Positively Promising: Women's Decision Making
Pregnancy and Health Promotion

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I declare that this thesis is my own account of my research and contains as its main content work, which has not previously been submitted for a degree at any tertiary education institution.

[Signature]

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Abstract

This thesis explores the ways in which health promotion campaigns presuppose the pregnant subject and how main stream health promoters construct theories and practices of empowerment, health literacy and rationality.

Two Western Australian main stream health promotion campaigns directed at pregnant women in the period 1996 to 1997 (the time of interviewing) and still current at time of writing, will be analysed and comparisons made with the development of health promotion theory and practice generally. The normalisation of medical/scientific approaches toward pregnancy care and behaviour will be illustrated by providing examples from health promotion literature, medical and health journals, popular pregnancy books, magazines and newspaper stories. The assumption that health literacy is the major attribute necessary to enable empowerment is interrogated and the limitations of this perspective illustrated.

The second part of the thesis deals more directly with the interview material and illustrates how the women interviewed related to, and engaged with, main stream health information. The diversity within the group of middle class women interviewed is highlighted, and the different philosophical positions they occupy in relation to main stream health information explored. The complexity and contextual situatedness of women’s decision making in relation to notions about health literacy, rationality and empowerment is outlined. The concluding chapters of the thesis discuss the most recent developments in main stream health promotion theory, examining the limitations of social capital theory, social
marketing and other health promotion strategies. The conclusion imagines the possible benefits for women as health subjects and main stream health promoters as experts, in re-thinking rationality and re-supposing women as positive health subjects that are promising rather than permanently risky and in need of improvement.
Introduction

The main focus of this study is the decision making processes of two groups of women in relation to pregnancy and birth choices. The emphasis is not so much on why women made certain decisions, although this will be discussed, rather my main interest is on how women made decisions. This intrigues me because there is so much information, both main stream and ‘alternative’ available to women in relation to pregnancy and birth. I want to chart how women make sense of, and how they navigate their way through, what are at times, competing and contradictory perspectives and philosophies. Most importantly the thesis considers women’s decision making in relation to the diverse contexts within which they live and work. I will outline what they found useful and what they did not, discuss their reasoning for complying, or not, with the range of main stream and other health information.

I would like to start by clarifying how I use a number of terms that occur regularly in the thesis. When I use the term ‘main stream’ in relation to health information in this thesis I am referring to that which is based predominantly on medical and/or evidence-based research. This is most often, although not exclusively, the domain of health promoters and medical doctors, nurses and midwives, working within government health departments and hospital research institutions. My critique of the theory relates to that which is devised and written by main stream health promotion professionals (particularly those that write the text books used in health promotion courses) as well as those that work in bureaucratic,
professional settings, such as the Health Department of Western Australia. The practice of health promotion is less easily definable, however, my critique emphasises those practices of main stream health promotion as used by the Health Department of Western Australia, which include the use of media, newspapers and pamphlets. I also analyse a number of other main stream health promotion techniques, methods and strategies, including population-based epidemiology, social marketing and the use of ‘fear’ and ‘threat’ appeals. My critique is informed through the critical analysis of a selection of Australian and international main stream health promotion journals, pamphlets, midwifery and women’s health journals as well as sociological and feminist literature that critiques main stream health promotion and other health and pregnancy related issues.

My use of the term ‘main stream health information’ refers to that which is offered in many popular pregnancy books and magazines informed by main stream health promotion theory and practice. Although these sources also often include sections on ‘alternative’ or ‘complementary’ information, these are presented for the most part as merely an adjunct or addition to main stream medicine. My use of the term ‘health promotion’ does not only refer to main stream campaigns such as those that inform about the importance of folic acid and listeria awareness, but also the literature written more widely for popular consumption, that emphasises the importance of these and other campaigns in relation to smoking and alcohol intake during pregnancy.

When discussing ‘alternative’ information I am referring to those health strategies and practices that deploy more holistic notions about what constitutes health practice and
include, although are not confined to, herbal, homeopathic and spiritual health practices. The health professionals that might emphasise these are more likely to be working within community-based midwifery settings or women's health centres that are informed by feminist philosophies and the social model of health, although this is not always the case and this will be discussed in the thesis.

I first began to think about the politics of pregnancy information while I was doing my honours dissertation on In Vitro Fertilisation. Although not the topic of that dissertation, I was concerned that although there was a need for the social determinants of health to be more carefully considered in relation to infertility, that this focus was not as argued by some writers, necessarily any more empowering for women. Instead what resulted was that more attention was paid to individual women's diet, work and life style and that this did not necessarily shift the notion of individual responsibility for infertility. Later on, with the advent of two major health promotion campaigns promoting folic acid and warning women about the dangers of listeria contamination, I became more interested in how health promotion information affected women who were either pregnant or considering pregnancy.

The thesis has also been driven and informed by my on-going interest with what is defined as ‘rational’ in Western industrialised countries and how women, particularly pregnant women, have been and are positioned as decision makers with specific reference to mainstream health information. To this end I engage with philosophical literature about how rationality has been defined in western developed countries. This is in order to provide an
insight into how women’s engagement and interaction with main stream health promotion and other discourses pre-supposes them as particular kinds of rational decision makers. I refer to what I term the impoverished version of rationality so as to argue that the problem with traditional versions of rationality is not just that they historically and consistently construct women as irrational (this is rather an area for philosophers to explore and not the specific topic of this thesis) but that they also unnecessarily limit ideas about what is an ideal demonstration of decision making and pregnancy conduct.

I interviewed two groups of middle class women. One group gave birth in hospital while the other chose or intended to give birth at home. For reasons that will be detailed later women who chose to give birth at home are a very small minority. I felt it important to include them because I was interested to see if they made decisions, or incorporated main stream health information, in different ways to women who gave birth in hospital. More detail about the two groups of women will follow in Chapter 4. Women from diverse cultural backgrounds, lesbian women and many other minority groups are not emphasised in this study because I am critical of the notion that it is generally middle class women (whose first language is English) who comply with main stream health information and promotion. This does not mean that I think other groups of women are unimportant. I believe that much research still needs to be done in the area of how different groups of people receive and act on health information and the meanings this information may have for them. However, I really did want to explore to what extent middle class women, the so-called most receptive group did comply with, or disrupt, main stream health advice. In this study I will demonstrate how the women I interviewed made decisions that were based on
complex and diverse processes within what is too often I believe, dismissed as an uncomplicated, homogeneous group.

I also discuss in Chapter 4 my rationale for including women’s stories about their birth as well as their pregnancy for this study. What at first seems out of bounds as far as what I am looking at, that is, how women make decisions about health promotion in pregnancy, is in fact crucial in how the main arguments of the thesis are developed. Inclusion of the birth stories not only provides information about differences and similarities between and within the two groups of women interviewed, it also sheds light on notions of rationality, how empowerment might be re-imagined and most importantly what women themselves consider essential in decision making.

Ideas about how to behave when pregnant, or what are acceptable birth practices, are contingent on the society, culture and time in which we live. The cultural context in which the women I interviewed made decisions is that of a Western, industrialised country. This is a context where although there is increased scepticism and critique of science technology and medicine; these are nonetheless highly valued. There may be a little more caution about what science can deliver than in the past, but “good” science and health approaches based on these are viewed as the way forward (Bury, 1997, p. 171).

The context in which Western women inform themselves and make decisions about pregnancy and birth is summed up for me in the following quote:
“The enlightenment was a turning point in the history of medicine and civilization: the point at which the dialogue between reason and unreason was broken and irrationality came to be identified with immorality” (Wilson, 1993, p.1).

This relates to the women I interviewed for this study in a number of ways. Responsible citizens are enthusiastically encouraged to inform themselves, read widely and make responsible and rational decisions in a number of areas (Harris, 1994). In relation to pregnancy and birth this convention is particularly emphasised as a way of demonstrating one's moral responsibility, not only to self but also to the baby. Rational decision making in this context can only be demonstrated by way of careful compliance with main stream health information. Compliance is what defines responsibility; compliance is reason. Ways of managing pregnancy and birth are bounded by conventional Western ideas about what is rational and responsible behaviour and this is the case whether women use main stream or alternative approaches to pregnancy and birth. This study will demonstrate the instances where women both conform with and disrupt these boundaries. I want to propose ways of re-thinking rationality and responsible decision making in relation to how women engage with main stream health promotion information by demonstrating the complex ways in which women live in the 'everyday.' By analysing the ways in which women make decisions in relation to main stream health promotion information, pre-natal tests, information gleaned from doctors, midwives, relatives, friends and many other sources I will demonstrate the dissonance between what is deemed to be ideal pregnancy and birthing behaviour and how the women themselves define what is realistic for them as individuals. To do this I will illustrate how rationality has been defined and understood in western
developed countries (and include Australia within this definition). I will argue that decision making has increasingly become an individualised process, where the role of the decision maker is understood to be that of not only a rational and responsible person but also a literate and mostly isolated one.

Notions of what constitute good health and responsible health practice both on an individual and institutional level takes place within a Western model that emphasises the importance and authority of ‘rational’ and ‘objective’ science. This is not to say that holistic, complimentary or ‘alternative’ approaches are not given space. However, in relation to pregnancy and birth the stakes are considered high and these ‘alternatives’ are still viewed with a great deal of caution by main stream health providers, health promoters and in many cases by women themselves. One only has to consider birth choices to demonstrate the authority of the medical/scientific/technological model, what I will refer to in this study as ‘main stream’ approaches. The dominance of this model in Western Australia is evidenced by the fact that in 1998 (the time of interviewing) home births comprised of only (0.4%) of the total of 25,924 births recorded in the state (Gee, 1998, p. 45; Thiele & Thorogood, 1998, p. 1). Medicare does not cover home births and the funding that is made available by the government for this option is limited in Western Australia. Not only are most of the births in Western Australia hospital births, there are also high rates of caesarean births (23.4 %) of the total (Gee, 1998, p. 2). This dominant model is not only confined to birthing women; in relation to pregnancy ultra sound and many other pre-natal tests are considered routine practice. The thesis will detail how women who question these ‘routine’ practices must demonstrate they have made the decisions based on processes that
demonstrate the narrow definitions of rationality that will be explored in Chapter 6 of the thesis.

There is a perception that women are better informed about their options than they have been in the past both in popular and other literature (Stoppard, 1994, p. 8). Some feminist theorists have argued that women are not victims or cultural dupes but are making choices in relation to a number of reproductive issues (Campbell & Porter, 1997; Lupton, 1994; Sandelowski, 1994). This study similarly does not assume women are victims and will outline many examples of women critically engaging with main stream discourses. However, what will be argued is that it is difficult for women to question main stream health approaches because they are pregnant and may be subjected to severe social and in some cases, even legal censure if they do not make what are deemed the ‘right’ and ‘responsible’ choices (Duden, 1993; Keane 1996; Rhul, 1999). There is evidence from a number of different sources, including the verbatim comments of women in this study, to suggest that women's ability to change or question pregnancy and birth practices are still severely constrained (Duden, 1993; Keane, 1996; Rhul, 1999; Rodmell, 1992; Shuttleworth, 1993/1994).

The multiple and complex ways in which women play out their pregnancy roles are demonstrated in this study by analysing how they have engaged with main stream health discourse and practice. This includes describing their interaction with various members of the medical and health profession, their responses to questions about pre-natal tests, main stream health promotion and other pregnancy information. A great deal has been written
about these issues and continues to be so. For the purpose of this research these issues are raised in order to illustrate and support the argument that despite the rhetoric about informed choices, the women I interviewed made decisions within particular social, cultural and political contexts. Scientific and technological discourse and practice are not deployed unopposed or unquestioned, neither am I suggesting there is no place for them; they are nonetheless pervasive discourses in Western industrialised countries such as Australia (Bury, 1997). This is not to say that some of the ‘natural’ or ‘alternative’ discourses do not also demand compliance of a different sort, neither do they absolve women from making decisions in conventionally rational ways. We can question what is meant by ‘natural’ or ‘alternative’ and demonstrate that the ways in which these terms are deployed are themselves contingent on particular social and historical contexts. What will be explored in this study is that the women who interacted with and used the ‘natural’ and ‘alternative’ discourses articulated their feelings around birth and pregnancy in more positive terms than did women who used more mainstream approaches.

The study will contrast and compare points of difference as well as similarity within and between both home birth and hospital birth women. It will also examine how women are constituted in western society as rational actors who must manage pregnancy and birth responsibly and safely. I will explore how women described what they considered ‘safe’ and responsible birth and pregnancy practice and how these were sometimes quite different from the ways in which mainstream medical and scientific discourses constitute them. I will illustrate how the women I interviewed navigate between the different sources of information at their disposal. These are many and varied, for example advice from doctors
and midwives, health promotion campaigns, ante-natal classes, various support groups, family members, friends and popular literature.

Health promotion campaigns directed at women who are pregnant or considered ‘of reproductive age’ are of particular interest to this study given they are presented within the rhetoric of ‘well-being’, ‘social model of health’ and so on. There is a history going back to the Ottawa Charter of 1986 which claims that health promotion is based on a social rather than a medical model of health, that it transcends mere prevention or curing of disease (Palmer & Short, 1994). It is claimed that notions of health must include the emotional, mental and biological aspects of health. According to this discourse health is not just about the individual; it is about healthy communities, cities and so on (Breslow, 1996).

There has already been some considerable critique of health promotion's propensity to advocate structural and community approaches to health in theory, while in practice campaigns ‘target’ the individual (Breslow, 1996; Bunton, Nettleton, Burrows, 1995; Gabe, 1995; Hall, Birch, Haas, 1996). Most health promotion campaigns in Australia, Britain, United States, Canada and New Zealand continue to be delivered in ways that emphasise individual responsibility, assuming that responsible, informed individuals will comply with the directives which are based on ‘good’ science and evidence-based research. This mismatch between rhetoric and reality has already been well documented (Becker, 1993; Breslow, 1996; Hunt, 1991; Palmer & Short 1994). However, it is of interest to re-visit in terms of pregnancy and birth because there is more at stake here than just an individual
taking responsibility for themselves; there is also another being or potential being who must be considered. These issues have been raised by a number of theorists in different contexts and the point made that the foetus has become so prominent as a separate ‘person’ or ‘patient’ that women's interests are often superseded by what is considered best for the child (Duden, 1993; Keane 1996; Ruhl 1999). It seems to be generally accepted by both health providers and the general public that a woman will place herself ‘second’ to these interests. Pregnant women are potentially subject to far more public, expert scrutiny and censure than the general population. This will be discussed in the thesis by referring to the literature that outlines this occurrence in a number of different situations and contexts, as well as the verbatim comments of the women that were interviewed for this study.

Women are considered the guardians of good healthy habits for their partners and family and when pregnant this responsibility is extended to the foetus. Women are bombarded with a great deal of expert advice from health promoters when pregnant or considering pregnancy. They are advised not only to eat healthily but to abstain from smoking, alcohol, coffee, licit and illicit drugs, inhaling petrol fumes, avoiding stress, ensuring they exercise and many more (Cosic, 2001; Department of Health Western Australia, 1994, 1996, 1997, 1998; Ellis, 1993; Keane, 1996; Rodmell, 1992; Shuttleworth, 1993/94). As far as this study is concerned, I am interested in the contradictions inherent in health promotion theory and delivery. I want to demonstrate how the health promotion campaigns directed at pregnant women construct decision making within particularly confining boundaries that fail to recognise the every day realities of women's lives. Health promotion campaigns based on so-called good science also contribute to the construction of decision making as
an individual, rational enterprise. I want to chart how the women I interviewed responded to these campaigns in terms of dissonance between what they saw as ideal pregnancy behaviour and what they actually did, as well as explore some of the ambivalence women described in relation to these campaigns.

In the process of exploring how the women I interviewed made decisions given the plethora of main stream and other health information; I also had another aim. This was to ask them specific questions about the actual process of their decision making as they saw it. This was especially in cases where there was contradiction, difficulty or disbelief in relation to main stream or other information. This raised issues around how rationality and commonsense is described by the women themselves and what made for ‘good’ or ‘sensible’ and realistic decision making. Some of the women discussed the role of the body or the baby in relation to how they made decisions, others mentioned spirituality. I do not want to argue that women made decisions based on gut-feelings, but rather want to demonstrate how decisions are made within contexts that are shifting. For example, a woman may read about an issue but will also be guided and informed by how she has previously experienced a pregnant body. The ways in which bodies are experienced is of course also mediated by discourse, and while I acknowledge this, most of the women I interviewed described their bodies in terms of what would be described by social theorists as a modernist, and in some cases essentialist discourse (Keane, 1996; Luke, 1992; Marshall 1996). This is an interesting area to explore because in this study women who had experienced previous births for example, were less influenced by main stream health literature and more likely to rely on bodily cues. I will argue for a more positive reading of
these bodily cues and so-called ‘modernist’ discourses as this complicates the simplistic understanding of what constitutes the basis for responsible decision making in pregnancy. There are a number of these ‘grey’ areas and I will tentatively attempt to tease some of them out so as to suggest ways of re-supposing women as decision making, pregnant subjects.

To further explore how definitions of what constitutes rational, common-sense decision making are constructed I will illustrate how women described their interaction with health professionals and various groups. These include midwives (home birth and hospital based) doctors and obstetricians, ante-natal classes, yoga groups and other support groups. I will discuss how home birth women describe having more space, opportunity and time to discuss issues and ask questions of midwives than hospital birth women did of doctors. Most of the home birth women belonged to one or more pregnancy support groups whereas hospital birth women tended to be more isolated or in more formal institutionalised settings such as hospital based, ante-natal classes. Whether hospital or home birth, ‘main stream’ or ‘alternative,’ the women I interviewed would describe their decision making in terms of being informed, reading widely and to varying degrees, discussing issues with other people both expert and non expert. What differed was the emphasis or importance placed on each of these factors both between and within the two groups of women. I will also highlight that even when women assume the mantle of health literate subject as defined by main stream health promoters, they do so in particularly strategic ways that do not always result in complete compliance with main stream health promotion directives.
By exploring how women have interacted with various pregnancy, birth and other sorts of support groups, I want to draw out how decision making that is informed by relational and social processes, and is not such an isolated and individual process may have real benefits for some women. I then want to go on to speculate how, from this, more complex ideas about what constitutes rationality and empowered health subjects can begin to be discussed. At the same time I do not want to idealise or privilege one kind of decision making over another. Groups and communities can also be oppressive in different ways and the study will illustrate on occasion how the women interviewed described this.

The concluding chapters of the thesis discuss the issue of empowerment, what it means for women and how it can be re-orientated to encompass more than improved health literacy. I am concerned with the way in which health literacy is automatically linked with empowerment. I discuss some theories outside of the bounds of mainstream health promotion that are useful starting points in this regard, theories that critically examine the capacity for experts to enable empowerment of the groups of people with which they are working (see Everingham, 1996 and Van der Plaat, 1999). I analyse some of the later developments in health promotion theory point toward some health promoters beginning to question the philosophical and research bases of mainstream health promotion (see Atrens, 2001; Erben, Franzkowiak, Wenzel, 1999; Labonte, 1999; 2001; Leeder & Dominello 1999; Moodie & Borthwick, 2001). These include the use of social capital perspectives within the main stream theory and I will discuss how these may be less useful than imagined by health promoters for addressing issues of empowerment (see Erben, et al. 1999 and Gleeson, 1999). The final chapter will reflect upon the processes of health promoters and explore
ideas and strategies that have been used in community development and other community settings and will make suggestions about how these might inform future health promotion approaches.

Essentially what I want the study to draw out and to argue is that what is considered rational, what is considered empowering, and what is considered good decision making, may be re-imagined and that this may have benefits for women and main stream health promoters. There are multiple ways in which women make decisions, these are contingent on particular social, cultural and historical contexts, whether a first, second or subsequent pregnancy and so on. I hope to illustrate in this study the richness and complexity of the women's lives in order to offer a constructive critique of conventional Western ideas about rationality, main stream health promoter's definitions of responsible decision making in relation to pregnancy and birth, and what might contribute toward strategies that are empowering. The thesis offers suggestions about how rationality, empowerment and the construction of women as pregnant subjects may be re-supposed as well as how main stream health promoters might address some of the reservations they hold in relation to their theory and practice.
The Health Promotion Context

This chapter outlines some of the international influences on the development of health promotion theory and practice in Australia. Australian responses to these are discussed along with an examination of the major strategies used. The chapter illustrates the staying power of particular philosophical positions within professional health promotion. The emphases on particular strategies in Western Australian main stream health promotion campaigns, in the period 1996 to 1997 (the time of interviewing) are analysed and comparisons made in light of the national and international trends. In particular the dissonance between health promotion rhetoric in relation to empowerment and addressing structural determinants of health, dating back to the 1986 Ottawa Charter, and the actual practice of health promotion campaigns is examined (Ottawa Charter, 1986).

