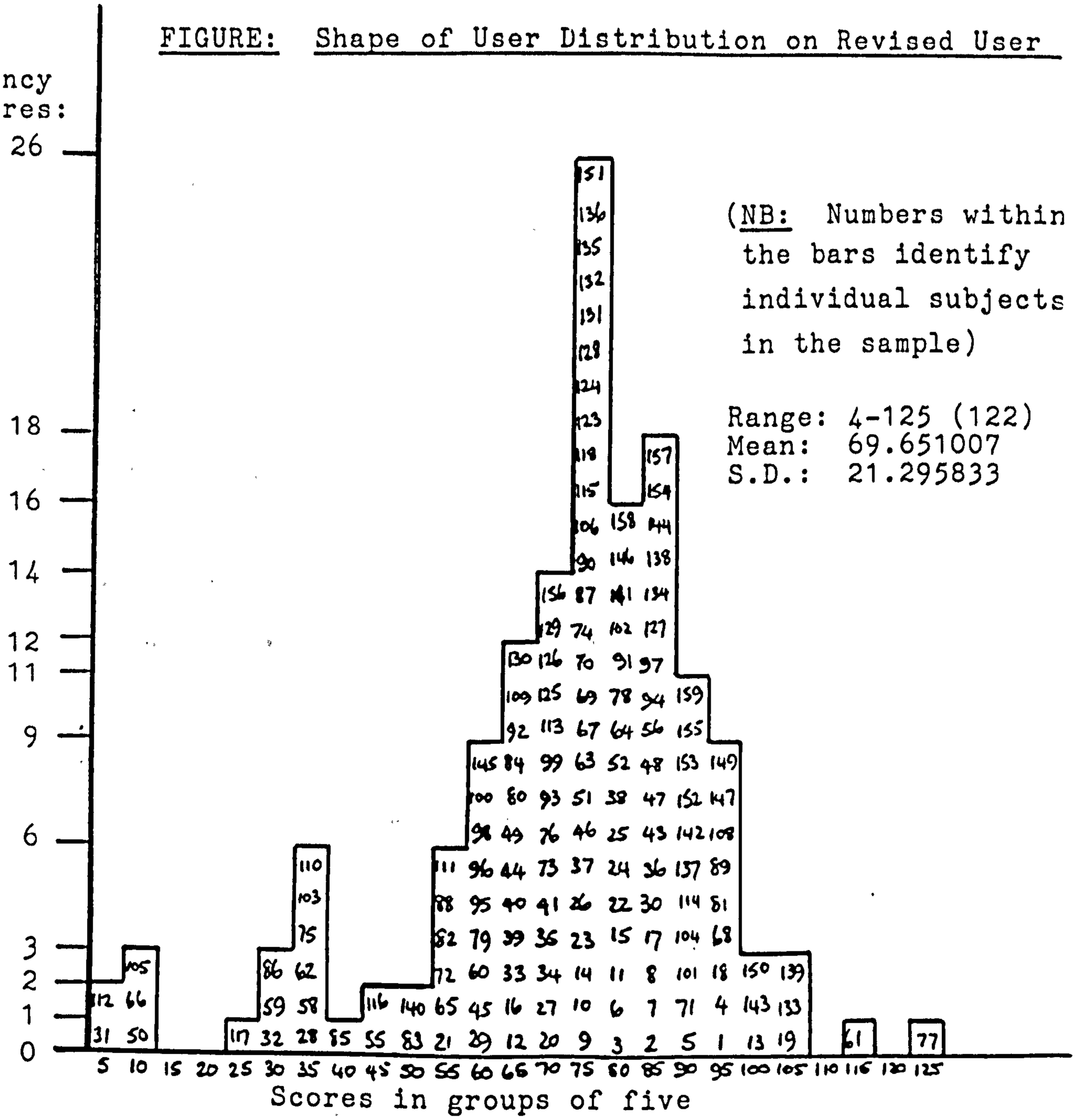
MANN, H.B. and WHITNEY, D.R. (1947):

On a test of whether one of two random variables is stochastically larger than the other. Ann. Math. Statist., 11, 367-392.

SIEGEL, S. (1956):

Non-parametric Statistics, pp. 116-127 New York: McGraw-Hill.

FIGURE: Shape of User Distribution on Revised User



(NB: Numbers within the bars identify individual subjects in the sample)

Range: 4-125 (122)
Mean: 69.651007
S.D.: 21.295833

FIGURE: Membership of Deciles

				135 136					
		98	129 131 156	124 128 132					
110 112 117	140 145	96 100 130	113 125 126	90 115 123		158	134 138 144	155 159	149 150
86 103 105	29 111 116	80 84 92	93 99 109	69 74 87	118 151	146 154 157	94 97 127	147 152 153	133 139 143
62 66 75	85 88 95	45 60 79	49 73 76	51 63 67	70 102 106	78 91 141	47 48 56	114 137 142	77 89 108
50 58 59	72 82 83	33 39 44	35 40 41	26 37 46	22 25 52	38 43 64	17 30 36	81 101 104	19 61 68
28 31 32	21 55 65	12 16 .	20 27 34	9 14 23	10 11 75	3 6 24	2 7 8	1 5 71	4 13 18
Decile no: 1	2	3	4	5	6	7	8	9	10
Range: 0-33	34-57	58-64	65-70	71-73	74-76	77-81	82-85	86-91	92-125

NB: The number of subjects included in each decile is slightly unequal, due to the need to keep like scores in the same decile (true decile value = 14)

7.8. Typical profiles of usage for each decile group

It is necessary now to show what membership of each decile means in terms of usage.

For decile 1, N = 15, the scores ranged from 4 - 33, a fairly wide range. In terms of usage;

a) none of them had voluntarily taken up the 4 assessments on offer, and 11 had none of them done. The remaining 4 had one or two done.

b) 10 of them had had their immunisations done, 3 had none and the remaining 2 had partially completed the course.

c) 11 did not voluntarily have the hearing test completed

d) None of them scored well on clinic attendance, they did not go either at all, or on more than 2 occasions.

e) Most months of the last 16 were characterised by no contact with the clinic or health visitor

f) 6 of them came to clinic early (scoring over 12) but ceased attending almost immediately. 2 came later and made a subsequent visit around the 12th month/age of their child. The remaining 5 never attended at all.

g) Only one persons attendance at clinic spanned over 12 months, the remainder lasted for one month.

h) 8 did not have a medical examination, 7 having had it done at clinic.

i) 6 had non-routine contact with the health visitor, and none had any non-routine contacts with the CMO at clinic.

In summary then, the only feature of service provision made use of was prophylaxis, they had attended for immunisations either at clinic or their general practitioner. Those scoring over 8 did so because of early attendance at clinic, and having had the medical examination done.

<u>The bottom scorer - score 4 in decile 1</u>

Did not voluntarily take up any health visitor assessments, had her immunisations completed, but did not have the hearing test done, did not go to clinic at all, had no voluntary contact with the health visitor or clinic over the 16 months of the study, did not have a medical carried out or have any non-routine contacts with clinic personnel.

<u>The top scorer - score 33 in decile</u>

Did not voluntarily take up any health visitor assessments, had her immunisations completed, did not have the hearing test done but attended clinic twice, once at 9 months and once at 11 months (age of child). For 14 months she had no contact with the health visitor or clinic. She had her childs medical done and had 2 non routine

contacts with the health visitor, and none with the CMO at clinic. Usage of the services then was minimal for this group, the bare essentials of contact being the only matters contributing scores on the index, namely immunisations.

For the 5th decile N = 20

The range of scores was much less variable. 71-73, giving a fairly homogenous picture for both the top and bottom scorers. Their profile of usage was as follows:

a) 10 (half) of them did not voluntarily take up the 4 health visitor assessments on offer, 6 had them all done and the remaining 4 partially completed them.

b) All but one member had had their immunisations done.

c) only one member did not have the hearing test done.

d) their clinic attendance rate was low, 8 members attended less than 19% of possible sessions (less than 11 or less than 5 visits) whilst the remaining 12 persons attended less than 40% of possible sessions (= less than 29 or less than 14 visits)

e) They all had gap scores below 6, showing that for long periods of time they neither attended clinic nor saw their health visitor.

f) They all however attended clinic early and attended again later in their childs life, giving high scores on duration of attendance.

g) Only 2 members did not have the medical examination

h) None-routine contacts with the health visitor were commonplace, all scoring more than 2, but none scoring more than 8.

i) Only 2 had non-routine contacts with the CMO at clinic.

<u>For the 10th decile N = 14</u>

The scores ranged from 92-125, a wider spread of scores, but the higher score can be attributed to an extreme value on item 10 by one interviewee.

a) Only one member did not voluntarily take up 4 health visitor assessments. 12 of them had 3 or more of them done.

b) Only 1 member had only partially completed immunisation uptake.

c) All members had had the hearing test done.

d) All had attended clinic for more than 39% of possible visits, and 3 members attended for over 79% of possible visits.

e) They all had low rates of gaps in care, showing that they had regular contact with the clinic or health visitor. Any gaps were for less than 4 months of the last 16 months. None had more than 4 missing months.

f) They all attended clinic early in their childs life (usually the first month) and were still attneding when the child was 16 months old, giving their duration of attendance exceeding one year.

g) They all had a medical examination carried out.

h) Non routine contacts with the health visitor were the norm all having had in excess of 11, active instances of uptake in this way.

i) 4 had non routine contacts with the CMO at clinic, so that even for high users this remained a rare point of usage.

The bottom and the top scorers in decile 10 can be distinguished best on items 4 and 10, i.e. clinic attendance and non routine contacts with the health visitor. Both of these pushed up the top scorers score more than any other item.

Each decile contains certain patterns of uptake. Most noticeable is the variability in scores evident in the 1st decile, in contrast to the more homogenous scoring in the 5th and 10th.

In the first decile the high and low scorers showed quite different patterns of usage. Those scoring less than 8 had not been to clinic at all or had not had the medical examination carried out. Those scoring above this had made some contact with the clinic (which was not sustained) early in their childs life and had had the medical done, and/or non routine contacts with the health visitor.

7.9. COMPARISON OF DECILES 1, 5 AND 10 ON EACH FEATURE OF UPTAKE

Table 20 H.V.Assessments

H.V. Assessments	not voluntarily done	some done	voluntarily done
N=15 Decile 1	11	4	0
N=20 Decile 5	10	4	6
N=14 Decile 10	1	5	8

In comparison to the higher deciles 5 and 10, those in the bottom were significantly less likely to have voluntarily had the assessments carried out.

Those in the 5th decile still show a marked reluctance, which is reversed in decile 10, where most voluntarily had them done.

Table 21 Immunisation Uptake

Immunisation uptake	not voluntarily done	some done	voluntarily done
Decile 1	3	2	10
Decile 5	1	0	19
Decile 10	0	1	13

Both users and none users can be seen to have immunisations carried out. Very low numbers in each decile did not voluntarily have them done.

The patterns of uptake change in a regular and ordered fashion as we move from decile 1 to decile 10 e.g.