Health promotion is a relatively recent strategy for addressing health and illness in society. Up until the 1970s health professionals concentrated their efforts in the three main areas of public health (more narrowly defined than present), doctors and hospitals, and health education. Public health was concerned with providing clean water and sewerage facilities, doctors and hospitals provided “cures” and health education adopted a “top down” approach in the provision of health information (Richmond, 1998, p. 157). This means people were instructed rather than persuaded in relation to a range of health behaviours. For example school nurses would conduct health checks on school aged children and instruct them on the benefits of personal hygiene and so on. It was understood that the health
professional was the expert and the health subject was constructed in terms of individual pathology and biology. In 1948 what has been described as a “revolution” in terms of how health is perceived occurred when the World Health Organisation (WHO) defined health as: “a state of complete physical, mental and social well-being, not merely the absence of disease or infirmity” (Shearman & Sauer-Thompson, 1997, p. 11). In 1974, WHO published a number of reports emphasising the social, cultural and economic contexts of health (Richmond, 1998, p. 158).

These World Health Organisation (WHO) reports included the Alma Alta Declaration of 1978, the Global Strategy Health for All by year 2000 (1981) and the Ottawa Charter of 1986 (Richmond, 1998, p. 158). The Ottawa Charter, in particular, was important as the seminal document outlining the philosophy and practice of health promotion. This document is invariably referred to either directly or indirectly in much health promotion theory and discussions about health promotion in books and journal articles (see Ashton & Seymour, 1988; Catford, 1997; Egger, Spark, Lawson, Donovan, 2002; Germov, 1998; Germov, 2002; Gleeson, 1999; Nutbeam & Harris 1999; O’Connor & Parker, 1995; Shearman & Sauer-Thompson, 1997). Health promotion was seen as a departure from the old authoritative methods of educating people about health issues which failed to acknowledge holistic interpretations and structural determinants of health. The new model emphasised the positive promotion of health, prevention rather than cure, persuasion rather then instruction. It importantly viewed community participation in health promotion strategies as essential suggesting that this could only be achieved by the empowerment of
communities and individuals. It also challenged medical orthodoxy in relation to how health issues were responded to.

Empowerment was understood to be a process whereby individuals and communities identified their own health needs and wants, and articulated and devised their own strategies to deal with them. A health promoter's role was seen as facilitative and enabling rather than instructive. Health promoters were also constructed as radical political lobbyists, far removed from the health mainstream and instrumental in politicising the arena of public health. A health promotion informed by the Ottawa Charter adopted a structural as well as an individual view of health issues, citing the importance of public health policy and the recognition of social, cultural, psychological, spiritual and economic factors affecting the health of individuals and communities.

One of Australia’s first responses to the WHO series of reports referred to above, was the publication of The Health for All Australians report in 1988 (Health Targets and Implementation (Health for All) Committee, 1988). The contents of this report outlined the ideal directions for Australian health promotion and could be described as Australia’s version of the Ottawa Charter. Unfortunately many of the areas of concern prioritised by the report were never addressed and much of the funding set aside for the delivery of programs was absorbed in the building up of health promotion infrastructure and bureaucracy. After the initial confusion in relation to health priorities and strategies, an agreement in 1994 by federal and state governments enabled a more systematic approach.
This was due to the setting of specific health targets that provided an environment for the institutionalisation (and professionalising) of health promotion (Richmond, 1998, p. 158).

Approaches to Australian health promotion share many of the characteristics of other Western developed countries such as Britain, Canada, United States of America and New Zealand. For example, responses to health issues are framed within a public health policy that reflects the philosophy of the Ottawa Charter 1986 and other key WHO initiatives. It also differs from these other countries in that it does have a strong, established infrastructure and bureaucracy that was there from the beginning, such as in the establishment of the Better Health Commission in 1985, and consequently the setting of national targets that has ensured funding and the growth of health bureaucracies to administer these (O’Connor-Fleming & Parker, 2001, pp. 58-60). However, while in some ways this may seem an advantage to more ad hoc approaches and less reliable sources of funding, it has resulted in a more conservative approach toward health promotion campaigns (Palmer & Short, 1994; Knight 1998). The health issues that are researched and promoted are usually those easily quantifiable, measured within the framework of epidemiological approaches and risk assessment. That is, they are for the most part, large-scale, concerned with the health of national populations rather than specific small groups. They are also conservative in the sense that ‘value for money’ must be demonstrated within relatively short time frames. Finally, Australian health promotion has also emphasised individual and lifestyle approaches rather than the more radical elements of health promotion that address major structural inequalities and environmental issues (Erben, Franzkowiak, Wenzel, 1999; Gleeson, 1999; Palmer & Short, 1994).
This emphasis on the individual’s lifestyle has been partly attributed to modern interpretations of “well-being.” Shearman & Sauer-Thompson (1997, p. 12) maintain that in 1948, the World Health Organisation’s (WHO’s) definition of “well-being” in the historical context of a “world shattered by war” probably referred more basically to: “food, shelter, employment, peace and freedom.” This contrasts with the modern context where “well-being” refers more expansively to the “desires of each individual” and incorporates such things as emotional and psychological wellness (Shearman & Sauer-Thompson, 1997, p. 12). While this has advantages, in that what is defined as ‘good health’ is more holistic, it also reflects Western attitudes in relation to individualism and individual responsibility for health. In this context health risk in a Western developed country such as Australia, can only be managed by relying on medicine and science to provide both the ‘facts’ about risk as well as advice about how best to deal with it. The risk discourse informing health promotion will be returned to at a later point, for now the strong individualist basis of Australian health promotion will be discussed.

The emphasis on the individual in health promotion theory and campaigns has endured over time, with articles published in the Health Promotion Journal of Australia and other health promotion publications commenting on the historical lack of acknowledgment by health promoters of the structural inequalities that persist (see Daly, 2000; Gleeson, 1999; Hanvey 1996; Labonte, 2001; Seedhouse, 2001). Exploring the interplay between the social context and the status of people’s health, Daly (2000) asserts that:
“One of the most persistent and resistant problems in public health is the impact of social disadvantage on health. We know it is there, we know it is getting worse, but we don’t know what to do about it; and so we avert our eyes, turning instead to the problems we think we can address – getting children immunised, encouraging the young to practise safe sex, and keeping the aged active” (p. 4).

Gleeson (1999, p. 183) echoes the concerns about Australian health promotion’s failure to adequately respond to the social context in all its diversity, despite the appearance more recently of new, seemingly more socially aware and egalitarian theories such as that of social capital. Gleeson (1999, p. 183) observes that social capital theory has been taken up by health promoters and others working in the area of public health because it is a term that is amenable to economists and politicians. I would add that it has perhaps become even more potent in recent years with an Australian government increasingly free-market oriented (since the Hawke government of 1983) and choosing to adopt policies that reflect a heightened concern with Australia’s position as a player in the global economy. Erben, et al. (1999, p. 180) also refer to the construction of “homo oeconomicus sanitatis” through the use of social capital theory, resulting in health subjects that are the: “health entrepreneur – the individual who sees health as a powerful ingredient for improving his/her chances in the market of social opportunities.” While the usefulness of social capital theory is debated amongst health promoters, concerns are raised by Gleeson (1999, p. 183) that it may be interpreted to support: “a conservative agenda of economic rationalism, the reduction of social infrastructure and the shifting of responsibility from social institutions to families and communities.” The emphasis on ‘the market’ and economic viability of health
promotion campaigns that can demonstrate quantifiable health outcomes has underpinned Australian health promotion theory and practice at least from 1993 to the present and is a point returned to later (see Gleeson, 1999; Hawe & Shiell, 1995; King, Coppel, Stoker, Noort 1995; King, 1996; Viney, 1996; World Bank 1993). In recent years the popularity of social marketing as a tool for mainstream health promotion has served to perpetuate this linking of health promotion with the market and to construct health subjects as consumers (Egger, et al. 2002; Nutbeam & Harris, 1999).

The philosophies that underpin the research basis and actual delivery of health promotion campaigns in Australia would seem to be at odds with the recommendations of The Ottawa Charter. The Ottawa Charter identified five major action areas as essential strategies for health promotion: “build healthy public policy, create supportive environments, strengthen community action, develop personal skills, reorient health services” (Ottawa Charter 1986 & see Appendix 2). The World Health Organisation report of 1993 expressed the desirability of a holistic approach to health (World Health Organisation, 1993). Subsequent reports while also documenting the importance of holistic, ecological and social models of health have not resulted in campaigns that reflect these philosophical stances or practices (Daly, 2000; Richmond, 1998; Shearman & Sauer-Thompson, 1997). The individual health consumer is targeted most usually in terms of chosen lifestyles with far less emphasis on the lobbying of major institutions and governments in relation to structural, social and economic inequality (Bunton, Nettleton, Burrows, 1995; Daly, 2000; Moodie & Borthwick, 2001; Richmond, 1998; Richmond, 2002). The tendency of health promotion campaigns and information to emphasise the role of the individual and de-emphasise the influence of
structural factors continues to be the subject of on-going critiques of health promotion. The emphasis on individual responsibility for a healthy lifestyle has been noted as a recurring theme in health promotion campaigns in Britain and Australia (Beattie, 1991; Daly, 2000; Labonte, 2001; Moodie & Borthwick, 2001; Richmond, 1998).

The Ottawa Charter while not privileging lifestyle approaches to health nevertheless mentions that personal skills are important in the attainment and maintenance of good health and well being (Erben, et al. 1999, p. 179). The attainment of personal skills is not favoured by The Ottawa Charter over the other four major strategies; however it seems that it is this particular component that is inevitably emphasised by health promoters in Australia and other Western industrialised countries. Much of the critique of health promotion suggests that this may be because it is easier for health promoters to devise strategies targeting the individual’s lifestyle than it is to effect major structural and environmental changes (Bunton, et al. 1995; Daly 2000; Keane, 1996; Palmer & Short, 1994; Ruhl, 1999). While this does not just occur in Australia the institutionalisation and professionalising of health promotion from the outset has ensured a particularly strong emphasis on the individual and lifestyle approaches toward health promotion campaigns.

Health promotion text books similarly emphasise personal skills such as rationality, literacy and cognitive preparedness to accept health promotion messages (Egger, et al. 2002; Nutbeam & Harris 1999). The emphasis on personal skills in health promotion discussion and evaluation of campaigns published in main stream journals such as The Health Promotion Journal of Australia and The Australian and New Zealand Journal of Public
Health revolves around such definitions and terms as “health-literacy” “satisfactory knowledge” about a particular issue, and “satisfactory practice” of a particular behaviour (see King, 1996 and Stafford, McCall, Logan, 1998). While these terms are used in health promotion campaigns generally (health literacy is particularly important) they acquire an intensified potency when referring to pregnant women and their responsibility for the foetus, as does the moral imperative to comply. As Seedhouse (2001, p. 2) asserts “Health promotion goals are mostly pursued as if they are unambiguously moral.” The health promotion campaign based on ‘evidence’ that clearly and simply demonstrates a cause and effect, for example, that spina bifida in babies is caused by a lack of folate, makes non-compliance with advice difficult.

It is obvious that there is enormous pressure brought to bear on women to comply with health promotion campaigns, particularly in relation to pregnancy. Women are not only responding to campaigns in a context of ‘healthism’ (the emphasis on health as an ultimate value) but also as pregnant women who are more likely to be publicly scrutinised by a range of people, including, medical professionals, partners, family members and even complete strangers. This emphasis on the personal skills or behaviour of the pregnant individual is not recent. Shuttleworth (1993/1994, p. 39) discusses the pregnancy manuals for pregnant women in the Victorian age directing women to maintain a tranquil emotional state while pregnant, while Wilson (1993) uncovers an even earlier example of pregnancy directives.
In the 1780's French Physicians were advised to ensure that a pregnant woman understood that:

“She should avoid fatiguing herself or being too idle. Occupy herself agreeably - hours of repose with short walks. Not exposing herself to great wind or humidity. Her home should be located on a spacious street, far removed from sewers, cemeteries, hospitals, tanneries and laundries. In the countryside she should be on a dry plain, away from stagnant river and marshes” (Wilson, 1993, p. 147).

Modern versions of this advice were presented in Western Australian health promotion literature in 1996 and 1997 (the time of interviewing) and also appear in current campaigns, the difference is that now they target pregnant women rather than physicians. The health promotion pamphlet on 'Pregnancy' published by the Western Australian Health Department also advises women to rest, but not too much, to exercise, but not too strenuously (Health Department of Western Australia, 1996). Pre-pregnancy as well as pregnancy information advises pregnant women to avoid environmental hazards such as dangerous work places and leaded petrol (Rothman, 1994, p.12). There are some similarities in the assumptions made by current health promoters to those in the past in relation to health information. One of the assumptions is that women are all equally able to access ideal economic and living conditions. Another is that there is a level playing field in terms of attaining health and well being and that all that is required is the correct information and the correct response (compliance) to that information. That this process is by no means as straightforward as it seems will be demonstrated in this thesis both by
examples from the literature and from the comments of the women interviewed for the study.

The complexity of decision making as rational actors within a risk society is outlined by Ruhl (1999) who focuses on the dilemma of pregnant women making choices in a context of potential social censure and disapproval, observing that: “establishing their status as liberal individuals, and conforming to a ‘natural’ standard of behaviour considered suitable for pregnant women” is particularly fraught (p. 14). That this situation is confusing and complex for pregnant women will be further expanded upon in the second part of the thesis. Here the women who were interviewed articulate the contradictions inherent in simultaneously being constructed as well informed and critical middle class subjects, while at the same time being expected to be wholly compliant and non-questioning in relation to mainstream health promotion.

The middle class values underpinning much of health promotion in Australia are similarly evident in other countries and other types of expert information (Bunton, et al. 1995; Harris, 1994). There seems little or only passing acknowledgment of the every day reality in which many people live. For example, whilst the earlier advice about living on a spacious street would not have been a possibility for a working class woman, so too, may it be difficult for other than very privileged women in the present day, to avoid leaded petrol or dangerous work places (Rodmell, 1992).
The tendency to intellectualise about health in abstract terms and to emphasise the individual responsibility of people without acknowledging the social and environmental contexts in which they live is noted in recent writing about health promotion. Social capital theory has not eventuated in health promotion campaigns that address structural concerns. Erben et al. (1999, p. 181) who are sceptical about the overuse of the term “social capital” describe this latest development in health promotion theory as a move away from the objectives of The Ottawa Charter with its explicit stance and acknowledgment of the social, cultural and economic contexts of health, stating that: “in this intellectual exercise we seem to have forgotten that health promotion supposedly links to real people living under real living conditions that in most cases are not conducive to their health.”

Other examples of this propensity to intellectually abstract or disembodied the subject from the everyday have been reported in a critique of North American health promotion as well as news stories in Western Australia. In a study comparing health promoter's responses to drinking alcohol in pregnancy in North America and Australia, Keane (1996) notes some differences in approach due to: “Australia's distinctive history of alcohol use and the relative subduedness of foetal rights discourse in this country” (p. 264). In North America, health promoters have emphasised the dangers of foetal alcohol syndrome, for example, posters illustrating small-for-dates babies as well as babies with deformities that are a consequence of foetal alcohol syndrome are visible not only in clinics but also bars and places where alcohol is sold. This has not occurred in Australia where advice about alcohol in pregnancy is framed within a context of uncertainty about the consequences. In Western Australia, the Healthy Pregnancy (1996) pamphlet instead cautions, that:
“It is best not to drink alcohol while you are pregnant. Alcohol can affect the unborn baby’s development. It is important to be particularly careful during the first few months you are pregnant.”

However, even this relatively qualified approach by health promoters in comparison to North America is still a sterner position than that advocated by doctors. The National Health and Medical Research Council (2001) states in the Australian Alcohol Guidelines: Health Risks and Benefits that:

“the literature review undertaken for these guidelines found no definite evidence that low-level drinking causes harm to the unborn child. Other authorities have, nevertheless, recommended no drinking during pregnancy” (p.16).

Some of the women I interviewed were mindful of the stronger stance in relation to complete abstention of alcohol and I will return to this later on in the thesis. Women in Western Australia are likely to be knowledgeable of developments in North America and the stronger stand against any alcohol at all in pregnancy as the following example demonstrates. A story in The West Australian (Bower, 1998, p. 19) sensationally entitled “Drinking mums-to-be face jail until babies born” describes how: “women who drink alcohol during pregnancy face jail under new laws in two American States.” The report is particularly moralistic in tone about a Florida Supreme Court that refused “to pit woman against foetus.” It goes on to state that: “many Americans, however, sympathise with Scott
Eccaruis, the senator who pushed for South Dakota laws and says of drinking and drug taking, that no woman has the right to do that to a child.” Furthermore, it is stated that: “health officials estimated last year that 140,000 woman had a least one alcoholic drink a day, classifying them as frequent drinkers and putting their babies at risk.”

Keane (1996) notes that although there are differences between the North American and Australian attitudes toward alcohol in pregnancy, that is, a higher cultural tolerance and acceptance in Australia toward alcohol generally, there are signs that approaches to this issue in Australia may begin to reflect North American ones. The insistence by health promoters (and many of the popular pregnancy books) that there should be complete abstinence from alcohol, not only for pregnant women but also those planning pregnancy should, according to Keane (1996, p. 267), be seen as much more than: “straightforward medical advice, if such a thing exists.” Rather she claims that this advice represents:

“A desire to reclaim the uterus as a space of purity on behalf of the foetus, to overcome the leakiness and permeability of the female body and to demarcate the uterus as a space which may be physically inside but is morally external to the woman’s body” (Keane, 1996, p. 267).

The discussion above demonstrates that a simple critique of the medical model does not provide an explanation for the moral imperative for pregnant women to completely abstain from alcohol. In this instance it is not medical doctors who are entrenched in a purist position of complete abstinence. Furthermore, the adoption of holistic and social models of
health does not in itself necessarily translate into practices or campaigns that subvert the
individualising tendencies of health promotion, nor does it contribute toward more
empowering models. The ever-expanding notion and increased interest with what
constitutes health and healthy behaviour (sometimes referred to as ‘healthism’) has resulted
in health promoters’ potential to act in ever increasing areas of people’s lives.

Health promotion campaigns in Australia and other developed countries reflect the notion
of health as an ultimate value, a goal that is never attained, but rather as one that is
constantly worked for (Becker, 1993; Thorogood, 1992, pp. 61-62). It is described as a
state that enables an individual to attain total well-being. So even being happy is perceived
as important in achieving total well-being or good health (Australian Institute of Health and

The preoccupation people have for their own personal responsibility in relation to health is
accompanied by an increased and expanding awareness of multiple risks to health. These
risk discourses inform health promotion campaigns and people’s responses to them. In
relation to health promotion generally Richmond (1998, p. 151) argues that there is a notion
that risk is everywhere, further that the meaning of what constitutes risk has changed. Risk
that was once “an economic notion related to liability” has taken on new and expanded
meanings. It has been interpreted by health promoters in ways that move it beyond a
mathematical term to implying that there is ‘danger’ and that this ‘danger’ and risk is
everywhere and always present. It is also an inherently negative concept according to
Hanvey (1996, p. 10) who claims that “the process of risk focuses on the negative; it
focuses on weaknesses instead of strengths, limitations instead of abilities.” It also results in an emphasis on the ‘problems’ with particular groups or individuals and the prediction of problems, rather than concerted efforts at solutions (Hanvey, 1996, p. 10).

Another consequence of the emphasis on risk is that while it may seem like a measured and logical way in which to frame responses to health issues it fails to acknowledge the context within which these occur. Risk assumptions presuppose autonomy for all and an ability to make unhindered and free choices to address risks (Knight, 1998; Rhul, 1999). Becker (1993) and Richmond (1998) observe that the belief that risk is everywhere constructs health subjects with an overweening anxiety about their own bodies, seemingly the only thing they can have some modicum of control over. The use of risk categories are also not value free, as Hanvey (1996, p. 9) asserts “it [risk] involves someone else deciding what is ‘normal.’” When middle class women are exhorted to read widely and inform themselves about pregnancy behaviour they do so within particular benchmarks of what is considered acceptable and unacceptable risk. There are expectations and assumptions from both proponents and critics of health promotion that middle class women as a group are more likely than others to understand the importance of, and comply with, mainstream health promotion advice. It is also assumed that as they are considered more likely than other groups of women from working class, culturally diverse or young women, to be rational and literate, they will assess risks and choose the correct course of action in response. A literate, tertiary educated, English speaking, middle class woman is considered the most adept or able to calculate risk and therefore more compliant in comparison with other groups (Bower, et al. 1997, p. 720; Bower, Blum, Watson, Stanley, 1997; Rapp, 1998;
Torvaldsen, Kurinczuk, Bower, Parsons, Robertson, 1999). The second part of the thesis will demonstrate how women who are adept at assessing risk may also be armed with the knowledge that enables them to question, disagree with and confound simplistic risk discourses (cf. Rapp, 1998). However, for now I want to discuss how risk has been described in the critique of mainstream health promotion and further how this relates to decision making.