Although each decile contains members who did not voluntarily have assessments done and those who had some done, the trend is clear. Larger numbers in the lower deciles did not voluntarily go for assessments, whilst large numbers did go for voluntary assessment in the higher deciles. The change seems to occur at the 4/5 decile when voluntary uptake becomes the norm.

Those in the lower deciles (4 and below) were slightly less likely to attend for immunisation uptake, however, the majority in these deciles did go for some at all of them (to either GP or clinic)

Table 22 Hearing Test

Decile	voluntarily done	not voluntarily done
1	4	11
5	19	1
10	14	0

The hearing test scores were significantly different for members of the bottom deciles. They were very unlikely to have voluntarily had this done, whilst almost all those in the upper deciles had.

Table 23 Attendance at clinic

Decile	High	Medium	Low
1	0	0	15
5	0	12	8
10	14	0	0

High - defined as more than 40% of possible attendances
Medium - as between 19% and 40%
Low - as less than 19% of possible attendances

Those in the bottom decile scored low on attendance at clinic, which is reversed for those in decile 10. Those in the 5th decile could still be characterised as low users, none of them scoring above 40% of possible visits.

Table 24 Gap Scores

Decile	low	medium	high
1st	0	0	13
5th	4	9	7
10th	14	0	0

Low - defined as less than 4 months missing
Medium - as less than 6 months and
High - as more than 6 months

Gap scores reflect position on the usage scale exactly.

Those in the 1st decile all had in excess of 6 months out of 16, during which they did not see the health visitor or go to clinic. Of those in the 5th decile most had less than 6 months during which no contact was made, and those in the 10th decile had very infrequent gaps.

Table 25 Early and late attendance at clinic

Decile	Minimum uptake	Medium uptake	Maximum uptake	Non uptake	T
1	9	1	0	5	15
5	0	0	20	0	20
10	0	1	13	0	14

Minimum usage - defined as came early and ceased early, or came late and ceased early
Medium usage - as came late and ceased late.
Maximum usage - as came early and ceased late

There is much more variability in decile one than either of the other 2 deciles. Unlike the other 2, it contained some members who did not go at all, some who came and ceased attending early, came late and ceased attending early, which can all be regarded as evidence of minimal or non usage of the clinic.

Both decile 5 and decile 10 members were concentrated in those having made maximum use of the clinic by attending early and carrying on attending late.

Table 26 Duration of attendance
(time between 1st and last attendance).

Decile	4 mths or less	5 - 11 months	12 months or more	T
1	14	0	1	15
5	0	0	20	20
10	0	0	14	14

Only those in decile 1 had attended clinic for the minimum length of time i.e. less than 4 months. Both deciles 5 and 10 members attended for much longer i.e. 12 months, showing a clear difference between the lower and higher deciles.

Table 27 Medical examination

Decile	done	not done
1	7	8
5	18	2
10	14	0

Decile 1 unlike the others was evenly divided between those who did and did not have the medical carried out. The majority in decile 5 did have it done, whilst decile 10 members all had it done.

Table 28 Non-routine contacts with HV

Decile	none	medium 1-8	high 11
1	9	6	0
5	0	20	0
10	0	0	14

Once again a clear pattern is evident, those in the bottom decile were unlikely to have had any such contact with the HV, and those who did, were more like members of 5th decile in terms of the medium number of contacts characteristic of the group. For members of decile 10, a large number of contacts was the norm, all scored in excess of 11.

Table 29 - Non-routine contacts with CMO

Decile	none	medium	high
1	15 all	0	0
5	18	2	0
10	10	4	0

Many non routine contacts with CMO were not found in this study, those who had such contact were confined to deciles 5 and above. For members of decile 1, they did not occur at all.

There is a section then of the sample studied who made less use of all the services monitored by the index. The very low users in the lower deciles were made up of people who had some contact with the services, and those who had none, producing more variable scores in these groups. It is evident then that even in the lowest scoring groups, some attempt to use the services had been made.

8.1. DIVISION OF DECILES INTO LOW, MEDIUM AND HIGH SCORERS.

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

Table 30a Grouped Deciles

	Deciles	N in each decile	T	% of sample
Low Scorers	1	15	44	29.5%
	2	14		
	3	15		
Medium Scorers	4	18	62	41.6%
	5	20		
	6	11		
	7	13		
High Scorers	8	15	43	28.8%
	9	14		
	10	14		
		149	149	

Table 30b Participants in relation to decile membership

	Deciles	No. of participants	T	% of decile
Low Scorers	1	5	19	43
	2	8		
	3	6		
Medium Scorers	4	12	40	64
	5	14		
	6	5		
	7	9		
High Scorers	8	8	28	65
	9	10		
	10	10		
		87		
whole sample		58%		

Table 31 Voluntary uptake of HV assessments

Usage Group	% of decile group encouraged	% of decile group voluntary	% of decile group some voluntary	T
Low	61%	0%	38	44
Medium	38%	32%	29	62
High	15%	55%	27	43
				149

The 3 groups are quite distinctive in terms of health visitor assessments, none of the lower group had voluntarily had them done. High scorers were very likely to have voluntarily had them done whilst the medium scorers follow the pattern for the sample as a whole.

Table 32 Immunisation uptake

Usage Group	% of decile group encouraged	% of decile group voluntary	% of decile group some voluntary	T
Low	11%	77%	11%	44
Medium	3%	94%	3%	62
High	0%	96%	4%	43
				149

More members of the lower decile group were to be found over represented in those not having voluntarily had them done, or having partial prophylaxis. The percentage having voluntarily had them done in the lower group was below that for the sample as a whole. Middle scorers were more likely to have had them done, whilst still having members who were partial uptkers or non voluntary ones. The highest scoring group has no members in the first column, and exceeds the percentage for the sample as a whole having voluntarily had them done.

Table 33 Hearing test take up

Usage Group	% of decile group encouraged	% of decile group voluntary	T
Low	38%	61%	44
Medium	9%	91%	62
High	7%	93%	43
			149

Only those in the lower scoring groups were under represented in the group who voluntarily had the hearing test carried out. The middle and high scoring group show no marked differences here, both being over represented in those voluntarily having it done.

Table 34 Attendance at clinic

Usage Group	attended 19% or less sessions	attended 20%-40% sessions	attended over 40% sessions	T
Low	100%	0	0	44
Medium	38%	56%	4%	62
High	3%	58%	39%	43
				149

All of those appearing in the low scorers, attended clinic for less than 19% of possible visits, unlike both medium and high scorers who were more likely to have attended clinic for between 20% to 40% of possible visits, whilst high scorers are the only group over represented in the high attendance column. The 3 groups are quite distinct in terms of the number of attendances made at clinic.

Table 35 Gaps in clinic attendance

(% in each decile group)

Usage Group	Less than 4 months	4-6 months	6 months plus	T
Low	0%	2%	98%	44
Medium	6%	48%	45%	62
High	72%	27%	0%	43
				149

High scorers were over represented in those having the fewest gaps in their visiting pattern, making them fairly consistent in take up terms. Medium scorers fall in the middle range of gaps for the sample as a whole, whilst low scorers are over represented in the group

having the largest number of gaps in take up, making them the least consistent attenders. The groups are distinct in their patterns of contact with the services.

Early and late attendance at clinic

Four patterns of usage of the clinic were identified in the data, whereby an interviewee may make minimal use of the clinic by;

1. coming to clinic early in their childs life (i.e. before 4 months) of age, but stop coming early also (i.e. before the child was 12 months old).
2. coming to clinic late (i.e. after child was 4 months old) and ceasing attendance early (i.e. before child 12 months old).

Medium use of the clinic by

3. coming late (i.e. after child was 4 months old) and ceasing attendance late (after 12 months old).

or

maximum use of the clinic by

4. coming to clinic early (i.e. before child was 4 months old) and ceasing attendance late (i.e. after 12 months old).

Table 36 Uptake of clinic sessions

(% of each decile group)

Usage Group	Minimal Uptake		Medium Uptake	Maximum Uptake	T
Type	1	2	3	4	
Low	36%	6%	6%	38%	44
Medium	0	0	0	110%	62
High	0	0	29%	97%	43
					149

The lower scorers were the only group to contain members who did not go at all, or made minimum use of the clinic. Whether they came to clinic early or late in their childs life, they finished coming early also. Unlike medium scorers they could also be found in those who came to clinic late and carried on attending up to 12 months of age. All of the medium scoring group made maximum use of the clinic in terms of attendance, whilst the high scoring group was made up of both medium and maximum attenders.

Table 37 Duration of attendance
(% of each decile group)

Usage Group	less than 4 months	5-11 months	12 months plus	T
Low	36%	22%	40%	44
Medium	0	6%	93%	62
High	0	2%	98%	43
				149

Only the lower scorers contained members who attended for 4 months or less out of the first 16 months of their childs life. They were over represented in those attending for 5 - 11 months of the time and under represented in those attending for over 12 months.

Both medium and high scorers were over represented in the group with longest duration of attendance. Almost all of the higher scorers were in this group.

Table 38 Uptake of medicals

Usage Group	Medical done	Medical not done	T
Low	65%	34%	44
Medium	83%	17%	62
High	95%	5%	43
			149

The 3 sets of scorers were quite distinct on this feature of uptake. The lower scorers were the only ones over represented in those not having had the medical examination and under represented in those having had it done. Middle scorers followed the pattern for the sample as a whole, whilst higher scorers produced exactly the opposite profile to the lower scorers, they were over represented in those having had it done and under represented in those who had not.

Non routine contacts with health visitor

(taken to represent particularly active and voluntary uptake by clients)

Table 39 None routine contact with HV
(% of each decile group)

Usage Group	none	few contacts	many contacts	T
Low	29%	70%	0%	44
Medium	1%	80%	17%	62
High	0%	20%	80%	63
				149

The groups of scorers were again quite distinct on this feature of uptake. Only lower scorers were over represented in the group having had no non routine contacts, whilst the higher scorers were over represented in those having had many such contacts.

Table 40 None routine contacts CMO

(% of each decile group).

Usage Group	none	1 - 4 contacts	T
Low	95%	5%	44
Medium	87%	13%	62
High	74%	26%	43
			149

Lower scorers were over represented in those having no non routine contacts with the CMO at clinic, and under represented in those having some contacts. Medium scorers were more like the sample as a whole, whilst high scorers were under represented in those having none and over represented in those having had some. Again the 3 groups of scorers were quite distinct on this feature, higher and lower scorers showing exactly opposite profiles.

From the tabulated comparisons outlined above, there seem to be good grounds for treating the 3 groups of scorers as separate and distinct in terms of usage.

On 7 of the features (items 1, 2, 4, 5, 9, 10 and 11) all 3 groups were quite distinct from one another in scoring patterns. On the remaining 3 items the distinctions were blurred by higher and medium scorers showing broadly similar scoring trends (items 3, 6/7 and 8).

The clear differences are further clouded by those members of the lowest scorers who scored differently from middle scorers, but not in an opposite direction from them.

Comparison of scoring trends across all three groups

Table 41 Comparison of scoring trends across usage groups
(Number of features on which the usage groups when compared are similar and disimilar)

Comparisons	similar scoring trends	different + opposing scoring trends	different not opposing scoring trends	different scoring trends
low & medium	0	8	2	10
low & high	0	10	0	10
medium & high	3	5	2	7

a) On all 10 of the features of usage, the higher scoring group and lower scoring group produced scoring patterns which were exactly opposite from each other. Their scoring profiles were quite different and showed opposing trends. The medium scoring group tended to follow the patterns of scoring found for the sample as a whole.

b) Lower scorers displayed quite different and opposing trends in their scoring patterns from the medium scorers on 8 features, and quite different but not opposing trends on the remaining 2 features. On these 2 features (items 5 and 10) a significant percentage of the lower scorers were to be found in the same categories as the majority of the medium scorers.

c) Higher scorers displayed quite different and opposing trends to middle scorers on 5 of the features; similar scoring patterns on 3 features and quite different but not opposing trends on the remaining 2 features. (items 2 and 4).

d) Features of the index identified in the 3rd column od table 41 above were those on which scoring patterns between the groups were different from one another (i.e the percentages for each decile grouping were different from that for the other groups), but where a

significant number of the members of the decile group were to be found in the same categories as the majority of the medium scorers. This indicates that a significant number of the lower or higher groups were behaving in terms of usage, like the majority of members of the medium group on certain features of usage.

e) In terms of the scale then, both lower and higher scoring groups differed markedly from the middle scorers on most features, and from each other on all features.

f) It is worth noting that caution must be excercised with regard to how exceptional the lower and higher scoring groups are seen to be in relation to trends in uptake for the sample as a whole. They are not to be regarded as exceptional in every sense, as on some features of usage, both higher and lower scoring groups can be regarded as part of the majority trends evident in the sample as a whole. On each feature of usage, it was noted (in the section discussing the scale) where the majority of the sample fell.

Table 42 Summary of majority trends

Feature no.	Majority Trends
1	69% had either none or only some voluntary assessments done
2	89% voluntarily took up immunisations
3	83% voluntarily had their hearing test done
4	86% were low or medium attenders at clinic
5	75% had gaps in usage of 4 months or more
6/7	81% started attending clinic early and ceased attending late, i.e. made maximum use of the clinic.
8	79% attended clinic for 12 months or more
9	82% had their medical carried out
10	60% had between 2 and 4 non routine contacts with HV
11	85% had no routine contacts with the CMO at clinic

User groups in comparison to the majority trends

On each feature, the medium scoring group were to be found in with the majority trend. Lower scorers, were very different from this on only 2 features (items6/7 and 8), for most items, a majority of them were to be found in those categories which held the majority of the whole sample. The high scorers, were markedly different from the majority on 4 features (items 1, 4, 5 and 10).

8.3. Summary

The patterns of scoring (in terms of percentages) in each decile grouping, when compared with the patterns of scoring for the sample as a whole, show there to be 3 usage groups which were distinct from one another. These are referred to as low, medium and high scorers. The high and low scoring groups were found to have nothing in common in their patterns of scoring, they scored differently and in opposing directions. They also differed from the medium scoring group on most features of the index.

Clear distinctions are blurred by a), the high and low scoring groups containing significant numbers of members scoring similarly to the majority of medium scorers, and b) high and low scorers appearing with the majority of the sample, on certain features.

APPENDIX 9

FATE OF THE ORIGINAL SAMPLE N = 159

Contents

C9.1

MAIN MATERNAL SAMPLE: DISPOSAL, EXCLUSIONS AND LOSSES.

Of the original sample of 159 mothers with children in the appropriate age group, ten were excluded at outset for various reasons such as removal from area; change of general practitioner; and possession of children other than the baby born during the selection period. Subsequently two further mothers had to be excluded due to removal from the area but were included in studies of the user scale since basic usage data was obtained prior to their departure. Disposal within the reduced main sample involved in user scale studies was as follows:

FIRST DECILE:	TOT:
TI: *32,59,112*	3
I: *103,110*	2
R: *31,86*	2
NI: *28,58,66,75,115,117*	6
L: *50*	1
O: *62*	1
TOT: (10.07 per cent)	15

SECOND DECILE:	TOT:
TI: *21,29,65,72,111,140,145*	7
I: *95*	1
R: *116*	1
NI: *55,82,83*	3
L: *85,88*	2
O:	0
TOT: (9.39 per cent)	14

THIRD DECILE:	
TI: *12,16,39,44,96*	5
I: *130*	1
R: *79,100*	2
NI: *33,45,60,80,84,92,98*	7
L:	0
O:	0
TOT: (10.07 per cent)	15

FOURTH DECILE:	
TI: *40,109,113,125-6-9,131*	7
I: *41,73,76,93,156*	5
R: *99*	1
NI: *20,27,34,35,49*	5
L:	0
O:	0
TOT: (12.14 per cent)	18

FIFTH DECILE:	
TI: *26,51,67,74,115-23-4-8,-35-6*	10
I: *37,46,69,87*	4
R: *63*	1
NI: *9,14,23,90*	4
L: *132*	1
O:	0
TOT: (13.40 per cent)	20

SIXTH DECILE:	
TI: *70,102,106,118*	4
I: *52*	1
R: *15,22,25*	3
NI: *10*	1
L: *11,151*	2
O:	0
TOT: (7.39 per cent)	11

SEVENTH DECILE:	
TI: *3,38,78,141,154*	5
I: *43,91,157,158*	4
R: *6,146*	2
NI: *24,64*	2
L:	0
O:	0
TOT: (8.69 per cent)	13

EIGHTH DECILE:	
TI: *2,47,48,97,134*	5
I: *94,127,144*	3
R: *7,30,138*	3
NI: *8,17,36,56*	4
L:	0
O:	0
TOT: (10.07 per cent)	15

NINTH DECILE:	TOT:	TENTH DECILE:	TOT:
TI: *1,5,71,101-14-42-53-55-59*	9	TI: *18,19,68,133-39-43-49-50*	8
I: *81*	1	I: *77,108*	2
R: *104,152*	2	R:	0
NI: *137,147*	2	NI: *4,13,61*	3
L:	0	L:	0
O:	0	O: *89*	1
TOT: (9.39 per cent)	14	TOT: (9.39 per cent)	14

GRAND TOTAL: TI=63 (42.25) I=24 (16.16) R=17 (11.4)
NI=37 (24.75) L= 6 (4.12) O= 2 (1.32) TOT=149

NB: TI: taped interview obtained from informant; I: an interview obtained but not taped; R: refused to be interviewed, either directly or by not keeping repeated arrangements; NI: never in - i.e. the mother was never found at the premises in spite of repeated visits after notes and letters warning of the visit had been delivered; L: 'lost' - i.e. premises found to be empty on arrival; O: omitted from the sample due to removal from area of study.

9.2. FATE OF THE ORIGINAL SAMPLE (N = 149) IN DECILE GROUPS

Table 43 — Fate of original sample
% of each decile group shown

Decile No.	Taped Interview	Interview only	Refusal	Never in	Lost	Ommitted	T
1	20 (3)	13 (2)	13 (2)	40 (6)	6 (1)	6 (1)	15
2	50 (7)	7 (1)	7 (1)	21 (3)	7 (2)	0	14
3	33 (5)	6 (1)	13 (2)	46 (7)	0	0	15
4	38 (7)	27 (5)	5 (1)	27 (5)	0	0	18
5	50 (10)	20 (4)	5 (1)	20 (4)	5 (1)	0	20
6	36 (4)	9 (1)	27 (3)	9 (1)	18 (2)	0	11
7	38 (5)	30 (4)	15 (2)	15 (2)	0	0	13
8	33 (5)	20 (3)	20 (3)	26 (4)	0	0	15
9	64 (9)	7 (1)	14 (2)	14 (2)	0	0	14
10	57 (8)	14 (2)	0	21 (3)	0	7 (1)	14
T	42 (63)	16 (24)	11 (17)	24 (37)	4 (6)	1 (2)	149

Table 44 — Comparison of participants across deciles
(% of each decile group shown)

Decile No.	Participated
1	33 (5)
2	57 (8)
3	40 (6)
4	66 (12)
5	70 (14)
6	45 (5)
7	69 (9)
8	33 (8)
9	71 (10)
10	71 (10)

Table (43) details the fate of each member of the sample according to decile membership. From tables 43 and 44 it can be seen that:

Taped interviews

Only 20% of decile 1 agreed to a taped interview, every other decile group contributed a larger percentage of their membership. In only 4 of the deciles were 50% or more of the members agreeable to a taped interview but these were spread across the usage scale (i.e. deciles, 2, 5, 9 and 10). The remainder contributed a third or more of their members for taped interview. The numbers agreeing to a taped interview then were low, most often less than 50% of the decile agreeing to this, particularly in decile 1 where there was a marked reluctance.

Interviews not taped

The remaining members of the participants who agreed to be interviewed but would not have it taped are spread across the deciles fairly evenly. As a percentage of the decile membership for each group however, it can be seen that non taped interviews were a small contribution to the number participating in each decile.

Refusals

In 6 of the deciles over 10% refused to take part in the study. Decile 10 is exceptional in there being no outright refusals. Deciles 2, 4 and 5 also contributed a small percentage of their membership to the number of refusals. The 6 deciles in which over 10% refused are spread across the usage range, 2 from the lower end of the scale, 2 from the middle and 2 from the upper end. Non users under users and high users then were almost equally likely to refuse participation in the study directly.

Never in

Those whose fate was classified in the 'never in' column can probably be considered as refusals. Even though they did not directly refuse participation, they were never available when the researcher called, and did not acknowledge any message left there. In 8 of the deciles 25% or less of the membership were never available for participation. These are spread across the usage scale (i.e. deciles, 2, 4, 5, 6, 7, 8, 9 and 10). In the remaining 2 deciles over 40% of the membership could not be contacted by the researcher. These were both the lower scoring deciles i.e. 1 and 3, where the percentage 'never in' exceeds both those participating (33.3% and 40% respectively) and those refusing (13.3% and 13.3%). In every other decile more took part than were never found in. Thus those appearing in the lower deciles were extremely difficult to secure for participation in the study.

Lost and omitted

Those persons who were lost to the study were members of the 2 lowest deciles (1 and 2) and the 2 middle deciles (5 and 6), whilst those who were omitted came from deciles 1 and 10. There were no particular patterns then worthy of comment.

9.3. PARTICIPANTS DETAILED BY DECILE MEMBERSHIP

From table 45 it can be seen that decile 1, contributed only 5.7% of those (87) participating in the study, every other decile contributed a higher percentage. Deciles 2, 3, 6 and 8, can also be regarded as having contributed a low percentage of participants to the 87 total. The remainder all contributed over 10% of participants. Deciles 1, 3 and 6 were distinct in that they each contributed relatively low percentages of participants in the study (5.7%, 6.8% and 5.7% respectively).