In relation to pregnancy, Rhul (1999) discusses how risk discourses underpin decision making. Here “responsibility is equated with the capacity to behave rationally, presupposing a calculation of expected benefits and risks” (Rhul, 1999; p. 95). The desired consequence of this calculation is then a decision that enables the greatest possibility of benefit with the least risk. The assessment of risk, is according to Landsman (1998, p. 77) inescapable. Discussing how risk discourse underpins decision making in relation to prenatal tests and the use of technology Landsman (1998, p. 77) makes the following observations. She argues that the inevitable engagement pregnant women have with prenatal testing, even the knowledge that the tests exist, means women are compelled to start assessing risks even if they choose not to avail themselves of them. The developments in science and technology have in turn enabled the possibility or conditions for the use of risk as a means to address health issues as well as a rationale for the practice of health promotion. Citing Skolbekken, Hanvey (1996) notes that:
“Skolbekken attributes it [risk] to the developments in science and technology, for example, we have more sophisticated probability statistics and computer technology, and a greater focus on health promotion and risk management” (p. 2).

As will be discussed throughout the thesis, the result for pregnant women as decision makers is an anxiety about how the ultimate state of perfect health is to be achieved and how one can demonstrate rational agency in the attainment of health objectives. The dilemmas associated with this are particularly intensified in the case of pregnancy, where pre-natal and genetic tests can present women with information that indicates the foetus they are carrying is less than perfect. Eccleston (1996, p. 15) cites Haan, who describes Australian society as “intolerant of imperfection.” The notion that as long as women receive accurate information and avail themselves of all the pre-natal tests considered necessary to eliminate the risk of giving birth to a less than perfect baby is not confined to Australia. Intolerance to imperfection has been noted in other Western developed countries as Landsman (1998), in a study of North American attitudes toward disability points out:

“Within the current cultural context, the prevailing discourse of choice and control enables people both to imagine the possibility of ‘perfect’ babies and to see ‘less than perfect’ children as the justifiable outcome of an individual’s less than perfect choices” (p. 95).

This concentration of individual effort to minimise ‘risk’ is expected by health promoters with behaviours in opposition to this defined as ‘risk-taking’ and therefore irresponsible
and even immoral. Once again this does not just occur in the area of pregnancy, young people who do not heed health promotion advice in relation to licit and illicit drug use or safe sex messages are similarly categorised as “risk-takers” (Hanvey, 1996, p. 6). That women should evidence their status as good pregnant persons by complying with health promotion advice and presenting for pre-natal and genetic testing is also acknowledged as responsible by society in general. This responsibility extends not only to the woman's own pregnancy and the health of the foetus, but is also perceived within a context of scarce health funds, as preventing costs in relation to caring for those with debilitating health conditions or disability. For example, the current health policy in Australia describes this as the “burden of disease” (Australian Institute of Health and Welfare, 1999, p. 3). While these attitudes may be pervasive and influential they are not shared by all. Main stream opinion is challenged by many of those already born disabled, who maintain their quality of life is good and who find the increased focus and zealous effort expended on producing only perfect babies somewhat confronting (Eccleston, 1996, p. 15). The pre-occupation with health, perfection and anxiety about risk factors in relation to health more generally is described by Richmond (1998, p. 161) as quite ironic, considering that in the industrialised countries at least, most people [with the exception of Indigenous peoples in Australia] are experiencing longer life expectancies and more attention is being paid to addressing and decreasing environmental risks. Another example of the pervasiveness of globalised risk in relation to pregnant women is evident in the ways in which they are categorised in obstetric evaluations as “low risk” or “high risk.” A “no risk” category does not exist and is never used (Ruhl, 1999, p. 101).
As previously mentioned the general critique of health promotion has mainly been concerned with its persisting emphasis on individual lifestyle and risk factors rather than on preventative public health and structural aspects of health promotion (see Daly, 2000; Gleeson, 1999; Parish, 1995; Richmond, 1998). This critique is mostly evident in the literature published by social scientists with some from health professionals involved in the practice of health promotion (see Bunton, et al. 1995; Daly, 2000; Palmer & Short, 1994; Richmond, 1998; Shearman & Sauer-Thompson, 1997). The critique in relation to pregnancy has particularly focussed on areas such as alcohol and substance abuse and the representation of women as little more than uterine environments (see Duden 1993; Hodson, n.d.; Lupton, 1994; Keane 1996). These issues have generally been raised as areas of concern by feminist informed writers from a number of disciplines. There are a number of other tensions that arise in relation to Australian health promotion, and it is to these that I now turn.

The first of these is health promotion campaigners' assumptions about autonomous, empowered, literate and rational subjects, reading and complying with the information presented. The particular notions of what constitutes responsible decision making will be explored and women’s historical marginalisation from, or at best peripheral association with, rationality detailed in another chapter. However, this chapter will discuss rationality in terms of how it relates to health literacy, a personal skill held in high esteem by health promoters, medical and health professionals and workers (Bresolin, 1999; Egger, et al. 2002).
Another tension that will be explored in this chapter is the dissonance between the rhetoric of health promotion theory and the ways in which the campaigns are practiced particularly in relation to the issue of empowerment. The stated need to incorporate structural concerns and move away from lifestyle perspectives that are individually biased, is one example of this. That very little progress has been made in this regard is apparent in critiques of health promotion generally, and in this study particularly in those campaigns directed at pregnant women (see Daly, 2000; Kickbush, 1998).

The claim by many health professionals that health literacy is the key to empowerment needs to be qualified and its potential influence carefully examined. As far as pregnant women are concerned the converse could be argued. That far from the health promotion advice empowering them it may instead present them with an anxiety producing checklist of demands. The linking of health literacy as a contributor to empowerment is similarly asserted by women’s health and community workers, community midwives and those involved in community development (Boston Women’s Health Book Collective, 1992; Hunt, 1991; Morison, Percival, Hauck, McMurray, 1999). The idea that health literacy holds the key to empowerment is then fairly well entrenched within the health systems of Western developed countries including Australia.

Health Literacy

There are a number of examples within the main stream health promotion literature advocating the importance of health literacy. The notion that a health literate person has the
ability to gain access to and use information is based on Western ideas about sovereign individuals and their right to act autonomously. Literacy is understood to be an individual’s ability to read and understand written text as well as the ability to communicate by writing. The Health Promotion Journal of Australia, The Journal of the American Medical Association, The Australian and New Zealand Journal of Public Health define health literacy in terms of an individual’s ability to seek out, read and understand health promotion advice and use it, by responding positively to its instruction, as a rational, learning subject (Bresolin, 1999; King, 1997; Stafford, McCall, Logan, 1998; Torvaldsen, Kurinczuk, Bower, Parsons, Robertson, 1999).

Health professionals other than mainstream health promoters consider literacy an essential component that enables women to make decisions about their own health needs that are empowered by knowledge. While this is often discussed in terms of women in developing countries acquiring literacy skills in order to raise their health status, in relation to mainstream health promotion in Australia, it is a very specific kind of health literacy that is being referred to. It is a health literacy linked to particular rational decision making processes. Before discussing how this differs from other attempts to empower women by feminist inspired women's health centres and the home birth movement, I will turn to how empowerment is discussed both in the international and Australian health promotion literature.
Empowerment

What is meant by empowerment is highly contested (Erben, et al. 1999; Labonte, 2001; Treloar, 1992; Van der Plaat, 1999). I am discussing it here within a context of health discourse and health promotion theory in particular. Although I am critical of how the term is used and understood by mainstream health promoters and other health professionals, I do not abandon the concept altogether. In much the same way as I discuss rationality as being impoverished in Chapter 3 so I see empowerment as needing to be understood as part of the context of women's daily lives. My idea of empowerment is one imbued with agency and a sharing of power and resources. It is not something that can be conferred on women by health promoters. I eschew a notion of empowerment that: “has at its root the transmission of power from an agent to a subject” (Van der Plaat, 1999, p. 773). Rather I am more interested in a notion of empowerment as relational and contextualised. It is also a notion of empowerment whereby the empowerment is: “not taken or given, rather it emerges through interaction with the other” (Van der Plaat, 1999, p. 776). This notion of empowerment is quite different to that of mainstream health promoters and even some feminist inspired notions. Both rest on an assumption that if the ‘right’ information is provided and women are actively pursuing this and comply with it they will be empowered. As Van der Plaat (1999) asserts in arguing for a concept of relational empowerment:

“At the very heart of relational empowerment is the principle that one never can be just an empowerer or a person in need of empowerment. As scholars and activists, we have numerous skills and considerable power to bring to the pursuit of social
justice and change. Yet, this capacity remains oppressive if not harnessed to the realities of others people's lives and experiences” (p. 776).

Her notion of empowerment as a mutual process is one that I will argue for in the second part of the thesis where I am dealing in a more direct way with the women I interviewed. Mutual empowerment recognises that everyone involved in the empowerment process: “regardless of position of power and privilege, recognises that he or she is both an agent and a subject in the empowerment process” (Van der Plaat, 1999, p. 776). I will also discuss in more detail in the concluding chapters, the complexity of mutuality and the need to acknowledge inequalities in power relations in the consideration of what empowerment means. For now, I will return to empowerment as it relates to mainstream health promotion.

Since The Ottawa Charter health promotion theory has discussed the empowerment and general well being of individuals and communities as prerequisites for good health (Erben, et al. 1999, p. 180). As previously discussed the extent to which women can be empowered in relation to pregnancy and at the same time play the ‘good pregnant person’ who will put her foetus rather than her own needs first is questionable. The whole question of empowerment and what it means becomes muddied by the often emotive responses in relation to how women should conduct themselves when pregnant. Here the empowerment of the individual pregnant woman, her desires and decisions about her pregnancy, may clash with community and health professional perceptions about what is desirable and moral pregnancy conduct. A woman is, according to Ruhl (1999, p.104) made to feel
guilty; that is, as a mother, she should always sacrifice her own selfish desires for the sake of her child. Further, that the: “responsibility granted to pregnant women to affect the outcome of their pregnancy does not put women in charge” (Ruhl, 1999, p. 118). While Ruhl (1999) theorises women's decision making within the context of the risk model in pregnancy, I will also explore the other factors inherent in the constructions of women as rational, active agents in pregnancy. One of these is a critique of an unexamined, unqualified linking of health literacy with empowerment. This seems particularly pertinent when even a woman who has a small amount of coffee or a few cigarettes is according to the health promotion regime, guilty, irresponsible, irrational or requiring better education.

As previously mentioned what empowerment means to different health professionals needs to be discussed in order to illustrate the more conservative processes of main stream health promoters. The empowerment processes described by feminists working in the women’s health, or home birth movement, do differ in particular ways. The information that guides women’s actions here are a result of “reconstructed knowledges.” These are often informed by women’s life experiences and their own stories about their bodies and health issues. It is asserted by women's health advocates that these “reconstructed knowledges” result in information that challenges the status quo and this is considered to be inherently empowering for women who read them (Boston Women’s Health Collective, 1992; Hunt, 1996). However, others have pointed out that individual or psychological empowerment, which is an increased awareness by the woman of different options that may be possible, are not inherently empowering unless she is at the same time provided with the
infrastructure, institutions and support to realistically pursue her ‘choices’ (Risell, 1994; Van der Plaat, 1999, p. 773).

I do not wish to be critical or diminish the attempts by feminists in the women’s health movement, or women in the home birth movement, to challenge the status quo and their aim of enabling “reconstructed knowledges” (Hunt, 1996). In the case of home birth for example, I would assert that home births should be a viable option for women considering birth options, an option that they have the opportunity to consider through the provision of relevant information. However, it is also clear that the infrastructure and funding have not in the past been adequate in this area to assist all the women who desire home births. Neither have many of the doctors women may visit to confirm a pregnancy been particularly enthusiastic about such a ‘choice’ (Lavender, Walkinshaw, Walton, 1999; Pitt, 1997). Similarly women’s health centres exist precariously on the margins of the main stream health system, rarely attaining more than one year’s guaranteed funding at any one time. Given that much of the health information presented to women by way of main stream health promotion does not challenge the status quo in terms of its emphases on pathology, biology and individual lifestyle, it is difficult to see how the information by itself is automatically empowering for women. Health promotion information is not empowering in the sense that it is a “reconstructed knowledge” rather it reflects the theory and practice of main stream approaches. Even if women choose to reconstruct their own knowledges in response to this, they do so within a context that does not provide them with the institutional or societal support to act upon this in other than a problematical way. The use of reconstructed knowledges by those in the women's health and home birth movements
may be seen as a step in the right direction toward empowerment. However, these strategies can only have limited success within a health promotion context that does not address the larger structural contributors to inequality and disempowerment. They may also have limited success in terms of critically reflecting upon the implications of delivering health promotion within professional domains entrenched in bureaucracies. In addition, the pervasiveness of risk discourses and the lack of acknowledgment by health promoters other than in problematical terms, of the social realities and everyday issues of pregnant women's lives, also need to be considered as impinging on the facilitation of empowerment.

In much the same way as women who give birth are categorised as always ‘at risk’ no matter how small, so too, pregnant women cannot ever safely imbibe, even in small amounts or infrequently, any of the substances defined as always and inherently dangerous by health promoters. As Lupton (1994, p. 6) points out, the birth of a disabled child can be blamed on the mother as “foetal rights” take precedence over “maternal rights” and as previously discussed this becomes even more intensified with the existence and increased use of pre-natal and genetic testing. Another strategy used by mainstream health promoters that seems to fly in the face of their stated aim to empower individuals and communities is their use of ‘fear’ and ‘threat appeals’ in health promotion campaigns.

**Fear**

The potential social and legal censures that may be experienced by pregnant women who do not ‘obey’ mainstream health promotion campaigns are discussed in greater detail in
Chapters 5 and 6 which explore women’s reactions and responses to these and other health promotion campaigns directed at pregnant women. In terms of health promotion theory however, particular strategies have been explicitly devised to engender fear in the health subject. These are not solely deployed in campaigns targeting pregnant women. However, “threat appeal” and “fear appeal” are two devices used by health promoters in a range of campaigns such as anti-smoking, drink-driving and safe sex messages (Donovan & Henley, 2000). This is interesting in terms of this thesis as a very clear example of an attempt to use emotions in order to elicit a supposedly rational response and decision to the health promotion message (Egger, et al. 2002, pp. 34-35). Here emotions or feelings of fear or impending threat are not problematical, as long as they are responded to with compliance on the part of the health subject.

An article published in the Health Promotion Journal of Australia evaluates the use of these “threat” and “fear” appeals in a review of the public health and health promotion literature and health promotion campaigns from 1970 to 1999 (Donovan & Henley, 2000, p. 84). Having briefly referred to those health promoters who question the usefulness of these tactics, Donovan & Henley (2000) go on to assert:

“On the other hand, a number of reviews of the fear literature have concluded that fear appeals can be effective, and that more fear is more effective than less fear - except perhaps for low esteem targets and provided the recommended behaviour is efficacious and under volitional control” (p. 84).
In this example the deliberate engenderment of fear per se is not questioned, only whether it is efficacious for all. The authors also discuss how fear needs to be clarified by health promoters and defined as either “anticipatory” or “inhibitory” (Donovan & Henley, 2000, p. 85). A comparison is made between the effectiveness of “anticipatory” fear and “inhibitory fear” (Donovan & Henley, 2000, p. 85). “Inhibitory” fear is described as that which evokes feelings of “nausea” and “horror” and is considered less useful than “anticipatory” fear. This is considered more useful: “since it is the link between the threat and the person’s continuing unhealthy behaviour that must be established” (Donovan & Henley, 2000, p. 85).

In relation to this study it is apparent that ‘anticipatory’ fear is used in both the folate and listeria health promotion campaigns; the fear of disability or deformity in the case of the folate campaign and of potential miscarriage or neonate death in the case of listeria. Other campaigns that also use the “fear” and “threat” appeals are the anti-smoking and alcohol campaigns targeting pregnant women which list a range of consequences resulting from non-compliance such as ‘smaller-for-dates’ babies, low birth weights and foetal alcohol syndrome amongst many others.

The use of “fear” and “threat” strategies in health promotion campaigns targeting women are intensified because women are primarily held responsible for the health and well-being of the foetus, and only secondly of themselves. The use of “fear” and “threat” is another example of how health promoters intellectually abstract health issues from the everyday. Here, “fear” and “threat” is used for the subject’s own good. The woman who is rational
and responsible will react to this campaign by feeling fear or threat and will then go on to comply with the advice. To ignore the feeling of fear and threat by not complying with the health promotion message would be seen as irrational, risk-taking or health damaging behaviour. This point is returned to when the specific health promotion campaigns of folate and listeria are analysed in the next chapter, and also in the second part of the thesis when women’s interactions with these and other main stream health advice is examined.

Although the use of “fear” and “threat” appeals is acknowledged, and that in conjunction with the prominence of the foetus as a separate person they intensify health promotion messages, I do not intend to focus on health promotion as an uncomplicated power oppressing all women. As Chapters 5, 6 and 7 which deal more explicitly with how the women I interviewed variously engaged with these campaigns amply illustrate, women are not cultural dupes or victims. However, the examples have been discussed here to illustrate that they do experience pregnancy in a context where high value is placed on issues such as quality of life, perfect health, consumerism and lifestyle.

While this section of the thesis does emphasise the theoretical trends underpinning much of main stream health promotion, Chapters 5, 6 and 7 will be particularly informed by the interviews and will explore how the women I interviewed engage with and demand ‘expert’ advice and information when pregnant or planning pregnancy. They will also illustrate those areas where women either do not comply or modify their compliance with health promotion advice. For now, I will return to the general theoretical trends underpinning main stream health promotion.
Health promotion theory at time of interviewing (1996 - 1997)

In the 1990s the structuralist versus individual lifestyle debate was still very current both within the critique of health promotion and in articles published by mainstream health promotion journals (see Bunton, et al. and 1995; Kickbush, 1998). Despite references to the importance of social contexts of health in health promotion theory (see Nutbeam 1996) little had changed in the way health promotion was practiced in campaigns. For example, Kickbush (1998) asserts:

“Research results consistently indicate that systems interventions are more efficient than individually oriented prevention programmes. Therefore health promotion must prioritize healthy public policies. This knowledge goes back to many of the public health pioneers around the globe who understood clearly the influence of economic, political and social factors on health, but it has as yet gained only minor acceptance in a health system dominated by a biomedical paradigm” (p. 5).

Health promotion campaigns also emphasised the personal skills necessary to be defined a good health subject and the subject of health literacy is revisited in the following section, as it relates to health promotion theory and practice at the time of interviewing.

At the time of interviewing a number of articles published in the Health Promotion Journal of Australia discussed the desired directions for health promotion theory and practice.
Many of the articles emphasised that health promotion campaigns should be evaluated in terms of reduction and prevention of mortality, morbidity and disability as well as economic viability (Hawe & Shiell, 1995; King, Coppel, Stoker, Noort, 1995; King, 1996; Viney, 1996). Articles addressing issues such as equity, access and social justice in terms of ‘Health for All’ were less often published (Hawe & Shiell, 1995). There was also an increased demand for health promotion campaigns to be informed by evidence-based research (Lowe, 1997, p. 152; Traynor, 2000). Evidence-based research is that which is informed by numerous, systematically documented scientific experiments, research and population based epidemiology. For example, the editorial of the Health Promotion Journal of Australia states that: “reports of programs submitted to the Health Promotion Journal of Australia are based more and more on scientific literature” (Lowe, 1997, p. 152). The aim at this time was to avoid the so-called “ad hoc” approach to health promotion research and practice by “well-meaning” but uninformed contributors such as “psychologists,” “social scientists” and even “clinicians” (Lowe, 1997, p.152). Traynor’s (2000) study of the rise of evidence-based medicine provides some useful insight into how evidence-based practices came to be privileged over other ways of doing research.