Table 45 Percentage of each decile to participants in study

Decile No.	Approx. % contribution to participants N = 87
1	5 (5)
2	9 (8)
3	6 (6)
4	13 (12)
5	16 (14)
6	5 (5)
7	10 (9)
8	9 (8)
9	11 (10)
10	11 (10)

Table 46 Comparison of ideal and actual percentage participation

Decile no.	Ideal % Contribution	Actual % Contribution
1	10	5
2	9	9
3	10	6
4	12	13
5	13	16
6	7	5
7	8	10
8	10	9
9	9	11
10	9	11

When the varying number of persons in each decile is taken into account, a more accurate assessment of each deciles participation can be reached. According to the number of persons each decile contributed to the sample as a whole, their ideal percentage contribution to those taking part can be arrived at and contrasted with the actual percentage contributed by each decile. (Table 46). This allows us to see the extent to which each decile was under/over or ideally represented in those participating.

Deciles 1, 3, 6 and 8 were under represented and 7 and 3 were severely under represented in comparison to deciles 6 and 8.

Both the two lower scoring and 2 higher scoring deciles were under represented in the participants. Only the 2nd decile contributed a percentage consistent with the ideal projected for them. The remaining 5 deciles (4, 5, 7, 9 and 10) were on the whole contributing a higher than ideal percentage of participants in the study.

The numbers dealt with in each decile are small, and it is difficult to attach any significance to the figures themselves. However, as the under represented deciles are spread across the usage groups, as are those over represented, there was no consistent relationship between taking part in the study and position on the usage scale. Some high scorers were as likely to take part(and not take part) as low scorers. At the lowest end of the scale the percentage participating was noticeably lower.

There was then no direct link between underusage and poor participation in the study, those preferring not to take part came from high, low, and medium scoring deciles. There was though a tendency for the lower scorers, i.e. under users to prefer not to participate.

When the deciles are grouped together to form the lowest 3, middle 4 and upper 3, (i.e. low, medium and high usage groups) the reluctance to take part in the lower scoring groups can more clearly be seen. (Table 47).

Both the middle scoring and high scoring groups were over represented in the participants, and only the lowest scoring groups were under represented. The differences are not however, so large as to make the

participants in the study a totally biased sample, i.e. biased in favour of the higher scorers, but the under representation of the lowest scoring groups will be taken into account in any interpretations of the findings.

It could still have been possible however, for those participating in the study to be untypical in some way, e.g. they may be a particular part of each decile group. Their scores then on the usage scale were compared, to see if they were typical scorers for their decile.

Table 47 Decile groups percentage participation in relation to sample as a whole

Decile Group	% of Sample (N)	% Participated (N)
Low	29 (25)	22 (19)
Medium	42 (37)	46 (40)
High	29 (25)	32 (28)

Table 48 Mean scores of participants and non participants in each decile

Decile No.	Participants mean score	Whole Decile mean score
1	24.8	21.7
2	54	50.7
3	61	61.2
4	67	67.6
5	72	72.6
6	75.2	75.2
7	79.2	79
8	83.3	83.8
9	88.5	88.7
10	100.3	99.9

Table 48 tabulates the mean scores of participants in each decile, and compares these with the mean score for the decile membership as a whole.

Participants from deciles 1, 2, and 10 scored slightly higher than the

mean score for their decile as a whole. The difference was not large though and when the range of scores is checked it can be seen that participants scored both the highest and lowest scores possible in their respective deciles. So, both ends of each decile were represented in the participants. Only decile 2 remained problematic in that the mean score for participants, exceeded that for the decile membership as a whole, and the lowest scoring participant still scored higher than the lowest scorers in that decile.

Participants from the remaining deciles (3, 4, 5, 6, 7, 8 and 9) produced means consistent with those for their decile as a whole. Participation in these deciles also included the highest and lowest scorers for each group.

APPENDIX 10

SOCIODEMOGRAPHIC COMPARISON OF USAGE GROUPS

Referred to in text 4.4.6.

Contents

CORE MATERNAL SAMPLE: SOCIODEMOGRAPHIC DATA USED IN STATISTICAL COMPARISONS, BY DECILES.

(NB: S = subject number; U = score on user scale; N = nominal scaling, utilised for frequency counts only; O = ordinal data; I = interval data.

		CATEGORY OF DATA:																	
S:	U:	1	2	3	4	5	6	8	9	10	11	12	13-4	15	16	17	18	22	23	24
31	4	34	-	-	-	-	-	3	-	-	-	-	-	-	-	-	-	-	-	-
32	27	22	3	16	2	3	5	5	1	8	2	4	1	2	6	30W	15B	3.5	0	1
59	29	22	2	15	2	2	3	0	1.5	4	2	3	0.66	1	0	5B	5B	0.5	0	0
103	32	23	2	16	1	0	4	2	1.3	4	3	2	0.66	1	2	5W	15B	0.5	1	0
110	32	23	1	16	0	3	4	3	3.0	2	3	4	0.66	3	7	10W	10W	2.0	6	1
112	4	17	2	15	0	1	0	2	1.4	2	3	4	1.00	0	0	10W	15B	0.0	0	0
21	55	30	1	15	0	1	4	3	0.5	7	2	2	1.00	3	7	20W	15B	8.0	1	0
29	57	22	1	16	0	3	4	3	2.0	2	2	5	1.00	2	5	10W	10W	0.5	3	1
65	52	25	2	15	0	2	4	2	1.3	3	2	4	0.66	2	7	5W	10B	1.0	1	1
72	54	20	1	16	0	3	4	0	1.5	2	3	4	0.30	0	0	20W	45B	0.0	5	0
95	56	22	2	17	2	3	4	3	2.5	3	3	2	0.66	3	6	30W	--B	1.0	0	1
111	55	25	2	15	0	1	3	2	1.0	3	3	2	0.66	3	6	20W	10W	0.8	1	0
140	46	24	3	15	0	1	5	3	2.0	2	2	2	0.66	3	7	30W	30W	0.0	2	-
145	57	21	1	16½	2	1	3	0	3.5	3	1	5	0.66	0	0	5W	20B	2.0	3	1
12	61	18	2	15½	2	1	0	2	2.0	2	2	4	0.66	2	4	10W	10W	0.2	2	-
16	62	22	3	15	2	3	3	3	2.0	3	0	5	1.00	0	4	20W	20W	1.0	3	0
39	61	23	2	16	2	3	1	2	3.0	3	2	2	1.00	2	6	10W	10B	1.5	2	1
44	61	23	1	16	0	2	4	3	1.6	2	1	4	1.00	3	7	10W	10B	0.3	0	-
96	59	26	2	16	2	2	5	3	-	-	-	-	-	-	-	-	-	-	-	-
130	64	20	2	-	-	-	-	2	-	-	1	-	-	-	-	2W	-	-	-	-
40	65	22	2	16	0	1	4	3	1.5	3	2	4	1.00	0	0	3W	20B	0.2	2	0
41	67	29	3	16	2	2	5	4	5.0	3	0	2	1.00	3	7	20W	10C	3.0	0	1
73	67	19	2	16	2	1	5	3	1.4	3	2	4	1.00	0	5	15W	--B	0.0	0	0
76	70	23	1	16	1	1	4	3	4.0	5	3	2	0.66	3	7	30W	--B	3.0	0	1
93	69	26	2	15	0	2	4	3	2.0	2	3	3	0.66	3	6	10W	5B	0.2	0	0
109	64	30	1	15	0	2	4	4	2.0	4	3	2	0.66	2	5	10W	15W	3.0	1	1
113	70	27	1	16	1	2	4	5	4.0	6	1	2	0.66	2	6	10W	15B	3.0	1	1
125	69	33	1	15	0	1	3	2	2.0	5	1	2	1.00	3	6	5W	5W	11.0	0	-
126	67	25	2	18	2	3	5	3	3.0	2	1	2	1.00	3	7	10W	10B	2.0	1	-

S:	U:	CATEGORY OF DATA:																		
		1	2	3	4	5	6	8	9	10	11	12	13-4	15	16	17	18	22	23	24
129	70	21	3	16	2	1	4	3	1.1	3	3	4	1.00	3	7	10W	10W	2.0	1	-
131	70	22	3	16	2	0	3	3	2.0	2	1	2	0.66	2	7	15W	15W	0.2	0	-
156	65	22	3	16	2	1	4	4	1.0	3	2	3	1.00	2	5	15W	15C	2.0	2	1
26	73	29	1	16	0	3	4	4	5.0	2	2	2	1.00	3	6	10W	10W	4.0	-	1
37	73	23	3	17	2	2	4	4	4.0	2	3	2	1.00	3	6	5W	--B	3.5	1	1
46	73	34	1	15	0	2	5	4	2.0	10	3	2	1.00	3	7	15W	15B	0.7	1	1
51	73	30	1	15	0	1	2	3	6.0	2	3	2	1.00	3	7	15C	15C	8.0	0	-
67	71	23	2	16	2	2	3	-	0.2	5	2	4	0.40	2	6	5W	10W	-	0	0
69	72	21	1	16	1	3	4	3	2.0	5	2	2	1.00	2	6	15W	30B	0.7	2	0
74	72	33	2	17	2	2	5	5	1.0	3	3	2	1.00	3	7	5W	--B	9.0	2	0
87	73	23	2	16	0	1	4	5	3.5	2	3	2	1.00	3	6	2W	2W	2.0	1	0
115	73	21	-	15	2	1	5	2	2.0	7	1	4	0.66	0	5	10W	90B	1.0	2	1
123	73	23	1	16	1	2	4	3	1.5	4	3	4	1.00	3	6	10W	10W	2.0	4	-
124	72	21	1	16	2	2	5	4	2.5	4	1	2	0.66	3	6	30B	30B	0.5	2	-
128	73	26	2	16	0	2	4	3	5.0	2	0	2	1.00	3	7	10W	10W	2.0	1	-
135	73	21	2	18	3	0	1	1	1.1	6	2	4	1.00	2	6	10W	15B	-	1	-
136	73	18	2	16	1	2	3	0	1.1	3	1	4	0.66	1	4	15W	15B	0.1	1	-
52	76	35	3	18	3	2	5	2	3.5	6	2	2	1.00	3	7	20W	7W	2.5	0	1
70	75	29	1	18	3	3	5	5	7.0	2	3	2	0.66	3	7	10W	30W	5.0	3	1
102	76	28	3	17	3	1	5	3	3.0	2	2	2	0.66	3	5	20W	20B	1.5	0	0
106	75	23	1	26	1	1	4	2	1.0	4	3	2	0.66	3	6	3W	5B	2.0	0	-
118	74	27	1	14	1	3	4	2	4.5	2	3	2	0.66	3	6	20W	10W	3.0	1	1
3	77	24	1	16	0	3	4	4	4.0	2	3	2	1.00	3	7	15B	15B	3.5	1	0
38	78	28	3	18	2	1	5	4	3.5	10	0	2	1.00	2	6	10W	10W	8.0	3	0
43	81	25	1	15	0	1	3	3	2.0	5	3	2	0.75	3	6	1W	1W	2.0	3	1
78	77	22	2	16	0	1	4	3	0.6	2	2	4	0.60	3	6	2W	--B	0.5	2	-
91	80	35	1	15	0	3	4	4	7.0	2	3	2	1.00	3	7	15W	5W	6.0	0	1
141	80	24	2	16	1	2	4	3	1.5	3	2	4	1.00	3	7	2W	2W	2.0	0	-
154	81	23	3	16	3	3	5	3	1.5	3	3	2	1.00	3	7	2W	2W	0.4	1	0
157	81	32	3	18	3	1	5	5	4.0	7	0	2	1.00	3	7	20W	20W	2.0	0	1
158	78	21	3	16	0	1	4	2	1.2	3	3	2	1.00	3	7	2W	2W	2.0	0	0
2	82	28	3	18	4	2	5	5	3.0	3	3	2	1.00	3	7	20B	20B	4.0	-	1
47	82	18	1	16	1	2	4	3	0.1	3	3	4	1.00	0	4	5W	10B	0.4	1	-
48	83	36	3	16	2	2	5	4	1.5	3	3	2	1.33	3	7	10W	4C	16	0	0
94	85	29	2	16	2	2	4	3	4.0	4	3	2	1.00	3	6	10W	10B	7.0	1	1