Some of the social and economic contexts contributing to the conditions under which evidence-based methods established a hold are shared by Britain, the place of Traynor’s (2000) study and Australia. In conjunction with a loss of: “international standing of UK science and technology” the economic climate was also one that emphasised the cost effectiveness of health care. Furthermore, evidence-based medicine as a movement “challenged individual clinical management.” As an approach that: “provided systematic
review of eligible [read scientific] research” and as disseminating much needed “evidence” it reflects according to Traynor (2000, p. 141) a hierarchical categorisation of that which is “pure” knowledge, compared with that which is “dangerous.” In relation to health promotion positioned in a presupposed arena of risk it may also provide a certainty and a kind of psychic security for health promoters, a position from which to respond. As minor players in a health industry dominated by medicine, evidence-based medicine may have formed part of a strategy to establish a “domain of practice” (Williams, 2002, p. 343). Traynor (2000) links this propensity to categorise within strict boundaries to biblical texts, and while I will not be developing his idea in this thesis, it is interesting to note how this desire to keep research “pure” is similarly articulated by Australian health promoters. For example, research by sociologists, psychologists, expert committees and independent health promotion practitioners is described as “low level, anecdotal and conflicting” (Watson & James, 1991, p. 4). Traynor (2000, p. 149) notes that in the case of evidence-based medicine (EBM), health professionals consider: “whatever is not EBM is an unacceptable mixture of witchcraft and science” [which no] “rational being would defend.” The emphasis on evidence-based research is reflected in a number of articles published by the Health Promotion Journal of Australia which emphasise the importance of research informed by evidence-based science in order to avoid the complex, messy and less economically efficient processes of other kinds of research (Lowe, 1996, p. 2; Oldenburg, Hardcastle, Ffrench, 1996; Viney, 1996). While Egger, et al. (2002) note that health promotion has:
“been clouded by competing philosophies and theories, by battles for professional territory, and by fights for government funds. Different players in this game have been adversely labelled as belonging to a medical model or, equally adversely, as related to an unscientific amateur model” (pp. 9-10).

Whilst not dismissing the internal debates within health promotion it is evident that at a policy and major strategy level, science and evidence-based medicine have won out over the: “unscientific amateur model.” Whilst social science in the shape of economics, for example, has been influential in health promotion theories, it is systematic, large-scale theorising that has superseded qualitative and localised approaches.

The increased emphasis on evidence-based research has not abated and in recent years has become even more important (see Lowe, 1996; Oldenburg et al. 1996; Traynor, 2000; Viney, 1996). Health promotion campaigns based on this kind of research claim that evidence-based approaches are not only measurable but adopt a consistent and methodical approach, enabling campaigns that are based on the authority of science, untainted by subjective opinion however well-meaning. For example, Oldenburg et al. (1996, p. 15) provide a definition of evidence-based health promotion practice as health research that results in the: “generation of new knowledge using the scientific method to identify and deal with health problems.” It is also argued by Oldenburg et al. (1996, p. 15) that the models of training and practices in health promotion need to be more “scientist-practitioner” based, and that this move toward evidence-based practice be rewarded in the policy environment. Oldenburg et al. (1996) call for:
“significantly more enhancers and rewards for evidence-based practice, rather than the current environment, which places many obstacles and barriers in the path of researchers and practitioners who wish to practice in this way” (p. 16).

Health promotion campaigns at the time of interviewing also reflected the emphasis on epidemiological studies stating objectives in terms of “health outcomes.” The development of the “health outcomes movement” is described by Jan & Mooney (1997, p. 88) as being a consequence of “health program managers and policy makers having to become more and more accountable in terms of both cost and outcome.” A health outcome in relation to health promotion practice is seen as being the result of: “a change in the health of an individual, group or population which is attributable to an intervention or series of interventions” (King, 1996, p. 50). However, Australian health promotion has emphasised the population approach to health promotion campaigns, emphasising large-scale epidemiological surveys. This is perhaps in response to the epidemiologist, Rose (1992) who claimed that large numbers of people at low risk, should be targeted rather than small numbers of people at high risk (this is also known as the ‘prevention paradox’) (Egger, et al. 2002, p. 14; Rose, 1992; Williams & Calnan, 1996).

The definition of a health outcome is defined as that which health promoters can measure on a population wide basis in the short term. Health outcomes are used to measure and compare the economic efficiency of different health promotion interventions (Jan & Mooney, 1997). The “interventions” referred to in this literature consist of the expert advice
of health promoters in the shape of campaigns or literature. That a health outcome can be anything other than a result of an “intervention” or series of “interventions” by health promoters is not discussed. Again the emphasis is on the individual’s lifestyle and how they take up the messages and act upon the “intervention.” Compliance with the “intervention” equals positive health outcomes in this equation (Jan & Moodie, 1997, p. 89).

Interventions as they are described here do not generally refer to any major structural changes. For example, an “intervention” such as lowering the speed limit on all Australian roads in order to achieve longer term, less easily quantifiable, positive health outcomes is not what is being referred to. As Burrows, Bunton, Muncer, Gillen (1995, p. 246) assert “the measurement of outcomes are, like costs, very difficult.” Further that the “outcomes measures of qualitative changes of subjective well-being amongst the population due to interventions are notoriously difficult to construct” (Burrows, et al. 1995, p. 246).

The use of “health outcomes” as a measure of how efficiently health promotion campaigns are achieving health gains further contributes to more conservative and quantitative and hence measurable approaches in the health issues targeted by health promoters.

The research bases of health promotion most valued by mainstream health promoters and the Health Department of Western Australia are those that reflect the scientific, economic and managerial enterprises. These systematic and quantitative disciplines accord authoritative status to the directives of the resulting campaign, making it difficult for those targeted to question, with their knowledge base considered to be less evidence-based and
more a consequence of the so-called subjectivity of anecdotal and bodily experiences. The accidental and anecdotal nature of how and why different health issues are chosen by health promoters themselves is not acknowledged, and the assumption that they are underpinned by careful and methodical, dispassionate science is rarely questioned or challenged. However, there are exceptions, Atrens (2001) for example, is critical of the ‘healthy’ diet messages presented by main stream health promotion:

“Health authorities and commercial interests have colluded to perpetuate an irrational belief in the apotropaic powers of food to ward off evil” (Atrens, 2001, p. 6).

The evangelical pursuit of diet as the answer to ill health is further criticised as being irrational:

“The irrationality of the view that dietary change in particular, and health promotion in general, improve health is shown by dozens of intervention trials. Irrespective of the nature of the intervention, these trials have uniformly failed to produce desirable outcomes” (Atrens, 2001, p. 6).

That health promoters are committed to particular kinds of research is illustrated in a 1997 edition of the Health Promotion Journal of Australia where it is asserted: “we continue to strive to improve and reduce the number of programs started by well meaning individuals who do not have health promotion background or understanding of the literature” (Lowe,
The only health promotion campaigns that have any real authority then are those that are based on evidence-based, quantitative, large-scale systematic research. The literature referred to in this quote is that which has been systematically reviewed, that is, it is: “a review of studies in which evidence has been systematically searched for, studied, assessed, and summarised according to pre-determined criteria” (Cochrane Research Glossary for Consumers, 2000, p. 10).

The only responses recognised as valid by health promotion campaigns constructed according to these criteria, are those informed by a rational, literate and compliant health consumer. Health promotion campaigns are based on large-scale and systematic methods that chart the health of populations and aim for certitude and validity. The systematic review picks up on that literature which has proven itself quantitatively in terms of health issues and simply leaves out the literature that is less certain or critical of particular findings. Richmond (1998, p. 163), discusses how people who responded sceptically to health promotion campaigns that acknowledged uncertainty would be disturbing to health promoters. Further questioning the faith in which epidemiological research data is held Richmond (1998) claims:

“The complexities of epidemiological research data are largely ignored by individual health promotion programs, the basic currency of which are simple slogans, which frequently go beyond the evidence” (p. 163).
Some of these concerns are taken up in a more recent edition of the *Health Promotion Journal of Australia* where it is asserted that: “health promoters must be prepared to accept a more fluid conceptual structure, to cope with uncertainty and ambiguity, and to move hesitantly without certain knowledge” (Moodie & Borthwick, 2001, p. 2). Despite this exhortation public health research continues to be dominated by large-scale systematic reviews of evidence-based research and meta-analysis. Health promotion in response to this is unlikely in practice to incorporate notions of “uncertainty and ambiguity” or for that matter value a health promotion subject who is similarly uncertain. While health promoters might not value a well informed health promotion subject in the sense that Richmond (1998) is describing, that is, a sceptical one, they certainly do value a subject who demonstrates a health literacy that absorbs health information in a particularly circumscribed fashion. They also value those campaigns that can demonstrate economic efficiency in terms of reducing costs associated with health care. In relation to this study the health literate and rational woman will also make choices as a health consumer in a health market place, which increasingly talks about the ‘burden of disease’ and where health promotion campaigns reflect economically rationalist philosophies and a need to demonstrate economic viability and efficiency.

**Health Promotion and Economics**

The economic value of health promotion campaigns was emphasised in many of the articles submitted to the *Health Promotion Journal of Australia* shortly before and during the period of interviewing (Hawe, et al. 1995; King, 1996; Nutbeam, 1996; Viney, 1996). More and
more the language in which new programs were devised borrowed from the ‘market.’ While in earlier years the health care system reflected the British mixed system of provision (public and private) this has begun to change in the last fifty years, with an increased emphasis on the private provision of services. Butler, et al. (1999, p. 256) assert that since: “the middle of the twentieth century, however, there has been a tendency to adopt North American [United States of America] approaches to funding and organisational initiatives.” Australia is increasingly adopting a system of health provision that reflects that of North America: “in the last decade, health care in the United States has increasingly become a market commodity in which profit is the motivating incentive of service providers” (Butler, et al. 1999, p. 256).

The following examples extracted from the Health Promotion Journal of Australia and other health promotion articles published at the time of interviewing, illustrate the dominance of market oriented theory in the delivery of health promotion campaigns, with articles referring to: “outcomes,” “cost-effectiveness,” “portfolio management,” “quality control” and “best practice” (see Hawe, et al. 1995; King, 1996; Nutbeam, 1996; Viney, 1996). More recently main stream health promotion in Australia has become enamoured with the language, practice and processes of social marketing, constructing health subjects as “consumers” health messages as “products” and considering responses to campaigns in terms of a “cost and benefit” analysis (Nutbeam & Harris, 1999, pp. 49-50). At the same time, as main stream health promotion adopted the strategies of corporate management and the market, there was an expansion and incorporation of health promotion into the main stream economic and political structures of society.
In ‘World Health’ (1997) a WHO publication published at the time of interviewing the main streaming of health promotion is described by Catford (1997) in the following way:

“This is not an irrelevant activity of a few health eccentrics, or social radicals. Rather is has joined the main stream nationally and internationally, and the goals of health promotion are increasingly winning political support even from world leaders” (p. 41).

Presenting an argument as to why governments should “invest” in health promotion the author describes health promotion as often the “best buy” for health care, as giving: “value for money and good return on investment” (Catford, 1997, p. 50). An article in the Health Promotion Journal of Australia raises the issue of health promotion programme management claiming: “like other public sector programmes in Australia, health promotion is increasingly required to demonstrate accountability and implement quality improvement systems” (King, et al. 1995, p. 12). Another responds to the call for “safe and best practice” in a different way; acknowledging that: “service provision based on health outcomes, case mix funding and program budgeting is inherently conservative” and another strategy is suggested (Hawe & Shiell, 1995, p. 4). Concerned about the circumscribing of the innovative potential of health promotion the authors state:

“We advocate thinking about health promotion campaigns in the way one would construct a prudent investment portfolio. This would range from ‘blue chip’
program investments, such as cardiac patient education, through to higher risk programs (that is, higher uncertainty programs) but potentially high gain investments, such as community development and intersectoral health action” (Hawe & Shiell, 1995, p. 4).

Although this is an attempt to move away from always playing it safe in terms of health issues addressed, health promotion strategies are still contained within a framework that reflects notions of risk based on finance and the market. It is a carefully calculated and apparently rational adoption of levels of risks that have clear boundaries. High risk or less certain campaigns will comprise only a small percentage of the total campaigns or mixed portfolio.

An editorial in the Health Promotion Journal of Australia (1996) reiterates the importance of sound economics reflecting the values of efficiency and evidence-based programs, as well as referring to management terms such as “best practice”:

“Working as a purchaser of health promotion programmes we can influence the system to purchase health promotion programs that are based on sound principles and those that have a demonstrable efficacy - that is evidence-based, best practice programs” (Lowe, 1996, p. 2).

Similar developments have been noted in Britain where it is claimed: “more and more the organisation and delivery of health care is being framed and articulated in terms of ‘value
for money’ rather than any alternative ‘moral discourses’” (Burrows et al. 1995, p. 242). In Australia the health promotion campaigns that have persisted have been those blue chip, low risk ones that “have a demonstrable efficacy” (Lowe, 1996, p. 2).

I have asserted that the development of mainstream health promotion in Australia has in many ways mirrored that of other Western developed countries. Also that health promotion programs and campaigns have tended to be conservative rather than radical or innovative. The research and strategies of health promoters in Australia and Western Australia have reflected an increasing concern with accountability and efficiency in an economic sense. This has been in conjunction with another major international trend in relation to research approaches to health issues which is evidence-based medicine. The combination of these trends, economically rationalist, scientist and conservative, as well as population based health outcomes, have resulted in the particularly circumscribed and systematic theory and practice of health promotion campaigns in many Western industrialised countries including Australia. Particular corporatist ways of managing and funding programs utilising theories and practices borrowed from private enterprise and management theory are also apparent in the mainstream Australian health promotion literature. These approaches toward health promotion are entrenched in Australia due to the early institutionalisation and mainstreaming of health promotion in the major health bureaucracies. While other more innovative, responsive and less rigid approaches toward health promotion may be practiced these are not accorded the same status, authority, recognition or funding.
In this chapter I have discussed the ways in which main stream health promotion campaigns have been influenced by scientific and economic rationalism in various ways, and how these in turn shape the sanctioned responses to health promotion campaigns. One of the reasons I interviewed both hospital and home birth women was that I assumed home birth women would be more likely to use ‘alternative’ or non main stream information. Whilst this was the case, it did not result necessarily in a dismantling of particular ways of making decisions or notions about rationality, neither were hospital birth women any more likely to be more compliant. The other interesting note in relation to this is that women who choose home birth are often constructed as middle class women of particular political and philosophical leanings; this raises all sorts of questions about empowerment, health literacy, rationality and decision making. The differences between and within both these groups of women provide the connecting thread of this thesis in terms of empowerment, rationality and decision making, further complicating the globalising and homogenising tendencies of main stream health promotion.

In the next chapter I turn more specifically to the interests of the participants in this study, pregnant women, the social and cultural contexts within which they make health decisions, and focus on two major Western Australian campaigns targeting pregnant women at the time of interviewing in 1996 and 1997.
Satisfactory Food Knowledge: Foetuses, Folate and Listeria.

The previous chapter has outlined the broad trends in the development of health promotion in Australia, Western Australia and other Western developed countries. This chapter provides some general background in relation to the social and cultural contexts within which women in Western, industrialised countries such as Australia make decisions as pregnant subjects. The focus shifts from a discussion of the general theoretical developments in mainstream health promotion and instead examines more specifically the contexts within which pregnant women make decisions. In particular two of the health promotion campaigns (folate and listeria) that were prominent at the time of interviewing, will be discussed in relation to the values and assumptions informing health promoter responses. Approaches by health promoters in relation to smoking and drinking alcohol in pregnancy will also be discussed, as these have formed part of the critique of health promotion in relation to pregnant women in Australia and other Western industrialised countries.

An analysis of the evaluations of the folate and listeria campaigns by health promoters and health promotion researchers inform the main focus of this chapter and provide an indication of attitudes and assumptions held by these professions. The evaluations highlight as problematical the responses of women from culturally and linguistically diverse backgrounds, young women, and in the case of listeria, women for whom it is a second or subsequent pregnancy. The chapter and indeed the thesis could have constructed a critique in relation to the stereotyping of culturally and linguistically diverse women and young
women as illiterate, risk taking or culturally different by health promoters. However, it is the way in which health promoters are silenced into incomprehension around second time supposedly well educated, middle class mothers that I have instead chosen to focus upon. This is because whilst the partial or non compliance of minority groups is always explained away by health promoters as a consequence of culture, language, illiteracy or youth, the non compliance of English speaking, middle class mothers is discussed in terms of inexplicability. This is partially because it undermines health promoter's opinion that all people require is the correct information and the literacy skills to access, acquire and process health promotion advice in order to make the correct decision. It is also difficult for health promotion evaluators to understand because to acknowledge it would be to undermine the unshakeable belief in the 'rightness' of health promotion objectives (Seedhouse, 2001, p. 2). In addition to this, in terms of what is considered rational decision making, the inexplicable less concerned approach of second time mothers is also seen as irrational. There are expectations that middle class, English speaking, educated women will be the most likely to conform and therefore health promoters have difficulty both acknowledging their non compliance or partial compliance and articulating it in terms of strategies in response.

The theoretical trends highlighted in the previous chapter, including economic rationalism, evidence-based practice, individualistic tendencies and the emphasis placed on the demonstration of personal skills such as health literacy and rationality are themes that are carried through into this chapter. Before these debates are engaged with in relation to the
Pregnant women and the context of decision making

It is only in the last twenty years that images of the foetus in utero have become common place in photographic and other visual forms. Ultra sound scanning of the foetus is a routine practice in pre-natal care and many women have more than one during pregnancy. No longer is the ultra sound image a blur requiring translation by the ultrasonographer. Recently there have been developments in the ultra sound technology that make it possible for ‘3D’ (three-dimensional) images of the foetus to be clearly seen. It has been argued that this visibility of the foetus has contributed to the production of women as little more than “environments” or “incubators” for the foetus (Duden 1993, p. 6; Rothman 1993, p. 4). Duden (1993, p. 10) also asserts that pregnancy in recent times has become more a seen than a felt experience. By this she is referring not only to the increased use of technology such as ultra sound, but also to the fairly recent historical development of a woman’s doctor being the first one to know she is pregnant. In the past women would have noted for themselves the changes in their own bodies and waited for the quickening (feeling the baby move) before announcing they were pregnant Weir (1996, p. 372) develops these themes further, pointing out that not only is there photographic like images of the foetus, ultra microscopes make visible the “very moment of conception.” In addition to visual images there is also much documentary evidence collected and stored about individual foetal cells and genetic codes.
The presence of the foetus is documented in a variety of ways that emphasise the visual, and the measured, whether it is by way of ultra sound imagery, graphs, tables or written records. It is argued that this ‘seen’ and measured pregnancy detracts from the woman’s own knowledge about the ‘felt’ experience, and has contributed to a de-valuing of the skills of doctors and midwives in terms of knowledge that relies on feelings and human touch (Sutton, 1996). This point may be argued. For example, other writers have pointed out that many women view their initial ultra sound appointment as the first opportunity to bond with their baby (Ihde, 1990; Petchesky, 1987). In relation to the arguments of this thesis, however, this increased visibility is pertinent because it has contributed to the construction of the foetus as an individual person or patient, apart from, and yet at the same time, completely reliant on, the mother. An individual that requires protection that is sometimes legal as discussed in the previous chapter. In addition, an individual that is perceived by main stream health promoters, other health professionals, and the community at large, as requiring protection from misguided or uninformed behaviours and actions on the part of the mother (Keane, 1996).

The previous chapter described how health promoters disemboby and abstract health issues from real women’s bodies. It also discussed how the themes of purity, morality and rationality permeate through the research bases of health promotion to the actual delivery of the campaign. This constructs the pregnant woman as a subject who is individually responsible but not entirely trustworthy. The moralistic overtones of health promotion toward alcohol and pregnancy previously discussed, and a desire for ‘pure’ space are echoed in approaches to smoking and pregnancy. In relation to illicit drug use pregnant
women are particularly in danger of being branded not only ‘bad’ pregnant people but also
deemed incapable of being ‘good’ mothers (Hodson, n.d.). These points are raised to
demonstrate that in terms of main stream health promotion advice women are making
decisions within contexts that value particular ways of being a ‘good’ pregnant person.
One of these is to retain the woman’s uterus as an uncontaminated and pure environment.
Another is to constantly assess and calculate the likelihood of risk and take steps to avoid
these.

In relation to smoking the “desire to claim the uterus as a space of purity” (Keane, 1996, p.
267) is particularly evident in a study publicised in the local West Australian newspaper
(Bower, 1997, p. 30). In this news article a study from the United States of America is
cited and it is asserted that there is a link between delinquency in boys and mothers who
smoke during pregnancy. The boys in the study had: “misbehaved for at least six months,
displaying at least three sorts of antisocial behaviour: lying, stealing, arson, vandalism,
physical cruelty or forcible sexual activity” (p. 30). The study results published in the
Archives of General Psychiatry concluded that: “mothers who smoked more than half a
pack a day during pregnancy were 4.4 times more likely to have children with conduct
disorders” (p. 30).

In contrast to health professional's concern with alcohol intake in pregnancy which more
immediately stresses the potential for foetal damage, women who smoke in pregnancy are
held accountable for longer term and wider ranging societal problems. It is her pathological
and toxic body, if she smokes, which is the ‘cause’ of these problems. This perspective
positions the woman as disembodied or existing in an abstracted way from the everyday complexity from which she negotiates her life as well her pregnancy. The boys in the study too it seems are similarly immune to the particular social and cultural contexts which shape their lives, their problems reduced to the biological, connected to the womb and the misbehaviour of their mothers.

This individually responsible pregnant woman is also the subject targeted by newspaper stories reflecting similar themes of the pathological and toxic leakiness of women’s bodies. One article describes how a child’s IQ: “may be shaped significantly by conditions in its mother’s womb.” Also that: “mothers may be able to influence the IQ of their children by altering what they eat or avoiding certain toxins” these are listed as: “alcohol, drug and cigarette consumption and also lead exchange” (Womb with a view, 1997, p. 17). Shuttleworth (1993/1994, p. 39) asserts that women’s responsibility for the health of their babies “retreats ever backwards” in both the examples raised here, it seems it is also projected ever forwards.

Women’s traditional responsibility for the health of others is plainly apparent in the health promotion campaigns in relation to smoking and alcohol intake in pregnancy in a number of Western, industrialised countries (Keane, 1996; Secker-Walker, et al. 1997; Shuttleworth, 1993/94). The propensity for health promoters to construct women who continue to smoke as not only pathological or toxic, but also irrational, has been noted by Oakley (1989) in her study examining the ‘stop smoking’ campaigns aimed at working class women in Britain. Oakley (1989) asserts, that the assumption made by health
promoters in her study, was that the women the campaign targeted who appeared not to comply with the advice were irrational, because they had been informed of the dangers but still persisted in smoking. Oakley (1989) then goes on to demonstrate how women’s non compliance with health advice needs to be examined within the social and class contexts in which they live. Oakley (1989) argues that the women she interviewed were well aware of the dangers and that there were a number of reasons why they continued to smoke. One reason was that smoking afforded them some personal space, in other words, while they were smoking their children kept their distance, they were literally kept ‘at arms length.’ In addition the women’s working class position meant that smoking cigarettes was a form of relaxation for people who may not have been able to easily afford other means of entertainment, leisure or holidays (Oakley, 1989). The assumption that women are irrational or illiterate if they choose to ignore or even modify health promotion advice is also evident in Australian health promotion campaigns and is a point to which this chapter returns later.

I have argued that main stream Australian health promotion campaigns continue to emphasise individual lifestyle and responsibility, as well as the personal skills (such as health literacy) required to both access and comply with main stream health information. But Australian health promotion campaigns also operate in conjunction with an established mythology of women as either irrational or on the verge of being so. This issue will be elaborated in the next chapter. However, in relation to this chapter and women’s responses to health promotion advice, the point is raised here to illustrate that the ways in which rationality can be demonstrated are curtailed even further in relation to pregnant women.
The assumption of the potential irrationality of women permeates through health promotion campaigns, pregnancy books and magazines and is also evident in other main stream health related information sources. An example of the pregnant woman as irrationality intensified is evident by reading the information web page constructed by the Australian Medical Association of General Practice. The document ‘Men and pregnancy: What men need to know about pregnancy (but haven’t quite got around to asking)’ is freely available on the Internet and has obviously been placed there for men to read. The web page starts off with the heading of ‘Mood swings’ and asserts:

“Your partner may experience great mood swings that seem quite unpredictable. These are due to hormone levels. These changes are like PMT or puberty several times over (try to remember when you were an angst-ridden teenager and multiply it!). The best you can do is keep calm and not get upset when she does. At about 4 months this may miraculously vanish and she may return to the woman you used to know and love (almost as if an exorcism had taken place)”

(Australian Medical Association of General Practice, 2000).

Despite this strong indictment of women as irrational, health promoter's obviously would not bother to provide literature and campaigns about issues of concern to pregnant women if they did not also believe at the same time there is at least a potential for women to also make decisions rationally. It is interesting to reflect on how the dualist construction of women as both irrational and yet at the same time retaining a capacity for rationality, operates in health promotion campaigns directed at pregnant women in Western Australia.
That health promotion campaigns rely on the premise that pregnant women are potentially literate and therefore rational is evidenced in the proliferation of information pamphlets directed at pregnant women on subjects such as, folate, listeria, iron, calcium, constipation, smoking, alcohol, exercise, diet and so on (Health Department of WA 1994; Health Department of Western Australia 1996; Health Department of Western Australia 1997; Health Department of Western Australia 2001). Pregnant women are constructed then as at least potentially literate and rational with the proviso that they read the correct information, that is, main stream health promotion literature. It is also argued by both health professionals and critics of health information and promotion that middle class women are more likely to demonstrate rational decision making, health literacy and compliance. This is partly attributed to the likelihood of their being more highly educated than other groups of women. Pregnant women can then evidence their understanding and rational response toward their pregnancy by complying in full with all of the information. Although this does not necessarily mean that pregnant women attain quite the same status of rationality as men or even other women and this point is discussed further in Chapter 3.

We can speculate that perhaps health promotion strategies reflect some of the traditional philosophical assumptions that women are capable of rationality but that it is of a lesser quality. At the same time, incorporated in health promotion strategies is a fall back position where those women who are not quite rational, illiterate, or simply immoral, irresponsible and non compliant will passively receive the wisdom of health promotion campaigns, for example, as in the fortification of foods with folate. Fortunately, unlike the United States
of America, health professionals in Australia do not yet have the power to imprison or
enforce medical procedures on women who do not comply (Keane, 1996, p. 275), although
in relation to illicit drug use during pregnancy women in Western Australia may have their
babies taken away from them at birth (Hodson, n.d.). In addition to the focus on behaviour
during pregnancy, women who are not yet pregnant may be similarly constructed as
irrational if they do not plan pregnancy.

It is now quite accepted that responsible and rational women will prepare themselves and
their body for conception quite some time before actually conceiving (Rodmell, 1992;
Stoppard, 1994). Women are exhorted to take personal responsibility for the health of their
foetus in many of the popular pregnancy books and manuals available (Shuttleworth,
1993/1994). Women are urged to “take control” of their pregnancy by informing
themselves and then acting on that information (Kitzinger, 1996, p.3). Even in some of the
less proscriptive and more holistic books such as Kitzinger’s, women are still nevertheless
advised to start taking care of themselves as soon as possible (Kitzinger, 1996, p. 3).
Shuttleworth (1993/1994, p. 39) notes that the: “St Michael Book of Babycare suggests that
both women and men should abstain from alcohol at least one hundred days before
conception.” One of the most popular pregnancy books used in Australia at the time of
interviewing (1996 to 1997) was Miriam Stoppard’s (1994) Conception, Pregnancy and
Birth. The introductory chapter of this book states: “giving up smoking and alcohol at least
three months prior to conception is a good idea for everyone” (Stoppard, 1994, p. 8). While
the examples cited previously focus particularly on alcohol and smoking during pregnancy,
and it is these topics that have been emphasised in the critique of health promotion
information aimed at women, the folate and pregnancy campaign similarly requires a: “responsibility that retreats ever backwards” (Shuttleworth, 1993/1994, p. 39). It also requires a responsibility that looks ‘ever forwards’ in terms of preventing deformity and disability. It is to this campaign as it was presented in Western Australia at the time of interviewing that the chapter now turns.

Folate

The origins of the folate health promotion campaign in Western Australia can be traced to a medical officer who, while working on the West Australian birth defects registry in 1980, came across an article published in the Lancet medical journal. This article outlined a large British study that had connected pre-conceptual folate intake with a possible decrease in the number of babies born with spina bifida and neural tube defects (NTDs) (Yallop, 2000, p. 6). From this humble beginning a number of projects and campaigns have been conducted in Western Australia promoting the preventative qualities of folate intake pre-conceptually and during pregnancy. It is interesting to note that there have been a number of articles published (and one unpublished) in medical and health journals raising some doubts about the usefulness of population based folate supplementation and fortification (Kloeblen, 1999; Mahomed, 1998; Ride, 1994; Wasserman, Shaw, Selvin, Gould, Syme, 1998). There is also some debate amongst medical and health professionals surrounding the multifactorial nature of what ‘causes’ or contributes to spina bifida and NTDs (Mahomed, 1998; Wasserman, et al, 1998). Others have raised the issue of the increased risk of multiple births (Owen, Halliday, Stone, 2000). The folate campaign and the evaluations of
the campaign in Western Australia do not refer to these debates in any detail. Instead articles written about the subject and approaches to the campaign refer to the results of the ‘Medical Research Council Vitamin Study’ that advocates blanket supplementation for everybody (not just “at risk” women) (Bower, Blum, Grace, 1992; Bower, Raymond, Lumley, Bury, 1993; Bower, Blum, Daly, Higgins, Loutsky, Kosky, 1997; MRC Vitamin Study Research Group, 1991). Here “at risk” women are those who have a previous history of a baby with spina bifida or an NTD.

A number of assumptions made by the health promoters are quite explicit in the folate campaign. For example, that all women are potentially reproductive and should be encouraged from adolescence to ensure adequate folate intake; that all women’s diets are suspect in terms of adequate folate intake, and that a good health promotion subject in this context is one who plans a pregnancy. The evaluation of this campaign by health promoters reveals the concerns they have about the significant number of women (over half) who do not plan their pregnancy (Bower & Blum, 1995).

The Western Australian folate campaign advocates that women start to take folic acid or eat folate rich food (preferably both) at least one month before pregnancy and three months after conception. Not only are all women planning to have a child advised to do this, there are also strategies put in place to try and capture all potentially reproductive women whether they have made a decision in relation to child bearing or not.
The case ‘for’ folate supplementation, despite the qualifications mentioned above, is
difficult to refute and I am not suggesting that pregnant women should purposefully ignore
the advice. Neither am I particularly qualified to question the scientific research on which
it is based, although the scientific ‘evidence’ for a mass campaign of this nature has been
questioned by others and it would appear that there is a strong argument for a more
qualified stance. For example: “there is no strong evidence to advise for or against a policy
of routine iron and folate supplementation in pregnancy” (Mahomed, 1998, p. 1). This
deviation is particularly interesting because it was sourced from the Cochrane Data Base,
an 'evidence-based' systematic, reviewed, international data collection of reputable medical
and health studies. Another study reports that the emphasis on folate supplement may be
misplaced and that it is lower socioeconomic status during a woman’s childhood that: “may
subsequently influence her risk of delivering offspring with neural tube defects”
(Wasserman et al. 1998, p. 7). This different viewpoint is sourced from the American
Journal of Public Health a well established main stream journal. Interestingly, a report
sourced from the Health Department of Western Australia that dissents from the orthodox
view has never been published. This paper raised concerns about the blanket fortification of
a number of commonly eaten foods (see Ride, 1994). At the time I sourced this paper (in
1996) it was the exception, however, since then I have come across the articles from
outside Australia referred to above that similarly question the automatic assumption that
blanket fortification of foods is of no concern. It is the lack of ‘visible’ debate about the
folate campaign at the point of campaign delivery that perhaps does deserve some critique.
That is, at the point of information presentation and dissemination there are no qualifying
statements made about the above issues of contention in the pamphlets given to women, or
by any of the health professionals working with the pregnant women I interviewed. There were some differences between home and hospital birth women in relation to how they were advised to ensure folic acid intake was adequate and this point will be returned to. The issue of informing women about all of the different aspects, advantages and disadvantages of folate in pregnancy does not just occur in relation to the folate health promotion campaign targeting pregnant women. However, due to the intensification of health messages and the increased prospect of social and moral censure when women are pregnant it seems even more pressing that they should be informed about the qualifications and debate in relation to the issue.

As I have already mentioned it is not my place to question the scientific evidence on which the folate campaign is based. However, in terms of the folate health promotion campaign, the implications that the directives have for women in terms of how they conduct their lives are pervasive. For example, Chapters 5 and 6 detail how the women interviewed responded to the campaign and will describe how they experienced their pregnancies feeling worried, anxious and guilty if they had not been able to comply. There are other more general issues raised by the campaign’s existence and these will be raised here.

I have mentioned previously it is not only women who are pregnant or even just considering pregnancy who are targeted by the folate campaign. The Vitamin Folate Before Pregnancy pamphlet produced by the Institute for Child Research and the Health Promotion Service Health Department of Western Australia (1994) states:
“Before pregnancy it is important to have a diet rich in folate for at least one month before pregnancy as well as for the first three months of pregnancy. However, a diet rich in folate at all times is good not only for you but for all your family.”

A number of the articles written by health professionals working directly in the area of folate research and health promotion advocate that all women from a young age should be aware they are essentially always potentially reproductive or of “child-bearing” age (Bower, et al. 1995; Chan, et al. 1993, p. 706; National Health and Medical Research Council, 1994; Streetwize Comic Strip, 1997 & see Appendix 1). In addition all women should demonstrate rational choice by planning their pregnancies (Bower, et al. 1995; Streewize Comic Strip, 1997). The folate campaign not only constructs women as inherently bad incubators, and all women as potentially reproductive; the success of a baby without spina bifida is best ensured by a woman who responsibly plans her pregnancy thus ensuring adequate intake of folic acid.

The national folate campaign also uses the fear and threat strategies discussed in the previous chapter. The Commonwealth Government has published a comic strip encouraging young adolescent women to enrich their diets with folate (Streetwize Comic Strip, 1997 & see Appendix 1). The comic describes the day of a young high school woman who goes to a child care centre for work experience. While there she notices a child in a wheel chair and is told that the child has spina bifida. She is also told that she can prevent this ever happening to any children she might have by eating a diet rich in folate. When the young woman asserts that she is not: “planning to have kids for ages” the supervisor
replies: “it’s really important to have folate in your diet - just in case” (Streetwize Comic Strip, 1997). Not only are the women in this scenario constructed as potentially pathological, that is, they may produce a baby with spina bifida, all women are assumed to be heterosexually active and at risk of pregnancy. In addition the threat of potential deformity and paralysis is used to reinforce the folate health message. Health promoters in the United States of America reflect similar concerns, claiming their intention is to: “increase the number of planned and wanted children in order to promote positive health behaviours during pregnancy and to ultimately improve the health status of women and children” (Altfeld, Handler, Burton, Berman, 1997, p. 30).

An article published during the time of interviewing in the Australian and New Zealand Journal of Public Health discusses an evaluation project researching the promotion of folate in Western Australia from 1992 to 1995 (Bower, et al. 1997). Claiming steady increases in the knowledge of doctors, pharmacists and “women of child-bearing age” over the years of the project, the article nonetheless raises a number of concerns. One of these is a concern that only half the doctors they surveyed knew the correct dosage for the folate supplement (Bower, et al. 1997, p. 719).

It is not clear from the article whether doctors really did not know at all what the correct dosage of folate was, or whether they only knew when a woman considering pregnancy or already pregnant, presented herself and they then took the time to look it up. One can also speculate that some doctors may tell women they require folate and then suggest they see a pharmacist, relying on the pharmacist to recommend the correct dosage. A prescription is
not required to buy a folate supplement. Another concern is also raised in relation to some women’s reluctance to take folate supplementation in the guise of a tablet or supplement, for example:

“the main barriers to taking a supplement being an unwillingness to take tablets and a preference for a dietary increase of folate rather than supplements. What we do not know is whether these women have an adequate diet, or whether they have the necessary knowledge to improve their diet if they are planning a pregnancy” (Bower, 1997, p. 720).

Here the concern of the health promoters at 'not knowing' whether women have an adequate diet demonstrates the importance they place on having a controlled response, one that is easily measured such as a 0.05mg dosage in the shape of a supplement. This quote also illustrates an assumption made by health promoters that it is likely women’s diets are inadequate and that if they persist with this response they still require further education about the necessity to improve their diet. It is not only assumed that women have a suspect diet, it is also assumed that ‘these women’ may not have sufficient knowledge to ensure adequate folate intake by dietary means alone. Given that the highest rates of spina bifida and NTDs occur in those populations where women are severely malnourished or poor (see Wasserman, et al. 1998) the emphasis on a blanket campaign in a relatively privileged, well, and even over nourished population can be questioned.
The point made about women preferring to enrich their diet rather than taking a daily folate supplement is one that will be returned to in the section of the thesis that discusses women’s decision making in this regard. The decision to rely on dietary sources was made by a number of the women interviewed and their rationale for this course of action challenges the assumption that seems to be made by health promoters that women’s diets are inherently faulty. Part of the reason why health promoters fail to understand women’s reluctance to take a daily supplement also relates to their particularly circumscribed view of what constitutes rational decision making on the part of health subjects. The other issue raised in the evaluative article by Bower, et al. (1997) is the importance of planned pregnancy.

Pregnancy planning was discussed by the women interviewed for this study and will be further discussed in terms of rationality in the next chapter. It will however, be discussed here in relation to the evaluative article referred to above and how it affects the processes of health promotion. The researchers maintain that about 60 per cent of the pregnancies in the survey were planned (Bower, et al. 1997, p. 720). Of this 60 per cent it was stated almost half had taken folate supplements and this was seen as an improvement on previous years. While there is not an explicit judgement made on women who do not plan their pregnancy, or on those who planned but did not take the folate pre-conceptually, it is suggested that doctors and health professionals should increase their surveillance of potentially pregnant women:
“in order to do this, health professionals need to be well informed, and to identify opportunities for informing women before pregnancy, such as when prescriptions for oral contraceptives are renewed, at postnatal checks, and after miscarriages” (Bower, et al. 1997, p. 20).

That these situations are deemed appropriate settings for informing women about folate sheds some light on the zealousness of the health promoters. The evangelical tendencies of health promoters are acknowledged in a recent editorial in *The Health Promotion Journal of Australia* (1999) where it is stated that health promotion:

“is an evangelical profession - health promoters want everyone to promote health - and the line between practitioner and the public can be fluid, with many other professionals metamorphosing into health promoters for five minutes at a time in the midst of their other preoccupations” (Moodie, 1999, p. 3).

To return to the specific example of folate given above, the logic underpinning these health promoters’ suggestions illuminates the ways in which health promoters in their overriding concern to get their health message across, fail to acknowledge the complexities of women’s lives. These processes also eventuate in the construction of a one dimensional woman, as potentially hetero-sexually active and reproductive, rather than one who may be homosexual, or having completed her childbearing or in the case of a miscarriage a woman who may be grieving.
Their one-dimensional view does not consider that a woman who is having a prescription for oral contraceptives renewed, is hardly likely to be contemplating pregnancy in the short term and may even resent or interpret as judgemental a doctor informing her about the importance of folate. She may have other health issues that concern her in relation to her oral contraceptive use and a doctor who is encouraging her to consider folate in the event she falls pregnant may not be perceived as being a particularly receptive or helpful person in this scenario.

Similarly, postnatal checks while perhaps more appropriate, in terms of being less likely interpreted as judgemental, are hardly the ideal time in terms of responsiveness of the woman concerned. She is likely to be preoccupied with the needs of her new baby, adjustments to her family and work life, as well as coping with changes in her body after the birth. She may also be more concerned with preventing pregnancy and want to know about her contraceptive options rather than be told about the importance of folate.

Finally, to advise a woman about folate intake after a miscarriage seems particularly open to question and if contemplated at all would need to be handled very delicately. The health promoters writing the article fail to acknowledge that the time after a miscarriage may be a traumatic and highly emotively charged one for a woman. The construction of the woman as removed from each of these situations in all their complexity typifies the propensity of health promoters to ignore or diminish the effects of the reality of women’s lives. The criticism that health promoters have an inclination to intellectualise about health issues in an abstracted fashion seems a valid one in relation to the folate campaign (Erben,
Franzkowiak, Wenzel, 1999). It also indicates that they assume their definition of what constitutes rational decision making should transcend emotions, even in situations that are fraught and complicated for the women concerned.

The issue of health literacy is also discussed in the project undertaken to evaluate knowledge and compliance with the folate campaign (Bower, et al. 1997). It was noted that women with a tertiary education: “were better informed about the association between folate and spina bifida at each survey” (Bower, et al. 1997, p. 720). The link between higher levels of literacy and a demonstration of ‘correct’ (that is, compliant) knowledge is made. Raising concerns about the increased likelihood of inadequate folate intake in those women who are less well educated, or of a non English speaking background, the authors state that it was the acknowledgment of these factors that were “major considerations in approval of the fortification of foods with folic acid in Australia” (Bower et al. 1997, p. 720).

There is a contradiction here in that an earlier contention was that any woman who did not take a folate supplement may not ensure adequate folate intake just through dietary means. In addition, that as nearly half of all women do not plan their pregnancy, their folate intake must also be ensured in ways other than dietary. While there is an implication that all women who do not take a supplement cannot be trusted to ensure enough folate, the stereotype of the lower educated and those from non English speaking backgrounds are explicitly stated as the rationale for the blanket fortification of foods. It has been deemed more efficient by health promoters and researchers to fortify a whole range of foods
potentially eaten by the entire population, rather than counsel individual women in relation to their dietary requirements, or identify so-called ‘at risk’ women within a population. This is perhaps, also an example of the prevention paradox referred to earlier, where large populations considered low risk are targeted rather than the minority of supposedly high risk individuals (Rose, 1992).