S:	U:	CATEGORY OF DATA: 1	2	3	4	5	6	8	9	10	11	12	13-4	15	16	17	18	22	23	24
97	85	27	1	15	0	2	4	3	3.0	2	2	2	0.66	3	6	5W	30B	1.0	0	1
127	85	23	3	17	2	2	4	0	1.0	3	2	4	0.66	3	7	10W	10W	-	1	1
134	82	25	1	18	2	2	4	4	5.0	8	3	2	0.66	2	7	5W	5W	4.0	0	-
144	83	24	3	16	0	1	4	3	0.5	2	3	4	1.00	2	6	-	-	2.0	2	1
1	91	30	1	15	1	3	4	3	1.0	4	2	2	1.00	2	6	20W	10W	-	-	0
5	87	24	1	16	1	3	4	4	1.0	2	3	2	0.66	2	7	10W	10W	1.0	0	1
71	89	19	1	16	2	3	4	2	1.5	2	0	4	1.00	1	6	60W	60B	0.5	1	-
81	91	20	2	16	0	0	3	0	1.5	2	3	3	0.33	3	5	10W	10B	1.0	0	1
101	89	27	1	16	0	3	4	3	9.0	3	0	2	0.50	3	6	10W	10W	0.3	0	0
114	89	23	1	16	2	2	5	3	4.0	2	1	4	1.00	3	6	10W	20B	1.0	2	1
142	86	24	1	15	0	1	3	0	5.5	2	3	3	0.66	3	7	2W	10B	4.0	0	-
153	90	20	2	16	1	2	4	3	0.6	5	2	2	0.66	3	6	10W	10W	0.4	1	0
155	87	20	3	16	3	2	3	2	0.2	3	1	4	1.00	1	7	10W	10W	1.3	1	-
159	86	20	2	16	0	2	4	0	1.0	2	2	4	1.00	3	1	5W	10B	0.1	3	-
18	93	30	3	18	4	3	5	5	2.0	3	3	2	1.00	3	7	10W	10W	2.0	0	1
19	101	21	2	16	0	3	3	3	1.3	3	2	2	1.00	3	7	10W	10W	0.3	5	0
68	93	23	2	15	0	1	4	3	1.0	4	3	3	0.40	3	6	15W	30W	0.2	1	0
77	125	20	1	15	0	3	3	3	4.0	2	0	2	0.50	2	3	10B	15B	0.7	3	0
108	95	21	1	16	0	2	3	2	1.0	7	3	4	1.00	0	4	5W	5W	1.0	1	1
133	105	32	3	16	2	1	1	5	5.0	4	2	2	1.00	3	7	20B	20B	3.0	2	-
139	103	30	1	15	0	1	3	2	6.0	3	1	2	0.66	2	5	10W	10W	5.0	1	1
143	97	21	3	16	2	1	4	3	2.0	2	3	2	1.00	3	7	20W	20W	1.0	0	-
149	92	31	1	15	0	2	3	3	8.5	2	3	2	0.66	3	6	10W	10W	7.0	3	1
150	99	23	1	16	0	2	3	3	1.5	3	2	4	1.00	3	7	5W	10B	0.2	1	-
DATA TYPE		I	N	I	C	N	N	N	I	I	O	N	I	N	O	I/N	I/N	I	I	N

NOTE: Two categories need further explanation. The measure given by conflation of categories 13 and 14 gives an index of relative space available in dwellings: i.e. the amount of bedroom space per person living in the property, given by dividing the number of residents by the number of bedrooms. Similarly, the scoring in category 23 represents the number of siblings which a mother may have been involved in bringing up to some extent: given by the number of siblings younger than herself in her parental family.

APPENDIX 10

10.2. STATISTICAL COMPARISON OF USAGE GROUPS ON EACH SOCIODEMOGRAPHIC FEATURE

a) Low, medium, high usage scores were grouped together.

low = deciles 1, 2, and 3
medium = deciles 4, 5, 6 and 7
high = deciles 8, 9 and 10

As the study is dealing with relatively small numbers, categories for comparison were also combined in an attempt to avoid expected frequencies falling below the convention of 5. (Robson 1973, page 88) for X2 calculation.

b) Varying numbers of responses were available for each factor depending on its source, i.e. factors which could be ascertained independently of the interviews show a higher response rate than those dependent on interview for collection. As mentioned earlier 1 tape was faulty rendering the data unuseable so that for most factors N = 86.

c) the factors were chosen as pertinent to the study in order to facilitate comparison with past research on underusage, to see if similar or different trends were in evidence here.

Table 52 Summary of relationships between usage groups and sociodemographic characteristics tested for significance

Usage Groups with factors	X2	df	PL	Significance
1. Age of mother	9.56	4	.05	NS*
2. School type	5.49	4	.30	NS
3. Qualifications	2.02	2	.50	NS
4. Health topics	2.84	2	.50	NS
5. Previous Occupation	3.11	2	.30	NS
6. Partners Occupation	7.77	2	.05	NS*
7. Years in accommodation	3.43	2	.20	NS
8. House moves	4.73	2	.20	NS
9. Contacts	0.3	2	.20	NS
10. Property type	10.80	2	.01	NS*
11. Clinic journey	2.49	2	.30	NS

* Percentage tables were drawn up to investigate trends which almost reached significance

None of the relationships tested reached a significant result, so that caution is necessary in the interpretation of trends noticeble in the data.

Three of the relationships almost reached significance and tabular summaries of the data in percentages allows us to see the trends.

Table 53 Age of Interviewee/Decile Group

(% of each decile group shown)

Decile Group	Age Group		
	17-21	22-26	27-36
Low	25	65	10
Medium	20	42	37
High	35	28	35

High scoring users were more likely to be younger than the rest of the sample, i.e. between ages 17 - 21, whilst lower scorers were older 22

- 26, but not in the oldest group, 27 - 36 years. The trend was not consistent though, and did not reach significance level showing the participants in this study to be tending towards partial confirmation of results found in other studies of underusage. Past research has identified younger mothers as the most likely to underuse the services, here they were one of the higher scoring groups. The partial confirmation lies in the lower users being under represented in the oldest age range of 27 - 36 years.

Table 54 Partners Occupation Across Decile Groups
(% of each decile group shown)

Decile Group	Professional/ Non Manual	Unemployed/ Unskilled
Low	13.8	86
Medium	39	60.7
High	21	78
Whole Sample	26.4	73.6

Those having unemployed, unskilled partners, were slightly over represented in the low usage group (as compared with the sample as a whole) and under represented in the medium scorers. The lower social class groups have consistently been identified as those most likely to underuse the services, and this trend would seem partially confirmatory in this respect. Those with college students, non manual or professional partners were more likely to be members of the medium scoring group, and unlikely (under represented) in the low scoring group. High scorers were made up of both occupational groupings in the same proportions to those for the sample as a whole.

The trends are not marked enough to be significant though, some members of the higher occupational groups underuse the services, but they are more likely to be medium, and not high scorers.

The lower occupational groups are to be found both in the lower and upper usage groups more so than in the medium scoring ones. Those members of the lower occupatinal groups making high usage of the services are rarely commented upon in research on usage.

Table 55 Property type occupied

Usage Group	Private	Rented
Low	33	66
Medium	70	30
High	62	37
Whole Sample	58.2	41

Those underusing the services were over represented in the tied accommodation category, and under represented in the private accommodation category. As another indicator of social class membership, this result is in line with that described in table 54, and the very general findings that underusers are likely to be from the lower end of the social class scale. Those appearing in the private accommodation category are over represented in the medium user deciles again confirmatory of the trends identified in table 54.

Both items 6 and 10 tabulated above were collected as indicators of class membership, in order to make the study comparable to others. 2 other indicators were included for this assessment, the interviewees previous and present occupation.

Previous occupation of interviewee

Table 56 Previous Occupation of Interviewee
(% of decile membership shown)

Decile Group	None	Service Industry	Professional/semi
Low	16%	75	16
Medium	5	62	35
High	3	82	14
Whole Sample	5.8	69	24

Interviewees who had had no previous occupation were over represented in the lower scoring deciles, the professional group was over represented in the medium scoring deciles, and the service industry/factory workers group were over represented in the high scoring deciles. None of these trends were significant but they tend to be confirmatory of those already outlined above. Certain lower social group members tend to underuse the services, i.e. those who were unemployed prior to motherhood. Those employed in service/factory work were both more likely to appear in lower decile groups, or make unusually (for the sample as a whole) high usage of the services. The high users (at least according to this table) from the lower socioeconomic groups were likely to have been employed before becoming mothers rather than unemployed.

Present occupation of interviewee

In addition to being mothers, only 7 members of the sample were also employed outside the home. The remaining 79 for whom data was obtained were full time housewives. There were no comparisons in terms of decile membership possible with such small numbers.

An attempt was made to look at educational qualifications and schooling in relation to usage to allow for comparison with previous research.

Schools attended

Table 57 School Type Attended

Decile Group	Secondary	Comprehensive	Grammar
Low	31	52	15
Medium	40	30	30
High	51	22	25
Whole Sample	41.8	32	25

Less lower scoring interviewees had attended grammar school, most had attended comprehensives, and more middle scorers were to be found having attended grammar school. The differences did not reach significance though, and the only other feature was high scoring interviewees being over represented in the secondary modern school category.

A comparison with school leaving age shows clearer trends:

School leaving age of interviewees

Table 58 School Leaving Ages
(% of decile grouping shown)

Decile Group	Before 16	After 16
Low	94	6
Medium	77	22
High	85	14
Whole Sample	83	16.2

Those who left school at or before the age of 16, were more likely to be found in the lower scoring deciles.

Formal Qualifications of Interviewees

Table 59 Formal Qualifications of Interviewees
(% of decile grouping shown)

Decile Group	No Qualifications	Some Qualifications
Low	50	50
Medium	35	65
High	46	
Whole Sample	41	58

Those appearing in the lower deciles were more likely to have no formal qualifications, whilst medium scorers were over represented in the group having qualifications.

Health education was assessed by means of documenting whether or not interviewees had covered subjects considered relevant to child care either in or out of school. They were merely to reflect whether the subjects of human biology, domestic science, sex education or baby care were covered or not (not their knowledge of such matters). There were no differences of any note between decile membership in terms of health education covered by interviewees.