Comparisons with the approaches other countries have taken also indicate the zealosity with which West Australian health promoters have approached the issue of folate intake. While other industrialised countries have encouraged pregnant women or those considering pregnancy to eat folate rich foods and to take a supplement if they are planning their pregnancy (or they are at high risk), the wholesale fortification of foods has not occurred (Wasserman, et al. 1998).

Little has been published in Western Australia about this issue in terms of a critique. As already stated Australian health promoters can list a number of reasons why they feel that the blanket fortification of food with folate is important. The folate campaign and the strategies of health promoters ensure that the unmanageable woman, the woman who does not plan her pregnancy, or who does not take her folate supplement will in the course of eating a range of popular breads, cereals and milk, passively receive her share. However, the American Dietetic Association does raise concerns, mentioning that the Food and Drug Administration and the Centers for Disease Control and Prevention in North America: “recommends that women limit their folate intake to less than 1mg per day unless under the supervision of a physician” (Wasserman, et al. p. 37). It is also stated that: “higher intakes
may interfere with the detection of pernicious anaemia, a form of vitamin B-12 deficiency that can lead to permanent nerve damage if untreated” (Kloeblen, 1999, p. 37). It was also found that in the sample of low-income women studied that at least 20 per cent would:

“consume more than 1mg per day of folate exclusively from fortified grain products, which potentially puts them at risk for complications from excessive folate intakes and makes routine folate supplementation unnecessary and unadvisable in this population” (Kloeblen, 1999, p.37).

Given that 20 per cent of low-income women were considered in this study to be likely to over consume folate, it raises the question of how greater a risk this may be for middle and high income women. This article not only raises the potential for real debate about blanket fortification of foods eaten by the entire population, it also demonstrates the inappropriateness of population based campaigns that fail to acknowledge differences within those populations, such as socioeconomic and cultural background, topics dealt with more explicitly in another article in the Journal of American Public Health (see Wasserman, et al. 1998). I have already referred to a paper (Ride, 1994) that was not published by the Health Department of Western Australia that questions fortifying food with folic acid that is eaten by the entire population. The National Health and Medical Research Council’s publication on folate similarly raises some concerns in regard to the fortification issue (see National Health and Medical Research Council, 1994). These inconsistencies and contradictions in relation to the main stream folate literature contribute to constructions of women as subjects in particular ways as discussed in the paragraph below.
The ways in which women are constructed as subjects by the folate campaign occurs on a number of different levels. First of all there is a contradiction in the construction of women as choosing subjects. Although women are given information and lists of foods that are rich in folate (and even menu cards) that they can buy, cook and eat, it is still considered necessary to ensure women obtain folic acid in other ways. That women cannot really be relied upon to eat the right foods is evident in the more recent push for women to take a daily folic acid supplement. On the other hand, because many women cannot be relied upon to plan their pregnancy the fortification of a whole range of popular foods is considered necessary. Stereotypical ‘good’ health subjects are also constructed, that is, those with higher education levels are seen as demonstrating greater literacy and therefore compliance with the campaign, in addition 'good' health subjects plan their pregnancy and will be assumed to have a healthier diet. This planning of pregnancy is most usually associated with career minded, middle class women, although as will be discussed in Chapter 4, just over half of all the middle class women interviewed for this study did not plan their pregnancy.

The propensity to link literacy with rationality and consequently compliance with health promotion advice is also evident in a North American proposal for a health campaign targeting women who smoke. In this example, women with “low literacy” are considered to “not like reading” and it is suggested that: “videotapes now used as home entertainment in most American homes, might be more appealing” (Secker-Walker, et al. 1997, p. 24). In later chapters I will suggest reasons why there is a need to qualify the notion that middle
class, well educated women are ‘good’ health subjects (as far as main stream health professionals are concerned) that perhaps this stereotype has been overstated, particularly in relation to the group of women I interviewed. In their attempt to recognise diversity, health promoters seem only to succeed in constructing static stereotypes of the typical ‘bad’ health subject. These are women who are considered to have a low level of education, to be young, Aboriginal or from a non English speaking background and also to be single. Difference here is seen as inherently problematical, marked out from the good, partnered, middle class, well-educated, English speaking health subject (Bower 1997; Torvaldsen, Kurinczuk, Bower, Parsons, Robertson, 1999). A closer examination of how the health promotion campaigns are received by English speaking, middle class women reveals that they may be less compliant than is commonly assumed. I argue that it is not that middle class women are necessarily more compliant, it is rather that their none or partial compliance is either not acknowledged or cannot be so easily explained away as the result of youth, culture or lack of education. Given that middle class women have often attained higher levels of education (or are at least assumed to) they are considered to be literate. Literacy is directly linked with rational decision making and therefore none or partial compliance by these women is incomprehensible to main stream health promoters (Bresolin, 1999; Stafford, et al.1998).

The other major health promotion campaign directed at pregnant women, the listeria campaign, is not so easily addressed by health promoters in terms of them being able to protect the foetus from the actions of the irresponsible or ill read mother. This campaign is also different in the ways in which it constructs women as illiterate, irresponsible and in
need of further education if they eat the ‘wrong’ food. It shares with the folate campaign similar, stereotypical assumptions about certain groups of women who are not English speaking, middle class or married. This is despite the evidence presented in the health promoter's own evaluation that second time mothers (of whom many are categorised as English speaking, middle class and married) are less concerned in relation to listeriosis than first time mothers.

Listeria

The development of the listeria campaign differs in a number of ways to that of the folate one. While it shares many of the same assumptions made by health promoters in relation to health literacy and what is considered rational decision making, an analysis of the strategies deployed raises some other issues. The use of “fear” and “threat” appeals as a strategy is more explicit in this campaign as is the notion of risk in terms of what women choose to eat. As the objective of this campaign is to stop rather than encourage eating specific foods the use of “fear” appeals and “risk” categories are more likely to be deployed and are easier to justify by health promoters.

Listeria refers to a bacterium: “which is commonly present on the surface of raw unwashed vegetables and in certain processed foods,” “It can grow rapidly in soft cheeses, pate and some meat products” (Torvaldsen, et al. 1999, p. 362). Pregnant women who are infected by the listeria bacterium may: “transmit the infection to the foetus, resulting in miscarriage, stillbirth, premature birth, or serious illness in the neonate” (Torvaldsen, et al. 1999, p.
Listeria is not only a concern for pregnant women it may also make other people very ill and can be fatal (Jones, 1990, p. 1171). Pregnant women are considered a particularly vulnerable group because of the serious effects infection may have on the foetus or newborn. Listeria cases, although rare, are often reported in very emotive terms and discussed in an atmosphere of fear. This is not only the situation in Australia. Some international articles reflect similar themes, although these do refer to somewhat larger outbreaks than have been the case in Australia. For example: “French cheese industry reacts to scare of bacteria in certain cheeses” (Times International, 1999, p. 44) and “Deadly hot dogs and ham” (Jacobson, 1999, p. 62). At the time of interviewing The West Australian newspaper (Bower, May 15, 1997) in an article entitled: “Concern at jump in listeria cases” opens the article with the following paragraph:

“At least one WA baby this year was stillborn and another severely malformed because of listeria infection, the Health Department revealed today” (p. 27).

The listeria health promotion campaign is an example of those health promotion strategies that rely on what health promoters refer to as “threat appeal” and “fear appeal” discussed earlier in the previous chapter (see Donovan & Henley, 2000). Here the fear is not only of stillbirth it is also linked to an increased risk of miscarriage and the threat of neonate death or deformity.

The first major listeria health promotion awareness campaign in Western Australia in 1990 was in response to a: “listeria outbreak in Western Australia involving 10 pregnant women
and resulting in six stillbirths” (Torvaldsen, et al. 1999, p. 362). A further campaign was prompted by a case in 1994 when one woman’s still birth was attributed to listeriosis. It is claimed that: “the mother had not received any information on listeria, despite being well educated about her pregnancy and, as a consequence, she had unknowingly consumed high-risk foods” (Torvaldsen, et al. 1999, p. 362). Once again the assumption is that as the woman was highly literate if she had been given the information she would not have 'knowingly' consumed high-risk foods because this would then have been irresponsible and irrational. Furthermore, the authors stated that it was: “concluded that the pamphlets were not reaching a sufficient proportion of the target population and a listeria awareness campaign was launched in 1995” (Torvaldsen, et al. 1999, p. 362). Then in 1997 in an investigation of five cases of listeriosis in pregnant women it was found that although women and their doctors had an awareness of listeria there was some confusion over what constituted a high risk food (Torvaldsen, et al. 1999, p. 363). In a “personal communication” by one of the “investigators” it was found that some of the women did not include: “sandwiches made with chicken or ham, soft serve ice-cream, and smorgasbord foods such as cold prawns or mussels” among the food items to avoid (Torvaldsen, et al. 1999, p. 363). As an aside, this example is somewhat ironic as it is quite evident that it is not based on a systematic review but rather by a personal communication.

Torvaldsen's (1999) evaluative article provides some insight into how those women who had not heard of listeria or had reportedly not changed their behaviour after hearing of it are constructed as health subjects. Women who did not change their behaviour after reading the listeria pamphlet were considered more likely to: “speak a foreign language at home,
having an unplanned pregnancy, being less well educated, having a lower income, being single, having smoked and having not taken folic acid during their pregnancy” (Torvaldsen, et al. 1999, p. 365). These judgements are reiterated later on in the concluding discussion of the article where it is asserted that those women who either had not heard of listeria or did not make any behavioural changes were described in the following way:

“They may be a group of women who are less likely to be aware of listeria or other health issues and/or may be resistant to health-related behaviour changes even when aware of the associated risks. Typically, these women are likely to be of low socioeconomic status, young, single and engage in health-damaging behaviours such as smoking” (Torvaldsen, et al. 1999, p. 366) (My emphasis in italics).

The assumption that those women of higher socioeconomic status, who were married or partnered were less likely to engage in “health-damaging” behaviour is a common one in main stream health promotion campaigns. Young people in particular are often portrayed as resistant to health messages (see Hanvey, 1996). It is expected that the rational, older and partnered woman will respond in more compliant ways despite some of the difficulties associated with complete compliance such as confusion or misunderstanding about acceptable and unacceptable foods. Despite the fact that less than half of all women plan their pregnancy it is interesting that at least some of the women included in this study; who did not plan their pregnancy must have been other than those “typically” categorised.
This issue is discussed somewhat differently in another article reporting on a survey of food safety and practice among women attending an antenatal clinic in Queensland. Again this survey was prompted by two cases of listeriosis being reported in December 1995. This article describes and measures women’s responses to the survey as “satisfactory knowledge” and “satisfactory dietary practices” (Stafford, et al. 1998, p. 121). These researchers acknowledge the lack of “statistically significant” diversity within their survey population, however, then go on to outline some of the findings in relation to older second time mothers, women from non English speaking backgrounds and Aboriginal women.

The researchers claim that: “women in their second or subsequent pregnancies were only half as likely as those in their first pregnancy, to have a satisfactory food knowledge and satisfactory dietary practices during pregnancy” (Stafford, et al. 1998, p. 123). Their response to this is to suggest that women who are in their second or subsequent pregnancy require “reinforced” education about the dangers of listeria and safe dietary practices (Stafford, et al. 1998, p. 124). Many of the women interviewed for my study were second or subsequent mothers and their reasons for “unsatisfactory” dietary practices could possibly challenge the assumption made by health promoters that all they require is education. Middle class, English speaking women's choices are not so easily explained away or justified as a consequence of culture, youth, marital status or lack of education and this point will be returned to. When so-called non compliance is contextualised from the perspective of women’s everyday lives it demonstrates how inadequately simplistic mainstream responses are to women’s health needs. Although this will be drawn out in Chapters 5, 6 and 7 that discuss the responses of the women I interviewed; this depth of analysis is
not evident in the study quoted here. The quantitative survey methods used by the health promoters only indicates the numbers and demographic details of women who did not comply. It is not informed by the women’s own stories about why they have not complied.

This impoverishment is evident in the discussion part of the article. For example, in this discussion women from non English speaking backgrounds are constructed as problematical in the following way. Despite the women having similar rates of satisfactory food knowledge to other groups they were: “significantly less likely to have safe dietary practices” (Stafford, et al. 1998, p. 122). Although this was acknowledged as perhaps being: “related to food items that are popular in their own culture” (Stafford et al. 1998, p. 124) it is still assumed that all that is required is: “an improvement in the education and promotion of safe dietary practices during pregnancy by health professionals who provide advice to this group” (Stafford, et al. 1998, p. 124). Choosing to down play their own finding that women from non English speaking backgrounds already had the necessary “satisfactory food knowledge” the ‘problem’ of non compliance is reduced to a need for further education. Much like the folate campaign’s tendency to down play or only refer in passing to the difficulties associated with health behaviour and the realities of everyday life, this evaluation similarly skims over the social and cultural diversity amongst populations of women. When difference is acknowledged it is only in terms of how to further educate or make appropriate information available whether it is in relation to Aboriginal, non English speaking women, second time mothers or young and single women. While it is not explicitly acknowledged it is almost as if, especially in the case of second time mothers, that they really should know better, or they must be forgetful. There is no other rational
explanation for non compliance as far as main stream health promoters are concerned and no other strategy than the need for reinforced education.

The emphasis remains on individual lifestyle approaches; other reasons for non compliance are not explored and cannot be, because of the quantitative methods used by the evaluators. They have not acknowledged or been informed by their target group’s diversity, they emphasise individual responsibility and ignore or gloss over the structural determinants of health. For example, it is stated that in relation to young and single women’s non compliance with the Listeria campaign:

“\[It is also possible that this group of women receive less ante-natal care and may therefore have less exposure to health and pregnancy messages. Given that this group may be at greater risk of other adverse pregnancy outcomes, efforts to change their health-related behaviours should not focus too narrowly on Listeria but should address other pregnancy issues such as smoking and folate\]” (Torvaldsen, et al. 1999, p. 367).

Apart from this quotation reading as if health promoters are promoting themselves it is also interesting that the emphasis is on other health promotion campaigns reflecting similar individual lifestyle approaches. The reasons why main stream health services are not available, appropriate or easily accessed by young women in terms of ante-natal care are not discussed or even referred to in any detail, as part of the problem. This is an example of the tendency of main stream health promotion campaigns to emphasise individual responsibility, rather than addressing the more difficult to tackle structural, social, cultural
and economic factors. Although the problem of ante-natal care is touched upon there are no strategies suggested to address why young women are missing out on this care.

This chapter has identified a number of persisting trends in the strategies adopted by mainstream Australian health promoters particularly in relation to two of the major health promotion campaigns focusing on folate and listeria. The emphases on individual rather than structural determinants of health have been well documented, as well as the privileging of personal skills in relation to how mainstream health messages are responded to. Two mainstream health promotion campaigns current at the time of interviewing have been described and it has been shown that they reflect the trends inherent in health promotion theory not only in Australia but also in other Western, industrialised countries. While the pervasiveness of these trends should not be underestimated in terms of how they circumscribe women’s possible responses to mainstream health messages there have been some recent debates in health promotion theory that indicate there may be some shifts in perspective. These may partially be due to changes in the editorship of the Health Promotion Journal of Australia which, since 1999 publishes articles written by a greater diversity of health professionals, critics and commentators. Whether these result in demonstrably different health promotion campaigns remains open to question, but health promotion research and theory and the values and assumptions underpinning these, is at least being examined more critically by some health promoters and researchers (see Atrens, 2001; Daly, 2000; Erben, et al. 1999; Moodie & Borthwick, 2001; Seedhouse, 2001).
From 1999 to the present, *The Health Promotion Journal of Australia* as the major journal of main stream health promotion has begun to publish a greater diversity of articles in terms of philosophical perspectives, than was the case at the time of interviewing. An example of this is Daly’s (2000) sociological discussion of the social contexts of health. That the leading article in this journal has been written by a sociologist rather than a health promoter indicates at least the potential for some cross-fertilisation in terms of interdisciplinary debate. Daly (2000) also importantly makes the point that: “we have to recognise their (target group) authoritative knowledge of their own lives” (p.8). Moodie & Borthwick (2001) discuss the relationship between health and equality and what they term the “minimalist” approaches of health promotion and assert that: “we must proceed without the armour of moral certainty. We must be less dogmatic, more open to doubt, and more tentative; and we may find this makes us better health promoters in other areas too” (p. 2).

In a similarly critical and reflective vein Seedhouse (2001, p.1) discusses: “the inevitable contestability of health promotion's goals and methods is demonstrated.” These reflections and discussions on the processes of main stream health promotion contrast quite markedly from articles published in the same journal around the time of interviewing where it was stated that the inclusion of other perspectives confused issues (Lowe, 1997, p.58). While these developments indicate a more flexible approach to health concerns and a more critical reflection by some health promoters of their processes, others have warned about the inherent conservatism exemplified in some of the more recent social theories that have been taken up by main stream health promoters.
More recently popular social theories and concepts such as ‘social capital’ are critically analysed in issues of The Health Promotion Journal of Australia with Gleeson’s (1999) article in particular warning of the dangers of an inherent conservatism implicit in this theory in terms of health promotion. This is because social capital refers to the capacity of individuals in communities and may not necessarily address broader issues of concerns in relation to structural inequalities and community empowerment. Neither does it address the emphasis which seems to persist on individual lifestyle. Analysing the contribution of Coleman the social capital theorist most often referred to and quoted in relation to social capital, Gleeson (1999) points out that Coleman’s concept of social capital is underpinned by particular assumptions about the “nature of rationality” (p. 184). She claims that a Weberian notion of rational choice theory is too narrow to account for the: “complex relationships between structure and meaning” and the “complexity and heterogeneity of the relationship between the social environment and health” (Gleeson, 1999, p. 185). While the scope of Gleeson’s (1999) article does not enable her to develop this important observation any further, or provide any specific examples, the next chapter will return to and develop this critique. The importance of the context that Gleeson (1999) refers to, the inclusion of the complicating everyday in relation to notions of rationality and how this influences decision making for the women interviewed for this study will be explored. Given that Australian health promotion directives are also influenced by international trends, it is hopeful that more expansive approaches to health issues will be aided by articles such as the one published in the American Journal of Public Health in relation to folate (see Wasserman, et al. 1998). Here the authors while acknowledging the importance of periconceptual folic intake also advocate for: “additional research into the etiologic interplay of
biological and social factors” as well as a consideration of how: “neighbourhood conditions, such as specific environmental chemical exposures, housing quality, food availability, or violence, relate to neural tube defect” (Wasserman, 1998, p. 1677).

Although articles published in the main stream health promotion journals appear to be acknowledging more holistic approaches to health promotion and acknowledging the importance of individual and community empowerment, there has up to the present been no demonstrable change in the way main stream health promotion campaigns are practiced. There is a basic dilemma in the continued emphasis on a particular kind of health literacy and the way in which access to information is viewed as inherently empowering. Another obstacle in the way of enabling health promoters to acknowledge the authoritative status of knowledge in the ‘target group’ refers to the particular ways in which health promoters assess decision making and responses to health promotion campaigns. Part of the inability they have in acknowledging none or only partial, compliance relates to how rational decision making is defined, as well as to the bio-medical tradition underpinning much of health promotion.

While there is a well established critique of the bio-medical emphasis in health promotion and similarly a more recent one in relation to economic rationalism, the interplay between conventional notions of rationality and how these inform what constitutes health literacy and consequently empowerment, has not been so well examined or teased out (Bunton, Nettleton, Burrows, 1995; Catford, 1995; Germov, 2002; Richmond, 1998; Richmond, 2002). The rhetoric of empowerment traced back to The Ottawa Charter and defined in
relation to health promotion as both empowerment of the individual and empowerment of communities have not been so easily translated in relation to health promotion practice. This is not because health promoters are not aware of the situation, many articles refer to the need to empower individuals, empower communities and address the structural impediments to good health (Daly, 2000; Gleeson, 1999; Rissel, 1994; Wasserman, et al. 1998).

I will be arguing throughout this thesis that part of the problem lies with what is defined as ‘rational’ decision making in relation to health behaviour and responses to health promotion advice and therefore a ‘good’ or compliant health subject. I have discussed earlier that middle class, English speaking women's none or partial compliance is difficult for mainstream health promoters to comprehend because they cannot simplistically explain it away as a consequence of illiteracy. Furthermore, to speak of empowerment, as it is generally understood, as enabling and facilitating individuals and communities in making their own informed decisions, is not possible in relation to mainstream health promotion because it relies on a premise of rationality that reflects the systemised and circumscribed processes associated with a literacy that privileges mainstream health promotion and decisions based on simplistic risk assessments, that are independent of the contexts of women’s lives.

Another obstacle in recognising a different or expanded notion of what rational decision making constitutes, relates to the problem mainstream health promoters have in dealing with difference. As I have demonstrated, difference is invariably constructed as deviant and problematical in evaluations of health promotion campaigns. Difference is also usually
discussed in terms of minority groups of women, those easily marked out as young, ethnic, working class or illiterate. The diversity within the group defined as middle class and English speaking is not adequately acknowledged either by health promoters or their critics.

In terms of what is considered a rational and responsible response to health promotion advice there is similarly little or no room allowed for manoeuvre or modification. The only response acknowledged as proper is that which reflects complete compliance. While this continues to be the basic premise underlying main stream health promotion advice and strategy, the stated desire of health promoters to ‘empower’ health subjects will not only continue to be partial, it will be difficult if not impossible to achieve. The next chapter provides an overview of the historical construction of rationality in Western countries such as Australia. It will also discuss how the attainment of particular understandings of what constitutes rationality is particularly difficult for pregnant women.
3

Rationality and the Wizard of Oz

The previous chapters have referred to the ways in which women’s decision making in relation to pregnancy behaviour is circumscribed by mainstream health promotion in particular ways. This decision making takes place within a specific social and cultural context where women are considered the guardians of other’s health. Further, that as pregnant women they are also subject to intense medical and public surveillance, as well as potential moral and social censure. I have asserted that, in addition to the above factors well established notions of what constitutes rationality and rational behaviour in pregnancy affects the ways in which women are able to make decisions. I have suggested that pregnant women are particularly disadvantaged in terms of being able to question or subvert mainstream health promotion information because of perceptions in relation to intensified emotionality or hormonal imbalance that are associated with the pregnant state.

This chapter will examine in more detail the philosophical and historical association of women as either less capable in terms of attaining a rational position, or as disadvantaged because of their reproductive capacity. As well as discussing the exclusion or marginalisation of women from the rational, I also want to explore how science and consequently many health professionals, are theoretically if not practically committed to what Reiff (1979, p. 2) has termed an: “irrational passion for dispassionate rationality.” While it is important to demonstrate how women have historically been excluded from certain definitions of rationality, it is equally of interest why traditional models of
rationality and particular kinds of decision making processes have been privileged over others. The problem is not that other models of rationality are non-existent, but that they are seen as lesser, derivative and impure contaminated by subjectivity, emotions, or the corrupting nature of the body. Reasoning processes that flow from these ‘lesser’ models are similarly marginalised.

The previous chapter on mainstream health promotion theory and practice described how health promotion detaches its subjects from the complexities and realities of everyday life. The chapter also discussed the economic and scientific rationality underlying much of health promotion theory, a model of rationality based on abstraction and a universal application that is context independent. I will argue that by excluding or rendering problematical ‘contaminants’ such as subjectivity, emotion, experience and the body, health promotion continues to perpetuate the kinds of decision making processes that reinforce the individualistic and disempowering tendencies of health promotion campaigns.

Inspired by the work of L. Code, (1993), M. Code, (1995), Lloyd (1984), Nicholson (1999), Tuana, (1992), Tuana, (1994) and Sagasti (2000) of whom all debate the complexities and bounds of rationality, I will elaborate on how the “play” of reason (that is a more pragmatic contextualised idea about rationality) is more useful for both pregnant women and mainstream health promoters, than traditional or context independent notions of rationality associated with: “logic, objectivity and the scientific method” or what Nicholson (1999) describes as the “older model” of rationality (p. 117).
The masculinity bias in definitions of rationality and reason (Lloyd, 1984; Code, 1993) not only affects perceptions of what is ‘authentic’ rationality but also plays a part in how the search for knowledge, especially health knowledge is constructed in terms of a heroic quest. There is a well established critique in a range of literature outlining the tendency of scientific and medical experts to position themselves as moral crusaders, working for the betterment of human health (Bunton, Nettleton, Burrows, 1995; Moodie, 1999; Richmond, 1998). This tendency is acknowledged by health promoters themselves, and the processes deployed and suggested has been described by The Health Promotion Journal of Australia editorial as “evangelical” (Moodie, 1999, p. 3). Traynor’s (2000, p. 139) critique of evidence based medicine, described in the previous chapter, outlines the reverence accorded to particularly systematic and supposedly “pure” scientific methods underpinning much health research.

In this chapter I also link the pervasiveness of traditional models of rationality with the more recent emphasis on literacy as an imperative in decision making, and in particular the importance of health literacy. I will question the assumption made not only by main stream health professionals, but also those working within social or holistic models of health, that a well-read and informed health subject is an empowered one. I will argue that the notion of a literate person in Western society is similarly bounded by notions about what constitutes a rational person and how they may demonstrate reasoned decision making processes. It is not only that certain information is privileged over others (for example, medical over homoeopathic) but that the decision making processes associated with health literacy are limited, excluding bodily experiences, anecdote and informal discussion. If they are
acknowledged it is most usually in terms of their being associated in relation to a ‘problem’ contaminating the ‘pure’ message derived from an abstract, disembodied and objective position.

A number of assumptions that underpin mainstream health promotion theory and practice have been referred to in previous chapters. Firstly, that the subjects of health promotion are autonomous individuals who have educated themselves in particular ways. Secondly, that the information provided by health promoters is benevolent or at worst neutral. As I have already mentioned many experts including mainstream health promoters too easily assume a correlation between literacy and empowerment. Health promoters construct empowered, literate subjects the only morally good, rational subjects in terms of health behaviours, as those who read the ‘right’ information (theirs) and comply with it in entirety. This process once again reflects exclusionary tactics because it does not recognise as valid other ways or means of making decisions. Literacy, the education and in some cases the re-education of health subjects is viewed as an essential strategy, part of the heroic quest for perfect health. It is not only mainstream health professionals who rely on this strategy.

Providing ‘alternate’ (to the main stream) information is also written about in terms of enabling “reconstructed knowledges” particularly by the women’s health movement (see Boston Women’s Health Collective, 1992; Hunt, 1991). I will argue that what this emphasis on health literacy re-enforces is the individualising and circumscribed decision making processes that are of concern to both mainstream health promoters and the women’s health movement. As Morgan and Scott (1993, p. 8) assert, to privilege the role
of knowledge: “as power over the body” does not disrupt either the mind/body or individual/society dichotomies so pervasive in Western philosophy, health and social theory.

The critique of rationality

The “older” model of rationality as has already been mentioned is not the only manifestation of rationality in Western societies; however, other more pragmatic or context dependent models are not privileged with the same authority. Criticism of the “older” model of rationality incorporates a number of different perspectives. Modernist, post modern and post structuralist theories explore how rationality and the ways in which it has been described in Western philosophical texts may be interpreted as other than a monolithic, circumscribed entity (Berlin, 1998; Code, 1995; Green, 1995; Tuana, 1994). The notion of a bounded, autonomous, rational individual has similarly been questioned (Hekman, 1995; Stainton-Rogers 1991). Feminist critique demonstrates how rationality has historically been associated with those attributes most commonly considered masculine; how women considered less capable of transcending the body they occupy are aligned with nature rather than culture and are always peripheral to ‘real’ rationality (Code 1993; Lloyd, 1984; Tuana, 1992; Tuana, 1994).

Feminist critique has also been concerned with much more than just questioning the basis of rationality. It has according to Ransom (1993, p. 137) provided important strategies for re-thinking rationality. Ransom (1993, p. 137) asserts that feminism’s role in questioning
how: “particular versions of reality were privileged over others” makes space for what else is: “epistemologically admissible” in definitions of reason. It is this expanded notion of rationality and the decision making processes that flow from it that is a central concern of this thesis. Not that reason is discarded but that it is less rigidly exclusive, for quite pragmatic, realistic and reasonable reasons. In an ‘information age’ where people are subjected to a deluge of competing interests and perspectives, that at best cause confusion and a sense of information overload, and at worst anxiety and stress, the usefulness and appropriateness of decision making processes need to be re-evaluated. The aim of this chapter is to speculate about the possibilities for women and health promoters to make decisions based upon a less rigid model of rationality and to suggest the possibility of less proscriptive ideas about what constitutes reasonable decision making.

Nicholson (1999) describes the dominant model of rationality in Western society as “older.” I think there may be a danger in describing it in this way as that might seem to suggest that the “older” should be discarded as useless and replaced with the new, fashionable and presumed superior. It is for these reasons that I would prefer to describe the “older” model in terms rather of impoverishment. It is not because it is “older” that it should be critiqued, but rather that it is rigid and exclusionary and requires some enrichment. That there are elements of the “older” model of rationality that should be retained is similarly noted by Sagasti (2000) who points out:
“Our lives are not determined exclusively by either biology or culture, or just by passion or by reason. We make value judgements about what is better or worse, good or bad, by intertwining our feelings and our intellect” (p. 600).

Definitions of rationality and reason are also importantly brought into question by the women I interviewed and this will be discussed in a later chapter.

I also want to make it clear from the outset that I am not arguing for a rationality that eschews all that is associated with the masculine, and replacing it with a superior form of feminine rationality embracing all that is associated with the feminine. That is simply privileging the other side of a false dichotomy and does not solve the problem of an impoverished model of rationality. Rather my position is informed by the critique of rationality covering a range of theoretical perspectives including feminist, post structuralist, modernist and post modern. It is a particular model of rationality an: “ideal type” that provides ‘the answer’ that is brought into question (Berlin, 1998, p. 137; Ralston Saul, 1997, pp. 103-104). Not that everything about the “older model” is to be discarded, but rather that rationality as an idea needs to be less exclusive and more inclusive, of those attributes that have traditionally been considered antithetical to its aim.

I will explore how the impoverished model of rationality influences and more importantly limits the processes of reasoning. My problem is with what is allowable or not in this process, the impoverishment of reasoning, not the idea of reasoning itself, or that there may be better or worse ways of conducting oneself, or making decisions. As Ransom (1993, p.
137) asserts: “by challenging not reason *per se* but a form of reason which defined itself in
opposition to the particular and the emotional, feminists sought to generate a different
vision of sexual and social justice” or in my case a different vision of what constitutes
reasonable decision making in relation to pregnancy and main stream health promotion
information. By this I mean that those women who choose not to fully comply with certain
aspects of main stream health promotion are constructed in ways other than deviant,
illiterate or irrational. More than this, that a different vision of what constitutes a rational
territory might eventuate in health promotion campaigns that interact meaningfully with
their target populations, enabling health promoters to respond to difference with a genuine
consideration and empathy to the realities of women’s everyday lives. A reflection by
health promoters on this aspect of their profession might eventuate in a more honest
questioning in relation to the myth of objectivity. Although the presentation of the façade of
objectivity might justify their claims to knowledge, it is at odds with their practice. What I
am describing then is not their actual practice but rather the imagined rationality they use to
justify their arguably quite contradictory (at times) strategies.

Before developing these arguments any further it would seem appropriate to begin at the
beginning and differentiate between ‘reason’ and ‘rationality,’ how I understand these two
terms and how I critique or use them in this thesis. I understand rationality, or the idea of
it, in Western philosophy and science, to be constructed as a systematic, objective,
Baconian and logical view of science and progress, as a way of thinking that results in a
universalistic and heroic quest for the ‘best knowledge’ that will most benefit humankind.
That a rational and indeed, truly ethical status can only be achieved if the thinker is
distanced from the body and emotions, and may thus remain ordered, systematic, pure and objective in their aim. Definitions of what constitutes reason that flow from this model of rationality are also based on ideas about logic and system, a method for weighing up different options in a linear fashion. Definitions or attributes of reason, what are considered reasoned actions or processes of decision making are usually defined in terms of the impoverished model of rationality in relation to health promotion and decision making generally in Western developed countries. These processes are individualistic and based on an assumption that literate, rational subjects, empowered by information that is also rational and neutral, are autonomously making choices. The processes are also linear, methodical and mostly devoid of unseemly desires such as ‘selfishness’ or pleasure especially in relation to approved health behaviours. This model works best by excluding, the body, feelings, emotions, anecdote and spirituality.

This model also works by describing information as neutral and intrinsically benevolent. By this I mean that it is assumed that information provided by health professionals is for the subject’s own good. One cannot rationally object to it, especially in relation to pregnant women because it is for the good of not only oneself but also another. This position is strengthened in the scientific and popular media, with many stories reporting that the way a woman conducts herself both before and during pregnancy has both short and long term implications for her baby’s health (see Bower, 1997, p. 27; Bower, 1997, p. 30; Bower, 1998, p. 19; Ferrari, 2000, pp. 4-6; Seafood improves child intelligence, 1997, p. 61; Smith, 1998, p. 1; Womb with a view, 1997, p.17). There is as already discussed in previous chapters, a plethora of pregnancy, birth and baby care manuals, magazines and books
available, many of which emphasise women’s personal responsibility for their baby’s health. In terms of this thesis, while there were many stories in the media during the years of the study relating pregnancy conduct to foetal health, more recently reports relate women’s pregnancy conduct to conditions such as cardiovascular disease and hypertension in middle aged adults. Many diseases that surface in middle age are traced back to the nutritional and health status of the mother during pregnancy (see Ferrari, 2000). This contributes to an emphasis on the personal and individual responsibility of the pregnant woman not only in terms of a healthy baby but also a future healthy adult.

As I have argued in previous chapters, the stated aims of health promoters to address ongoing issues within health promotion theory and practice such as an emphasis on individual lifestyles versus structural strategies, empowerment versus instruction and devising health promotion campaigns that are relevant to the targeted populations, remains largely rhetorical. The main thrust of my argument is that these will continue to remain rhetorical for as long as health promotion research, theory and practice is underpinned by particular notions of what constitutes rationality and reasonable decision making in terms of responses to main stream health promotion campaigns.

**Health literacy and empowerment**

I have discussed in a previous chapter that main stream health promotion research is based on an ideal (if not in actuality) of a context independent, abstract and pure science in terms of the health claims it makes. That it currently lays claim to being based on ‘evidence-
based’ medicine, but does at the same time recognise a need to market its message in a way that appeals to the audience. I also discussed some of the more negative aspects of this such as the “threat” and “fear” strategies. However, these are not the only tactics used. In recent literature published by health promoters there is a much more clearly articulated concern about the actual practice of health promotion campaigns in terms of empowerment. As previously mentioned concerns are also raised about community participation and the emphasis on the individual rather than structural determinants of health (see Erben, Franzkowiak, Wenzel 1999; Gleeson, 1999).

In the previous chapter it was asserted that the theoretical trends aimed at empowering health subjects remains largely rhetorical and this can be evidenced by analysing the evaluations that health promoters themselves conduct in terms of health promotion campaigns.

It is for these reasons that I would propose that perhaps it might be more fruitful to shift the critique from concentrating solely on why women have been excluded from traditional definitions of what constitutes rationality and reasoned thinking (although this is important) and examine why it is that health promoters seem so committed explicitly or otherwise to the impoverished model of rationality.

Elements of exclusion and normalising tendencies are implicit and explicit in strategies that aim to empower the individual and that privilege a literate health subject. To limit what is considered valid information and the allowable responses to it is to ensure a safe and secure
hold for the health professional, this is not only in a psychological sense, security in ‘the
known’ but that it also acts to preserve the territories of professions. It is not only main
stream health promotion that is problematical in this sense, alternative discourses similarly
set parameters about what is good and rational behaviour although they may be more
flexible and holistic in their approach. The underlying processes that relate to the
dissemination and validated responses to the information are similar, regardless of content.
There is still an emphasis on information that is largely literature based and the same
assumptions in relation to this new information being intrinsically empowering are still in
place, as well as the expectation of compliance with the information provided. It is for these
reasons that I am critiquing not only the content of health promotion information but also
the decision making processes that are recognised as valid in response to it. Literacy alone
cannot empower unless the real structural constraints in which individuals make decisions
are addressed seriously as being both potentially enabling as well as restricting, as positive
spaces as well as problem spaces.

There are other problems with the emphasis on health literacy as an empowering strategy.
In later chapters where I examine the responses of women I interviewed to the range of
health information available to them while pregnant, I will discuss how the exhortation to
be literate can cause problems in terms of confusion and even result in a kind of sceptical
resistance to information, that appears and in fact often is, contradictory. Women’s
response to this confusion is to then utilise other ways of knowing, such as bodily
experience and discussion with others. These contradictions may then be discussed with a
range of other people who may or may not include health professionals. Others relate to
this by using only one source of written information, or conversely an exhaustive literature search is undertaken. While I will come back to these issues in more detail in the later chapters, I raise the point here to illustrate how a model of rationality that is impoverished, that then results in decision making processes that are limited in the ways discussed, is ill equipped to deal with the complexities of the everyday circumstances of pregnant women.

My emphasis is not solely on how certain ‘right’ information becomes privileged over other sources which are consequently lost or seen as less authoritative, it is also in the ways that decision making is constructed as a reasonable response or not to the information provided. While much of the critique in relation to health promotion has criticised the content of information and the unrealistic expectations of health promoters, less attention has been paid to the actual decision making processes that are allowable, socially sanctioned and approved, in the situation of pregnancy in particular. Ways of making decisions in our society generally are limited by the impoverished model of rationality. In this context even though pregnant women may have access to an array of different information their response to it is measured by their ability to demonstrate these circumscribed processes of decision making. Of course the only way they can demonstrate that they are indeed responsible, health literate subjects is to fully comply with the health promotion information. There is an inability or reluctance to recognise and acknowledge as valid in the decision making process, the role of feelings, bodily experience, imagination, disagreement, women’s own risk assessment, or what Code (1995, p. xi) describes as: “adventurous musings and speculations.” More than this, that not only is there a failure to recognise these elements as positive contributors to rational decision making on the part of health subjects, that health
promoters themselves fail to recognise the usefulness of an enriched rationality in their own theory and practice. That a health promotion based on an enriched rationality might be one strategy health promoters could use in their attempts to overcome their own self stated, persistent problems, including the emphasis on the individual and the lack of relevance their campaigns have for different groups of health subjects.

While concern about the lack of relevance is usually articulated in terms of there being problematical minority groups such as, young women, ethnically diverse women or illiterate women, differences amongst what on the surface would seem to be a homogeneous group, such as English speaking, middle class women are not so much discussed either by health promoters or their critics.

One of the main contentions made throughout this thesis is that difference is not adequately acknowledged within what appears to be a homogeneous group, such as the English speaking, middle class women interviewed for this study. In the chapter that deals with the women interviewed for this study I will demonstrate the diversity within the group of English speaking, middle class women that I interviewed. However, as I have already pointed out, the incapacity of main stream health promoters to deal with difference in other than negative terms is evidenced in their evaluations of the folate and listeria campaigns (see Bower, Blum, Watson, Stanley, 1997; Torvaldsen, Kurinczuk, Bower, Parsons, Robertson, 1999).
One of the reasons that difference may be so difficult for health promoters to tolerate is that to acknowledge and accept responses to main stream health promotion advice that may be none or only partially compliant would undercut a basic and enduring philosophical position on which their discipline is based. Richmond (1998, p. 138) discusses how personal and individual responsibility for health is part of the Western philosophical tradition. Describing how Hippocrates was one of the first physicians to break the traditional connection made between health and astronomy or spirituality, instead arguing that health should be understood with: “reference to what a person eats and thinks, that person’s occupation and habits and their consequences” (Hippocrates, as quoted by Precope 1961, p. 244). Richmond (1998) also finds an example in Plato’s writing where he asserts: “the need for a physician to refuse to treat a patient who is not willing to live a good life” (as quoted by Precope 1961, p. 244).

Health promoters often face quite different responses to their campaigns than they anticipated and there is a sense of incredulity and even exasperation in their discussion of women’s responses to particular campaigns. The previous chapter discussed the Listeria campaign for example and the ways health promoters constructed those second time mothers who did not comply with the campaign, as those who should have known better. Their non compliance, refusal to live as good pregnant subjects seemingly unexplainable could then only be seen as irrational. Interestingly, there seems to be a lack of acknowledgement by health promoters that in fact these women may well have made a decision not to comply explicitly with the listeria or folate campaigns because they had already made what could be considered a rational risk assessment. That is, the chance of
their babies either being affected by listeriosis or a neural tube defect was rare. This risk assessment was likely to be informed both by literature on the subject and also by women’s own knowledge that they had previously given birth to healthy babies. They therefore felt capable and confident about basing their subsequent pregnancy behaviours on a risk assessment informed by both strategies. The sorts of risk assessments I am describing here are illustrated in the second part of the thesis in more detail, however, I have raised them here to illustrate the conceptual closing off of the bounds of rational behaviour. There were a number of other responses to the folate and listeria campaigns that also did not reflect complete compliance by pregnant women. It is the recognition of these responses in terms of other than ‘irrationality’ or lack of literacy and education, for which I would argue mainstream health promoters are inadequately prepared.