Stability of Living Arrangments

An attempt was made in this study to monitor the 'stability' of living arrangements of the interviewees, as measured by the following features; number of years living in present accommodation, number of home moves made by the interviewee (excluding her parents home), marital status at time of interview, length of time the interviewee had known her childs father; and length of time they have been living together. The results are tabulated below.

Number of years living in present accommodation

Table 60 Years Living in Present Accommodation

Decile Group	Less than 2 years	Over 2 years
Low	52	48
Medium	32	68
High	53	47
Whole Sample	43	57

Both high and low scorers were over represented in those having lived in their present accommodation for less than 2 years. The middle

scorers were more likely to appear in those having lived in their present accommodation for over 2 years. On this table then, both low and high scorers would be considered to have less 'living stability' than medium scorers.

Table 61 Number of times interviewee has moved home
(% of decile group shown)

Decile Group	4 or less	over 4
Low	88	11
Medium	70	30
High	89	10
Whole Sample	80	20

Both high and low scorers were over represented in those having moved house 4 or less times, negating the implied lack of stability found in table 6. They were no more likely to move house many times than any other groups.

Marital status at time of interview

Table 62 Marital Status of Mother
(% of decile group shown)

Decile Group	Single	Separated	Married
Low	21	8	69
Medium	7	2	90
High	6	-	93
Whole Sample	10	-	86

The lower scorers were more likely to be single parents or separated than the sample as a whole, whilst high scorers were more likely to be married. The trends were not significant.

Table 63 Years interviewee has known father of child
(% of decile group shown)

Decile Group	2-4 years	4-6 years	over 6
Low	18	25	56
Medium	12	17	69
High	28	28	44
Whole Sample	18	22	58

High scorers were more likely to have known the childs father for less time than others, whilst medium scorers were more likely to have known him for over 6 years.

Table 64 Years parents have been living together
(% of decile group shown)

Decile Group	less than 2 years	2 - 4	4 - 6	over 6
Low	18	31	12	37
Medium	10	42	31	15
High	7	57	15	19
Whole Sample	11	45	22	21

Lower users were over represented in both extreme groups i.e. those who have been together for less than 2 years and those who have been together for more than 6 years, making assertions with regard to stability of living arrangements very uncertain.

Living conditions were further examined in terms of whether or not interviewees had regular contacts with their family friends and neighbours; the experience of over crowding and domestic facilities available to them. The condition of their home was assessed by the interviewees themselves, as to whether there were problems with their accommodation.

Table 65 Regular contacts in neighbourhood
(% of decile group shown)

Decile	only family	family, & others
Low	22%	77%
Memium	27.5%	72.5%
High	21%	78%
Whole Sample	24%	75.5%

There was no noticeable trend in evidence here.

Overcrowding was assessed in terms of the number of people whose home accommodated more persons than there were bedrooms for. In each decile group 3 persons had problems of overcrowding

Table 66 Condition of property
(% of decile group shown)

Decile Group	poor condition	OK/good
Low	35	64
Medium	10	90
High	15	85
Whole Sample	16	83

Lower users were over represented in those who assessed their property as very poor, or having a chronic problem e.g. damp, subsidence. Medium users were more likely to be content with their home.

Table 67 Domestic facilities available
(% of decile group shown)

Decile Group	no washing machine/ telephone or car	all facilities
Low	41	59
Medium	5	95
High	14	86
Whole Sample	15	85

lower decile members were over represented in the group having fewer domestic facilities, whilst medium users were more likely than others to have access to these 3 facilities.

Table 68 Journey to clinic
(% of decile group shown)

Decile Group	10 or less	over 10
Low	64	36
Medium	60	40
High	77	23
Whole Sample	65	35

It was slightly more likely for high users to live within 10 minutes or less of the clinic, and slightly more likely for the medium users to live further than 10 minutes away. Again the figures were not significant and the trends inconsistent with the notion that those nearer to clinic will make more use of it.

Table 69 Journey to general practitioner/minutes
(% of decile group shown)

Decile	10 or les	over 10
Low	52	48
Medium	54	46
High	70	30
Whole Sample	59	40

High users were over represented in the group where the general practitioners surgery was less than 10 minutes away, and lower users slightly over represented along with medium users in the group where it took over 10 minutes to get to their general practitioners surgery.

The relationship between accessibility and uptake again is not a very robust or consistent one.

Table 70, Mean ages for each decile

On the face of it, the number of house moves would seem more likely to reflect stability of residence, but as both high and low scoring interviewees tended to be younger than medium scorers, maybe this accounts for their lower rate of moves, older people being more likely to have moved house more times. If age were the main determinant of house moves, one could expect higher scorers to show more than lower scorers.

From Table 70 it can be seen that, this was not the case, both low and high scorers having made less house moves. In any case with such small numbers it is difficult to be sure if trends are to be treated seriously or not.

Table 70 Mean ages for each decile
(% of each decile group shown)

Decile Group	Mean Age
Low	22.3
Medium	26
High	24.7
Whole Sample	24.5

10.3. SELECTION OF CASE STUDIES FOR IN DEPTH QUALITATIVE ANALYSIS TABLE 71

Table 71 Fate of members in lowest 2 deciles
N = 29

Fate	Decile 1	Decile 2
Taped interview	2	4
Taped interview/HV	1	2
Interview, not taped	2	1
Never in	6	3
Refused	2	1
Lost	1	2
Omitted	1	0
	15	13

Ideally the researcher would have preferred to present detailed case studies for all those who took part from the lower deciles. In practice this was not possible.

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

APPENDIX 11

TABULATED SUMMARY OF CONTENT ANALYSED INTERVIEW DATA.

Referred to in text 5.2. and 5.6.

Contents

11.1 RESPONDENTS VIEWS ON BECOMING A MOTHER AND SERVICE PROVISION

Tabular summary of content analysis

Table 73 Learnt from own family re child rearing

Decile group	yes	no	T
Low	9	8	17
Medium	21	18	39
High	14	14	28
	44	40	84

X2 = 0.099
df = 2
N.S.

Lower scorers were not likely to claim to have learnt from family than any other decile group.

Table 74 Knowledge of provision

Decile group	none FR	some FR	T
Low	10	7	17
Medium	30	10	40
High	18	10	28
T	58	27	85

X2 = 1.741
df = 2
p = 0.419

All groups felt equally uninformed

Table 75 Mothers view of hospital stay

Decile Group	Problem Type 1	2	3	4	5	6	7	8	9	10*
Low	7	7	8	5	1	3	3	3	3	4
Medium	13	11	14	6	4	2	2	6	6	9
High	12	13	3	4	2	8	0	5	9	4
	32	31	25	15	7	11	5	14	9	117

X2 = 23.431
df = 18
no differences between deciles

p = 0.15

* 1 no problems
2 humiliat ed
3 felt neglected
4 staff inept
5 unnecessary pain
6 poor facilities
7 forced against will
8 depressed
9 terrifying experience
10 no rest

There were no significant differences between deciles in reporting problems in hospital stay, (columns 2 - 10) or reporting no problems (column 1). The most frequent reported problems were those of feeling humiliated by the hospital staff feeling neglected by staff and inept staff. These 3 accounted for 43.3% of responses of the remaining 37.5% responses, 21.3% concerned physical hardship e.g. unneccessary pain, poor facilities and lack of rest.

A sizeable minority reported depression and hospitalisation as a terrifying experience.

Table 76 Relationship with midwife

Decile	positive *	negative *	
Low	16	2	18
Medium	36	2	38
High	25	2	27
	77	6	83

X2 = 0.227
df = 2
p = 0.900
no differences

* Positive = knew her well and found her helpful
Negative = afraid of midwife/found her unhelpful

There was a consensus in favour of the midwifery service: being helpful and appreciated by the sample as a whole.

Table 77 Preparation for baby's arrival

Decile	Problem Type None	Housing	Money	Advice	Unmarried
Low	7	7	5	5	2
Medium	26	3	5	2	2
High	14	4	4	4	0
	47	16	14	8	4

X2 = 10.845
df = 8
p< = 0.250

There were no major differences. Over half had no problems. The problems cited were fredom (most frequently reported) houseing, unsuitable, and money problems, poor advice was important for some and being unmarried could be a difficulty.

Table 78 Major worries during first year
(1st few weeks of motherhood)

Decile Group	Worry Type 1	2	3	4	5	6	7	8	*
Low	7	6	3	2	1	4	1	0	
Medium	21	16	16	7	7	8	5	2	
High	16	12	7	7	5	0	0	1	
T	44	34	26	16	13	12	6	3	

* 1 Doing everything correctly
2 Worries made worse with child
3 Could not cope
4 Questioned ability as mother
5 Illness
6 No worries
7 Depression
8 Disfigured

X2 = 13.881
df = 14
p> = 0.500

In early days of motherhood, the interviewees recalled these to be their major worries.

Personal competence as a mother columns (1 + 4) was a major concern, as was worry about being able to cope with increased demands (2 + 3). Only 12 resported no worries, whilst the incidence of depresion was also low here.

The table does give some idea of a mothers major worries which could be taken into account in provision.

Table 79 Summary of problems for whole of first year

	Problem Type					
Decile Group	1	2	3	4	5	*
Low	5	2	2	5	6	
Medium	26	17	3	5	3	
High	13	8	8	3	3	
	44	27	13	13	12	

1. Feeding
2. Illness of baby
3. Immunisations
4. Difficult child
5. None

X2 = 21.989
df = 8
p< 0.01
X2 crit = 20.09

There were differences in reported problems across deciles. More mothers from the lower scorers reported no worries, more mothers in higher scorers reported problems to immunisations, whilst more of the lower scoring mothers reported having a 'cranky' baby. They were less likely to report problems in general, but when asked specifically about possible problems they had them too.

As some of the expected frequencies fell below N = 5 the X2 was invalidated, so comparison of differences in scoring pattern within each decile in relation to that for the sample as a whole was undertaken.

Table 80 Scoring patterns in relation to expected sample frequency from Table 79

Problem Type	Decile Group Low	Medium	High	Expected FR Whole Sample
1	25%	48%	37%	36%
2	10%	31%	22%	21%
3	10%	9%	8%	14%
4	25%	5%	22%	12%
5	30%	5%	8%	14%

X2 = 67.43
df = 8
p< = 0.01

Fewer of the lower scorers reported feeding or illness of baby as their major worries for first year whilst more of the middle scorers did. More lower scorers than would be expected reported immunisation problems. Less middle scorers reported having no problems or a 'cranky' baby. High scorers were more likely to report having a cranky baby.

For the sample as a whole, feeding was by far the most frequently reported problem; followed by illness of their baby and their child just being difficult (sleepless nights, constant crying, difficult to soothe child). Very few reported having no major problem, (11%) after each one had been asked about. Feeding was the most frequently mentioned problem (Confirmatory of Graham 1978 study). Whilst illness of the child was a major source of worry for 1/4 of the sample.

Table 81 Perception of help available

Decile Group	Problem Type 1	2	3	No Problem Type 4	5 *
Low	6	4	4	2	4
Medium	12	9	6	1	11
High	4	9	5	5	6
T	22	22	15	8	21

* 1 Forced to act alone
2 Not sure where to go
3 Unrealistic preparation
4 Just get on with it
5 Plenty of help

X2 = 7.54
df = 8
p = 0.5

Trying to manage alone because of unsatisfactory advice and being unsure of where to get help were the most frequent perceptions of help and advice. A similar percentage reported having had plenty of help.

Table 82 Types of Financial Problems

Decile Group	Problem Type 1	2	3	4	5	6	7 *
Low	3	8	6	3	4	3	1
Medium	3	18	6	8	5	4	8
High	2	17	6	6	5	2	0
T	8	43	18	17	14	9	9

* 1 No problem
2 Relied on family
3 Outlay
4 Unrealised cost
5 Constant problem
6 OK now
7 Just manage

X2 = 12.26
df = 12
p = 0.4

A small percentage had no financial problems to speak of; reporting that they/their partner was well paid. Most who had problems relied

on their family for back up, whilst the main problems were the initial outlay, being unexpectedly high or the problem of finance being a constant one.

Table 83 Illness of Mother Type

Decile Group	Problem Type 1	2	3	4	5 *
Low	11	7	3	4	0
Medium	23	8	7	3	1
High	16	4	5	4	2
T	50	19	15	11	3

* 1 no time to be ill
2 non specific ailments
3 depression
5 long term

X2 = 5,435
df = 8
p = 0.7 4 disfigurement

The most notable response here was the majority who reported they had not had time to be ill. Irritating problems, infections, pain, flu, rashes, etc. were the kinds of illnesses most frequently reported whilst 15% had found themselves depressed, during this first year and 11% felt disfigured from the pregnancy.

Table 84 Illness of Baby Type

Decile Group	Problem Type 1	2	3	4	5*
Low	9	6	4	3	4
Medium	21	20	12	6	4
High	15	11	4	3	9
T	45	37	20	12	8

* 1 Respiratory
2 Teething
3 Gastro intestinal

X2 = 7.5
df = 8
p = 0.5

The most frequently reported type of illness in children was respiratory type e.g. flu, infection colds) followed by teething problems followed by teething troubles as a major source of concern.

Table 85 Apprehension about clinic

Decile Group	Yes	No	*
Low	16	3	
Medium	27	13	
High	19	9	
T	62	25	

* Yes = uncertainty/afraid to attend
No = positive expectations

X2 = 3.7
df = 2
p = 0.2

A majority of the respondents were apprehensive about going to clinic in the first place, only (25) i.e. 29% of responses were positive in expectations.. They were on the whole uncertain of what it was all about, and some in addition were agraid to go. (table 86)

Table 86 Apprehension about clinic attendance in relation to expected frequency for sample as a whole

Apprehensive	Decile Groups % Low	Medium	High	Expected % For sample
Yes	84	67	67	72
No	16	33	33	27

X2 = 9.84
df = 2
p< .01

Lower scorers were more likely to report feeling apprehensive about attendance (uncertain of what to expect and fearful).

The clinic was regarded as primarily there for the weighing of children, and to a lesser extent as a source of advice, or specific testing. Socialising was not regarded as a particularly major function.

Table 87 Perceived Functions of clinic

Decile Group	Function Type 1	2	3	4	5	*
Low	11	8	4	5	1	
Medium	31	15	15	9	4	
High	23	14	10	6	6	
T	65	37	29	20	11	

1 Weighing
2 Advice
3 Testing
4 Socialising
5 Post natal check up

X2 = 3.63
df = 8
p = 0.000

Lower scorers were more likely than the sample as a whole to report feeling apprehensive about attending clinic (being uncertain of what to expect and fearful) and less likely than the sample as a whole to report no apprehension about attending and positive expectations.

Table 88 Preferred system of attendance

Decile	Pop In	Combined	Appointments	Not Sure
Low	8	3	3	2
Medium	30	6	2	1
High	19	6	0	2
T	57	15	5	5

X2 = 9.4
df = 6
p = 0.2

An overwhelming majority reported preferring the pop in system whereby no appointment is necessary and it is up to the client to choose when to attend. (X2 = 11.719 df 1. p< 0.001).

Table 89 Productivity of Clinic Visit

Decile Group	Non Productive 1	2	Productive 3	4*
Low	7	2	4	4
Medium	17	6	9	5
High	15	4	6	4
	39	12	19	13

* 1 Only for weighing
2 Only as a safeguard
3 Just attend for essentials
4 Enjoy attending

X2 = 1.78
df = 8
p = 0.9

The overwhelming majority felt clinic was a waste of time regardless of whether they continued attending or not. (X2 = 5.128, df = 1, p< 0.05). Very few claimed they enjoyed attending. Those who did not think it a waste of time said it was because they only went when it was absolutely necessary to do so, for specific purposes or that they enjoyed going.

Reasons offered for underusage

The sample were all asked why they thought people didn't go to clinic.

Table 90A Underusage as mothers fault

Decile Group	Mothers failings types 1	2	3 *	T
Low	4	5	1	10
Medium	3	3	3	9
High	7	2	1	10
T	14	10	5	29

* 1. Due to idleness
2. Due to lack of care
3. Due to stupidity

Table 90b Underusage as Services fault

Decile Group	Service failings types 1	2	3	4*	T
Low	3	1	3	3	10
Medium	7	6	9	3	25
High	8	4	6	1	19
T	18	11	18	7	54

* 1. Interfering staff
2. Staff don' care
3. Advice is nonsense
4. Clinic unpleasant

Table 90c Underusage as 'sensible' option

Decile Group	Sensible Options 1	2	3*	T
Low	4	4	2	10
Medium	12	13	6	31
High	8	6	2	16
	24	23	10	57

* 1. No reason to go
2. No time to go
3. Must be good reason

X2 = 15.7
df = 18
p = 0.60

Category c) reasons were the most frequently offered; followed by b) and lastly a). There were no links with decile membership, showing a reasonable consensus of views on this matter. Overall it was thought mothers had good reasons for not attending, e.g. it was of no use and they have more important things to do.

When the percentage distribution of responses for each decile was compared with that which would be expected from the sample as a whole; there were significant difference between the percentage frequency patterns for the decile groupings.

Table 90d Reasons for Underusage

Comparison of tables 90a-c with expected sample %

Reasons for Underusage		Decile Group Low	Medium	High	sample expected
A	1	13.3	4.6*	15.3	11.1
	2	16.7*	4.6	4.4	8.5
	3	3.3	4.6	2.2	3.3
B	1	10	10.8	17.8*	12.8
	2	3.3	9.2	8.9	7.1
	3	10	13.8	13.3	12.3
	4	10*	4.6	2.2*	5.6
C	1	13.3	18.5	17.8	16.5
	2	13.3	20*	13.3	15.5
	3	6.8	9.3	4.6	6.

Discrepancies which could be found in the responses and which contributed the highest figures to the X2 are marked *

There were no features of the responses on tables 90a-c which distinguished between the decile groups as a whole, but within each decile group the pattern of responses were found to be significantly distinct from that of the sample as a whole in some ways.

A higher than expected percentage of the lower scorers responses thought underusers did not care enough to attend clinic. Both middle and higher scorers were less likely to offer this as a reason.

Middle scorers were particularly unlikely to suggest underusers were lazy or idle.

Lower scorers were more likely to suggest the unpleasantness of the clinic as a reason for underusage, in contrast to higher users, who were more likely to suggest that it was because of the health visitor's interfering attitude. The middle scorers were more likely to suggest that mothers haven't got the time to go to clinic.

This table does not reflect what each group thought of themselves or underusers exactly, but which popular reason for underusage they invested in. Lower scorers then seemed more aware of the possibility of blame being put on underusers themselves, as uncaring mothers, or to see the clinic as being unpleasant. Middle scorers were more in favour of seeing underusage as a sensitive course of action for busy mothers. Higher scorers, were aware that the health visitor might be regarded as interfering, and unlikely to consider the clinic premises themselves as unpleasant as a popular reason for underusage.

Table 91a The importance of Services at clinic

Decile Group	Affirms Importance	Questions Importance	Denies Importance	T
Low	9	4	1	14
Medium	26	6	6	38
High	25	2	0	27
	60	12	7	79

The majority affirm the importance of checks. When the percentage response (out of responses from each decile group) are tabulated, there is a significant difference between frequency patterns for each decile grouping ($X2 = 35.838$, $df = 4$. $p<.001$

Table 91b Comparison of Table 91a with expected frequencies for sample as a whole

Response Type	Decile Groups % Low	Medium	High	Expected % sample
Affirms	64.3*	68.4	92.6*	75.1
Questions	28.6*	15.8	7.4*	17.26
Denies	7.1	15.8*	0 *	7.63

* indicates where observed freuqency of percentage response was noticeably distinct from the expected frequency percentage for the sample as a whole.

Lower scorers were slightly less likely to acknowledge the importance of health as a whole. Middle scorers were more likely to suggest that the tests could be irrelevant to a mother's real concerns. The higher scorers were unlikely to question either the relevance or importance of the checks.

Table 92a Adequacy of Home Visiting

Decile Group	Infrequent 1	2	3	Frequent 4	5*
Low	6	7	0	0	1
Medium	15	14	5	4	2
High	14	11	3	0	1
T	35	32	8	4	4

* 1. not as often as desired
2. not often but OK
3. only for problems
4. often and valued
5. often and reliable

The majority of responses indicated that the health visitor was not perceived as a frequent visitor, whilst attitudes toward this state of affairs was quite variable. When the percentage responses from each decile are compared there are significant differences in the frequency patterns within the deciles ($X2 = 37.494$, $df = 8$, $p, 0.001$)

Table 92b Comparison of % responses in Table 92a with expected frequency for sample as a whole

Response Type	Decile Group Low	Medium	High	Expected % whole sample
1	42.9	37.5*	48.3*	42.9
2	50 *	35	37.9	40.9
3	0 *	12.5*	10.3	7.6
4	0 *	10 *	0	3.3
5	7.1	5	3.4	5.16

$X2 = 37.4$
$df = 8$
$p< 0.001$

Only higher scorers were more likely to indicate they would like to be visited more often, whilst lower scorers and middle scorers were content with infrequent visiting. Middle scorers were slightly more likely to see increased frequency of visiting as an indication of a problem family, whilst none of the lower scorers mentioned this interpretation. Only middle scorers mentioned being well pleased with the frequent initial visits made by health visitor.

Table 93a Approachability of Health Visitor

Decile Group.	Approachable 1	2	3	4	Not Approachable 5	6	7*	
Low	3	6	5	0	2	2	0	18
Medium	12	8	4	5	5	3	4	41
High	11	4	3	1	4	3	3	29
T	26	18	12	6	11	8	7	88

* 1. Yes when necessary
2. Yes experienced and helpful
3. Yes, but mother does not take up
4. Yes, even has HV number to ring
5. No, HV takes no notice
6. No, order mothers around
7. No, never approachable

The most frequently offered response was that the health visitor was approachable, when it was necessary to see her. 20% of the responses were very positive seeing her as a very helpful, whilst a small percentage recognised that the health visitor was meant to be approachable but they would never do so (13%).

A very small percentage of responses indicated the health visitor to be totally unapproachable whilst the other 2 main responses complained of her being rude or ordering interviewees around. When the pattern of responses offered by each decile group are compared there were significant differences. ($X2 = 56.583$, dr = 12, 9, 0.001).

Table 93b Comparison of % responses in Table 93a with expected frequency for sample as a whole

Response Type	Decile Group Low	Medium	High	Expected % Whole sample
1	16.7*	29.3	37.9	27.9
2	33.3*	19.5	13.8*	22.2
3	27.8*	9.7*	10.3*	15.9
4	0 *	12.2*	3.6	5.2
5	11.1	12.2	13.8	12.3
6	11.1	7.3	10.3	9.56
7	0	9.8	10.3	6.7

X2 = 56.5
df = 12
p< 0.001

Lower scorers were less likely than the sample as a whole to see the health visitor as approachable when necessary, and the higher scorers particularly likely to offer this response. The lower scorers also tended to invest in a 'credible' health visitor, i.e. one who was herself an experienced mother - a less likely criteria to be offered by higher scorers. Lower scorers were more likely than average to acknowledge the purported approachability of the health visitor, but add that they would never do so. Middle scorers were keen to report the fact that they had been given the health visitor's telephone number as an example of how approachable she was.

Table 94a Maternal perceptions of health visitor role

Decile Group	Role Types 1	2	3	4	5	6 *
Low	4	7	5	2	1	3
Medium	16	7	6	4	5	4
High	12	3	5	5	4	0
T	32	17	16	11	10	7

* 1. Checks for child abuse
2. Not sure at all
3. Checks homes for cleanliness
4. Familiar with role through work
5. Just visits mothers
6. Problem solver

6. Problem solver

Checking that babies were okay, and not suffering from abuse was by far the most numerous response. The next most frequent response was puzzlement, those not sure what the health visitor was there for. Only 11% knew exactly what she was there for, as a result of their work experiences. The percentage frequency response pattern within each decile group was noticeably in favour of certain interpretations of the health visitor role. (X2 = 45.158, dr = 10, p,0.001

Table 94b Comparison of % responses in Table 84a with expected frequency for whole sample

Response Type	Decile Group Low	Medium	High	Expected % whole sample
1	18.2*	38.1	41.4	32.5
2	31.8*	16.7	10.3	19.6
3	22.7*	14.3	17.2	18
4	9.1	9.5	17.2*	11.9
5	4.5 *	11.9	13.8	10
6	13.7*	9.5	0*	7.7

Lower scorers were less likely to mention the health visitor role as a policing agent with regard to the detection of child abuse, but much more likely to mention her checking for household cleanliness, or to be unsure of her role altogether. Both middle and higher scorers emphasised her policing role in child abuse and not house checking, whilst only higher scorers claimed to understand her role well, which did not include problem solving.

The two features most frequently offered by the interviewees were of the policing type work, checking the child for abuse and the house for cleanliness, giving a picture of health visiting distorted in this direction. These were perceived as the two main features of her role for all respondents.

Table 95 Mothers assessment of baby literature
(Comparison of % responses with expected frequency for whole sample)

Response Type*	Decile Group Low	Medium	High	Expected % whole sample
1	16.7	43.6*	16.7	25.6
2	22.2	20.5	22.2	21.6
3	22.2*	10.3	16.7	16.4
4	27.8	23.1	38.9*	29.9
5	11.1*	2.5	5.5	6.3

X2 = 33.5
df = 8
p< 0.001

* 1. Informative
2. Good for problem solving
3. Of limited use
4. Too General/limited
5. Caused more worry

Responses were almost equally divided between books being regarded as informative and too generalised to be of any use. The most frequent response for both high and low scorers was to find them of no use or limited use, whilst middle scorers found them informative. Lower scorers were particularly likely to regard them as liable to add to one's worries.

Table 96 Relationship with general practitioner
Whole Sample

Reluctance to seek help	Relationship with GP Poor	Good	T
Yes	17	15	32
No	14	41	55
T	31	56	87

X2 = 5.601
df = 1
p< 0.02

For the sample as a whole there was a significant relationship between those expressing a reluctance to seek professional help, and having a

poor relationship with their general practitioner. For lower scorers, the association was especially marked ($X2 = 8.83$, $df = 1$, $p<0.01$).

The same was not true for relationships with midwives, the majority reporting there to be a good one (90%), or for relationships with health visitors, where a majority reported a good one (72%).

Table 97 Respondents Advice to others re clinic attendance

Decile Group	Advice Type 1	2	3	4
Low	80%*	0	6%	13%*
Medium	69%	7%	15%	7%
High	63%	14%	14%*	7%
Expected % whole sample	70%	7.5%	12.3%	9.4%

* 1. Unreservedly would recommend attendance
2. Yes with some reservations
3. No advice is conflicting and unhelpful
4. No, there is nothing to be gained from attendance

Lower scorers were particularly likely to recommend attendance, whilst high scorers were more likely than the sample as a whole to recommend attendance with some reservations.

Table 98 Changes mothers would like to see in provision

Decile Group	Changes recommended type 1	2	3	4	5*
Low	8	5	4	2	6
Medium	14	14	10	10	6
High	13	8	6	7	6
T	35	27	20	19	18

* 1. More care shown towards mothers
2. Change in hospital care
3. Social outlets for mothers
4. Change in HV service
5. Change in medical care

All groups were most concerned about staff showing more care and concern for mothers, and changing practice in hospital procedures towards this end.

Table 99 Mothers major losses since advent of motherhood

Decile Group	Loss Type 1	2	3	4	5*
Low	10	9	6	4	1
Medium	24	12	12	12	3
High	20	8	7	7	3
T	54	29	25	23	7

* 1. Freedom and time to oneself
2. Having ones own money
3. Work outside the home
4. A social life
5. No losses

Freedom and time to oneself were the most frequently mentioned privation, followed by missed personal income and work outside the home.

Table 100 Mothers intentions for change in any future pregnancy

Decile Group	Changes intended type 1	2	3	4	5*
Low	6	4	3	0	1
Medium	27	18	2	0	2
High	17	11	5	1	2
T	50	33	10	1	5

* 1. Not to worry as much
2. Use services differently
3. Breast feed successfully
4. Have a home delivery
5. Don't know

Half of the respondents would be less worried next time, whilst 1/3rd would use the services in a different way, namely by having more control over what happened to them (especially in hospital).

11.2. SIMILARITIES BETWEEN USER GROUPS - SUMMARY

On the following areas no significant differences could be found between the usage groups.

Table 73

There were no differences between groups in relying on family for help and advice, those who could, did regardless of decile membership. It seemed unlikely that underusers could be distinct in this respect.

Table 74

A majority (69%) of respondents felt equally uninformed about the services or what to expect regardless of decile position.

Table 75

The likelihood of reporting a bad hospitalisation was unrelated to subsequent uptake but may have contributed to a general poor expectation of the services.

Table 76

All groups were equally appreciative of the midwifery service

Table 77

There were no differences between groups in terms of the likelihood of having problems in preparing for their childs arrival

Table 78

There were no differences between groups in either the type or likelihood of experiencing problems on first coming home from

hospital, whilst for the year as a whole some differences between percentage responses were found.

Tables 79/80/81

With regard to the frequency with which the most frequently mentioned problems occurred, there were no significant differences between the groups. (tiredness, feeding, sleep loss).

Table 81

There were no differences of note between the groups with regard to their views on help and advice, the sample being more likely to report problems of being unsure of where to go, or finding self reliance the only solution to conflicting, or unsatisfactory help available.

Table 82

There were no differences between usage groups in the reporting of financial difficulties, which had been a problem for most.

Table 83

Illnesses suffered during the year did not produce significant differences between the groups in either incidence or type, most suggesting they had no time to be ill.

Table 84

With regard to illnesses their babies had suffered through the year, there were no significant differences between groups in either incidence or type. Respiratory infections and teething being the most common.

Table 87

All groups were similar in their perceptions of the clinics function, i.e. mainly for weighing and to a lesser extent, for advice, tests, socialising or post natal check ups.

Table 88

All decile groups preferred the pop in system at clinic to any other suggested.

Table 89

There was no difference between the groups in the likelihood of their regarding visits to clinic as a waste of time or their preferences for attendance.

11.3. DIFFERENCES BETWEEN USER GROUPS - SUMMARY

Table 80

There were some differences in the patterns of responses in relation to their usage position with regard to problems they had encountered during the first year as a whole. Lower scorers were less likely than the sample as a whole to report feeding problems or illness of their child as their major concerns. They were more likely to offer 'no problems' as such. Middle scorers were more likely to report feeding and illness of baby as problems and less likely to suggest they had no problems or a 'cranky' baby. High scorers only differed from the sample as a whole in offering having a 'cranky' baby as a major problem.

Table 86

Although there were no significant differences between deciles with regard to apprehension towards clinic attendance, (Table 86b) within the deciles the profile of responses were significantly different from that of the sample as a whole to warrant comment. Only the lower scorers percentage response profile contributed large X2 values, they were more likely to report being apprehensive about attending clinic for the first time (did not know what to expect and were fearful) and less likely to have positive expectations about going.

Table 90b

There were some differences in the profile of responses offered by the different groups with respect to their favoured explanations for underusage (not going to clinic). Lower scorers seemed more aware of the likelihood that underusage could be indicative of an uncaring mother; and that the unpleasant environment at clinic could put people off going. Middle scorers were more inclined to suggest that underusage was a sensible option for a busy mother, whilst higher scorers were more likely to suggest that an interfering health visitor could put people off going.

Table 91b

Lower scorers were more likely to question the validity and importance of the checks and tests carried out at clinic, unlike the higher scorers who were unlikely to question them at all and more likely than any other group to unhesitatingly affirm their importance. Middle scorers were more inclined to suggest that they may not be relevant to a mothers concerns.

Table 92b

Only higher scorers were more likely to indicate that they would like more home visiting from health visitors. Middle scorers tended to stress the supposed link between frequent visits and problem families. Lower scorers in particular were content with few home visits.

Table 93b

Lower scorers were less likely to regard the health visitor as approachable, high scorers being more likely to regard her as approachable. Lower scorers in particular valued an experienced mother as a health visitor. Lower scorers also tended to stress the fact that health visitors were meant to be approachable but were not really.

Table 94b

Lower scorers were less likely to stress the health visitor checking for child abuse, but more likely to stress her checking one's home for cleanliness, or to confess to being unsure of her role altogether. Both middle and higher scorers stressed her role as looking out for child abuse, whilst higher scorers were more likely to claim to knowing all about health visitor roles and relevances.

Table 95

Middle scorers were relatively more likely to regard baby books as informative. Both lower and higher scorers were more likely to regard them as of limited use or no use at all.

Table 96

Lower scorers in particular demonstrated a significant relationship between reluctance to seek professional help and advice and having a poor relationship with their doctor.

Table 97

Lower scorers were more likely to not recommend attendance than the sample as a whole. Higher scorers were more likely to stress its value to those who were desperate for help.

Table 100

Middle scorers were more likely to suggest that they would worry much less should they have another child, and stress that they would make use of the services differently. Lower scorers in particular claimed they would like to get breast feeding right next time round.