It can be argued that the tenacity with which mainstream health promoters cling to the impoverished model of rationality says more about the irrationality of mainstream health promotion’s position than it does about women’s supposed inherently irrational response. The critique of the impoverished model of rationality from post modern and post structuralist perspectives in particular, are useful in terms of thinking about ways to enrich rationality that include for example, emotions and experience, but I think that it is also important to acknowledge the pervasiveness of the gendered nature of the impoverished model of rationality. So while mainstream health promoters might construct all none or partially compliant health subjects as irrational, this is intensified in relation to pregnant women who are much more likely than other health subjects to be considered incapable or handicapped in relation to reasoned decision making. In addition to the moral censure and
surveillance to which pregnant women are more likely to be subjected, they also negotiate their decision making as women, philosophically defined as less capable than men of using reason. The previous chapter referred to an example of this in relation to the information men were given from the Australian Medical Association about how to deal with their pregnant partners (see Chapter 3, p. 63). I now want to turn to a more detailed discussion about how women have traditionally been situated on the margins of ‘real’ rationality, how this rationality has been described by a number of feminist philosophers as being based on ideas about the “maleness of reason” (Lloyd, 1984; Tuana 1992; Tuana 1994).

**Rationality, ethics and the pregnant woman’s body**

I have stated in the chapter dealing with the development of health promotion that women are constructed by mainstream health promoters as being at least potentially capable of rationality. The history of philosophical theory also reflects this theme. While that which is reason is associated with those qualities or attributes most often associated with masculinity, such as rising above or controlling the senses, appetites, passions and so on, philosophers such as Plato, Rousseau and Kant did not completely exclude women from this (Tuana, 1992). However, in order to ‘think’ like a man, women had to disassociate themselves with what was defined as ‘feminine’ such as being emotional, passionate and so on. Implicit in philosophical theory since Plato is the assumption that the ‘feminine’ is out of order; to be a woman is to be a victim of not only one’s senses but also to be trapped, much so more than men, in a body (Lloyd, 1984; Tuana, 1992).
It is well established that in Western philosophy it is far more difficult for women to attain an objective, transcending rationality than it is for men. Although this point is qualified by Green (1995) who describes how the philosophical tradition can be differently viewed by analysing the work of feminist philosophers such as De Pisan and Wollstonecraft. Green (1995, p. 8) asserts that implicit in the musings and philosophical writings of these philosophers is an enlarged notion of what constitutes rationality, for example, that reason is: “enlivened by the imagination.” Whilst an acknowledgement of these deviations is important, it also needs to be said that these ideas about rationality have not been as influential as those that reflect and are associated with the masculine philosophic tradition.

It is also clear that historically women have been excluded from a learned and literate status; this has been an enduring problem even for white, Western women occupying a relatively elite position and is exacerbated for other groups of women such as those who are poor or ethnic.

This “maleness” of reason is not always explicit in the theory. As Tuana (1992) points out, there are frequently situations where theory appears to be androgynous. For example, she discusses how Hume does not construct emotion and rationality as oppositional states. However, implicit in his theory is that a woman’s ability to reason is tied in with such qualities as virtue. Implicit in his value system and consequently his theory is that women more than men find it difficult to keep a check on their potential as sexual beings. Throughout philosophical theory a woman’s body is always more of a problem in terms of being able to attain a rational state than it is for men. A woman’s potential for rationality is therefore confined to what Tuana (1992) describes as a kind of practical or lesser form of
reasoning. Objective, abstracted, universally principled rationality, one capable of transcending the corrupting influence of the body is the domain of men. This transcending and untainted rationality is rarely and with great difficulty ever achieved by a woman. It is arguable that for pregnant women it is even more difficult.

I now want to link up these ideas of rationality being associated with what is masculine in terms of form and activity with another point that has been raised by Sagasti (2000). This is what Sagasti (2000, p. 599), refers to as the: “enduring presence of the Promethean myth - extending over 2500 years - in Western Civilisation.” This myth which Sagasti (2000) maintains has been appropriated and used by Bacon defines the search for knowledge in terms of an “heroic quest.” While Sagasti (2000, p. 599) critiques this in terms of its excluding nature (for example, he points out that only a very “small portion of humanity has benefited from the bounty generated by this quest””) I think it can also be seen as a predominantly masculinist quest. In terms of main stream health promotion while actual health promoters and researchers may not be necessarily male, their practice and theory is thus gendered. The search for knowledge and ways of presenting knowledge that will enlighten the target audiences mirroring the more general thrust for ‘heroic’ responses to health problems in society generally. It is difficult to argue with or subvert the information provided by the representatives of heroes, especially if you are a pregnant woman.

The heroic quest for knowledge is similarly circumscribed by processes that reflect the processes of the impoverished model of rationality. For example, the quest does not acknowledge positively the experiential knowledge of the body or an oral history, informal
chats with neighbours and friends. Its route by way of an education based on expert literature and knowledge is tried and tested, straightforward, linear and methodical.

Health professionals who occupy the position of rational expert are also attributed with a higher form of ethical and moral decision making. The importance of ethical and moral decision making is again particularly intensified in the case of pregnancy and the following example illustrates the assumption that health professionals are ‘naturally’ rational and morally superior in contrast to pregnant women who are constructed as less selfless and more prone to ‘wrong’ and even unethical decision making.

The example, this time provided by the British Medical Association, discusses how health professionals are sceptical of a woman’s capacity to make the ‘right’ decisions when inhabiting what is constructed as a problematical, hormonal, emotional and pregnant body.

The article relates to the increased use during pregnancy, of: “sophisticated diagnostic technology” enabling the identification of medical conditions that may result in a “critically ill” or “malformed” baby (Hammerman, Lavie, Kornbluth, Rabinson, 1998, p. 409). The authors raise concerns about the ability of women to make the morally ethical decisions necessary in relation to treatment for their babies while pregnant. What they are referring to here is invasive medical intervention. While acknowledging the rights of parents to make decisions about what kind of treatment or intervention their babies will receive after birth, they are nonetheless concerned about the processes of decision making. They state in relation to the parents: “it is incumbent upon us to realise that no one who is intimately
involved can be totally objective or completely free of any conflict of interest” (Hammerman, et al. 1998, p. 12). By implication, the medical professionals own capacity to be “totally objective” and “completely free of any conflict of interest” is not questioned, it is assumed they are already operating from a basis that reflects their expertise as properly rational, unaffected by emotions, subjectivity or desires, they are as not “intimately involved experts” the guardians of authentic ‘male’ rationality. They then go on to reinforce why it is that the experts should take over the decision making especially in terms of “life-sustaining” treatment and medical intervention.

Claiming that the parents must: “struggle with violently conflicting emotions” Hammerman, et al. (1998, p. 412) assert that the: “love, concern and hope for the baby’s wellbeing is counterbalanced by the grief, disappointment and feelings of guilt over the reality of their imperfect infant.” That a woman who is pregnant or who has just given birth in particular, cannot be trusted to make the right decision (accept intervention and sustain life) according to the experts, is evidenced in the following statement:

“Decisions concerning the limitation of medical treatment are never simple, however there are those of us who feel that it is somewhat easier [for the mother] to forgo life-sustaining treatment in a foetus or neonate because a deep psychological bond between the mother and infant has not yet been established” (Hammerman, et al. 1998, p. 412).
An interesting paradox appears to have been overlooked here by the authors. The experts are claiming to be operating from a totally objective and conflict free position, yet claim that a “psychological bond” in other words a very strong emotional connection to the baby, is necessary to persuade women to make the ‘right’ decisions. The woman and her partner’s own emotional responses are both dangerous to good decision making but in the case of a “psychological bond” between mother and baby, conducive to good decision making. That a woman’s own emotional state is dangerous to good decision making is further justified by describing pregnancy as a time of “emotional disequilibrium” (Hammerman, et al. 1998, p. 412). This is worth quoting at length:

“In addition, pregnancy itself is often accompanied by emotional disequilibrium, both as a result of pregnancy-induced endocrinological alterations contributing to emotional stress and of preoccupation with physical changes causing a disruption in body image. Excessive stress during pregnancy can precipitate depressive symptoms which, in turn, can lead to poor self esteem, poor identification with motherhood, indifference towards, and even rejection of the unborn foetus. To the extent that the pregnant woman is focused predominantly upon herself, thoughts about carrying an ill or malformed infant are likely to be viewed from the perspective of this foetus’s impact upon her life. This is not to imply that the pregnant woman is not interested in the child’s welfare, but rather that the vantage point from which she perceives what is best for this child may be somewhat shifted” (Hammerman, et al. 1998, pp. 412-13).
This quote demonstrates that not only are all pregnant women who are expecting to give birth to an ‘imperfect’ baby constructed as emotionally unstable, they are also pathologically concerned with their changing body image and without really meaning to, are also intrinsically selfish with flawed perceptions about what is best for their baby.

Not only do the health professionals who have written the article reflect a rhetoric that their own processes are based on a model of rationality that excludes emotive, subjective desires (or conflicting interests), but that their decision making is also superior morally and ethically. They then use this to justify and authoritatively state their right to intervene in how the baby is treated, while failing to acknowledge or reflect upon their own use of emotion, to question their love affair with “sophisticated diagnostic technology” or their use of aggressive medical treatment that keeps a baby alive regardless of other ethical issues such as quality of life and the wishes of the parents. It is interesting to reflect on their own words which perversely would evidence their own lack of objective evidence, for example, that some of the health professionals “feel” mothers are not making the right decisions (Hammerman, et al. 1998, p. 413). It seems in this scenario empowered women, pre-warned and armed with the knowledge about the implications of caring for a critically ill or malformed infant are not to be trusted, with a not so subtle intimation that the pregnant woman is self-centred: “focused predominantly on herself” (Hammerman et al. p.412). Once however, women have given birth assume their proper, less selfish place (that is, bonding with their infant, they will make the right decision.) They are it seems capable of a lesser form of rationality, rational enough (tempered by the psychological bond with
the infant) to bow to the authentically rational health professional. I now want to turn to how it is that women have come to occupy this space on the margins of ‘real’ rationality.

Lloyd (1984) refers to the impoverished model of rationality in terms of a sexual division of mental labour and it is a useful insight into the context within which Western women make decisions about pregnancy behaviour. By this she means that men are left to the real work of rationality, the abstracted, objective attainment of truths while women struggle with problems of a lower order, more everyday and pragmatic, more tainted by emotions, and their bodies and importantly of course their close emotional relations with others. While men have bodies that may distract them too, women’s are seen as particularly problematical, because they are associated with childbirth, menstruation, lactation and a corrupting sexuality, all of which are linked to ‘emotional disequilibrium’ and imbalance.

There are dilemmas inherent in even raising the issue of women’s association or not, with rationality. It is even more problematic to propose different ways of thinking about what constitutes rational behaviour. When advocating for a less exclusionary understanding of what constitutes rational behaviour, to argue for a process of reasoning that includes the senses and the acknowledgment of everyday concerns there is an almost automatic alignment with a ‘lesser’ form of rationality. This rationality is not as intellectual or idealist, it is a more practical and at best complementary rationality. As Code (1993, p. 21) points out the ideals of rationality: “have been constructed through processes of excluding the attributes and experiences commonly associated with femaleness - emotion, connection, practicality, sensitivity and idiosyncrasy.” The dilemma in arguing for a definition of
rationality that is more inclusive of emotion, practicality and connection is that it may reinforce the model of rationality which is associated with the feminine, that is a lesser or derivative form of authentic rationality.

While these negotiations are fraught I think that it is possible to speculate about more inclusive processes of reasoning. The global applications or universalising tendencies of the impoverished model or rationality are splintered and to challenge these does not necessitate sliding down into essentialist explanations or justifications. In his discussion about the apparent absence of the body in much of scientific and social theorising, Bury (1997, p. 175) observes that even amongst scientists: “a recognition of the interaction between mind and body is now commonplace, as the massive research literature and popular discourse on stress, for example, demonstrates.” Similar work has been done with women in the area of grief, where a researcher has used a phenomenological perspective to explore the: “experience of body memory following a significant loss” (Hentz, 2002, p. 161). Here the usual time lines used to measure ‘appropriate’ grief (as defined by counsellors) are disrupted and the: “emphasis on the cognitive and affective aspects of grief” is found to be inadequate in understanding the grief experiences of the women interviewed (see Hentz, 2002, pp. 161-172). There are other grounds for re-thinking rationality. It can be argued that in an age when everyone is swamped with information, much of it competing and contradictory, skills in addition to literacy are needed in order to negotiate and make decisions that are reasonably based. A process of reasoning that does incorporate the values that appear to be excluded from mainstream health promotion.
The increasing popularity of alternative therapies and Eastern philosophies not only amongst ‘lay people’ but the medical profession as well, signals that a shift in the direction of a plurality of rationalities may already be occurring (Harris, 1997). While the dominance of the medical model is evident and stories of technological and scientific miracle breakthroughs occur on a regular basis, at the same time, the effect of psychological well being on health outcomes is the grist informing new stories that are being reported. This is particularly apparent in the main stream medical and health literature in relation to ageing populations (Australian Institute of Health and Welfare, 1997, p. 16; Minichiello & Coulson 1999).

While this work is still gaining in popularity and does still privilege “mind over matter” it also demonstrates a shift in thinking, an acknowledgment of the intangible and mysterious collaborative workings of the body and mind. Medically trained doctors are beginning to incorporate alternative or complementary therapies in their treatment of patients. Others may actually work in their practice with alternative health practitioners (Easthope, 2002, p. 325). As Bury (1997, p. 175) asserts perhaps the legacy of Cartesian dualism is not as thoroughly successful as thought when the practices of health professionals are examined.

While Bury’s (1997) assertion that Cartesian dualism does not have a completely successful hold in medicine may illustrate a window of opportunity in terms of re-thinking rationality, the pervasiveness of the primacy of mind over body should not be underestimated in health discourse, particularly in main stream health promotion. Further, that what appear to be moves away from dualist conceptions are not always entirely successful. For example,
Morgan and Scott (1993) assert, that by advocating for more holistic understandings of health, ones that incorporate acknowledgment of the social and behavioural, the primacy of the mind over the body is not always superseded. They provide the example of how some alternative health discourses assign certain types of personality with disease, such as “cancer personality” (Morgan & Scott, 1993, p. 8). In this scenario they state: “thus it is not what happens or even what we do to our bodies which produced ill health, but the sort of people we are, and the self is located in the mind” (Morgan & Scott, 1993, p. 8). Rather than the mind/body dichotomy being disrupted by these challenges to medical models of health they merely reinforce the importance of the mind that: “determines in the last instance what happens to the body, and dualism is restored” (Morgan & Scott, 1993, p. 8). While these reservations are not easily addressed there are still very compelling arguments for continuing to speculate about how rationality and the reasoning processes that flow from it may be re-thought.

Re-negotiating an enriched rationality

Nicholson’s (1999, p. 118) work on what she describes as the “play of reason” an argument for a more pragmatic approach, based on a context dependent model of rationality, does not she claims necessarily mean: “rejecting the idea of rationality as a means of differentiating types of judgement or argument.” It is also as if some new words need to be invented that do not have the negative connotations that are associated with them in terms of describing rationality. For example, while it might pay to be cautious of the use of the word ‘pragmatic’ in relation to rationality, given the danger that this will once again be
associated with that which is derivative or lesser, to be pragmatic in terms of being faced with reality does seem eminently reasonable. Code (1995) makes a similar claim for re-thinking rationality although is more critical of particular attributes that have been traditionally associated with the older model of rationality and philosophical inquiry. Discussing science as the authoritative symbol exemplifying all that is authentically rational Code (1995, p. x) maintains that science is itself a “speculative inquiry” based on “a plurality of rationalities.” Code (1995, p. 216) claims the idea that Western philosophy has only described rationality as a systematic, ordered and objective state is not completely accurate. Code (1995, p. 216) points out that the history of philosophy can also be differently described, claiming that an overview of the Western philosophical canon is as likely to uncover: “a storehouse of more or less adventurous, inspired and imaginative musings” as opposed to: “more or less well-founded, coherent and consistent monolithic explanatory schemes.” Tuana (1994, p. 163) similarly makes the observation that although modern philosophers often refer to Plato as the: “founder of Western philosophic rationalism” that he can equally be associated with “another” Plato, that is: “Plato the poet, celebrator of Eros, the dreamer, the maker of myths and allegories” that there is pathos and irony in his writing. This is similarly argued by Berlin (1998, p. 326) who while acknowledging the impoverished model of rationality as the: “central tradition in Western thought which extends at least as far back as Plato” also refers to the backlash from those philosophers who felt that:

“constructions of reason and science, of a single all-embracing system, whether it claimed to explain the nature of things, or to go further and dictate, in the light of
this, what one should do and be and believe, were in some way constricting – an obstacle to their own vision of the world, chains on their imagination or feeling or will, a barrier to spiritual or political liberty” (Berlin, 1998, p. 328).

Arguing for plurality in relation to rationality and what is considered reason, Code (1995) not only advocates the use of poetic and imaginative insight but also demonstrates how these qualities may at times be more useful than systematic modes of thought based on logic. Furthermore Code (1995, p. 215) argues that the insistence on systematic modes of reasoning is underpinned by “masculinist” imaginary and that the denial of the vague and ambiguous is itself irrational manifesting as a: “deep-seated and passionate desire for a safe and secure, delimited region of serious inquiry” (such as that of mainstream health promotion). Code (1995) does not really develop this analysis in terms of the gender bias in philosophy and consequently the ways in which rationality is defined, because he has a different agenda, however this issue has been taken up by other philosophers and I will return to it.

In terms of health promotion Code’s (1995) work is important for other reasons. For example, Code (1995) questions the emphasis accorded to certainty and describes efforts to avoid any sense of uncertainty as futile. Vagueness is in Code’s (1995, p. 215) opinion “omnipresent” and he maintains that it is not possible to: “demarcate real philosophy from pseudo philosophy - or real science from pseudo science.” This observation has been supported by one of the minority of dissenting health promotion voices that similarly question the usefulness of certainty (previously referred to in Chapter 1 & Moodie &
Borthwick 2001). While Code’s analysis is useful in terms of critiquing the “older model” of rationality it does not fully explain why its hold has been so tenacious. Or why it is that Baconian philosophy rather than the musings of other more poetic or less systematic thinkers has dominated particularly in science, medicine and consequently health discourses including main stream health promotion. However, it does demonstrate, and he gives many examples of these, that implicit in the writing of even the most ardent “rationalists” there are areas where they too are ‘guilty’ of speculative and imaginary thinking.

It would seem in light of the above that the attainment of ‘pure reason’ and a traditional conception of rationality may be opened up for question for a number of reasons. That to continue to cling to this ‘secure’ place is not in the end productive either in a pragmatic or philosophical sense. The metaphor that springs to mind is that it is somewhat akin to Dorothy’s desire to be saved by the Wizard of Oz. The ideal of the impoverished model may be emphatically asserted but if it is, only so much authoritative bluster, as it so often seems to be, other options may need to be considered. Further that there needs to be a shift in my position from a defensive one, that is the need to ‘prove’ or justify that the decision making processes used by women, based on a plurality of rationalities (including at times the impoverished model) are ‘just as good’ as those used by main stream health professionals. Or that they are different in a superior kind of way, evoking the old argument that women are essentially more intuitive or governed by their bodies.
It is perhaps better to simply assert that pregnant women’s decision making and reasons for compliance, non-compliance or partial compliance to health promotion advice, exist in multiple and diversely complex form. That if it is acknowledged that rationality and consequently reasoning and decision making can never be impervious to so-called contaminating influences, this may be the case for main stream health promoters as much as it is for pregnant women. To blindly assert that rationally there is only one conclusion or decision that a woman can make in relation to health promotion advice that is, the same one as the health promoter, is similarly akin to burying one’s head in the sand. Further, that if a woman does not comply it is because she is irrational or lacking in literacy. As Code (1995, p. 217) argues it is only: “once the rational thinker has renounced the obsessive search for one reason” that there will be balanced reasoning and decision making albeit “localized and temporary.” Neither can the health promoter’s insistence that aberrant women just require further education be upheld as a viable strategy in terms of empowerment or meeting the needs of target groups. As much as decision making on the part of women may be based on reasoning processes that are “localized and temporary” so too do main stream health promoter’s strategies need to incorporate these qualities.

The emphasis accorded to the impoverished model of rationality can be questioned in another way. Not only because it excludes those attributes mentioned above such as emotion and so on, but also because it excludes decision making underpinned by a reasoning process that does not reflect Western philosophy. It may be difficult for people to question reasoning processes if they are unaware of how these may have been constructed by the colonising nature of Western philosophy. So not only are the ways of
thinking about reason and decision making masculinist, they are also culturally biased in a number of ways. By this I mean not just in the ways mainstream health promoters respond to ‘ethnicity’ but also in how the idea of rationality and over reliance on the “Baconian program” is in itself a form of cultural imperialism (Sagasti, 2000, p. 597). What constitutes rationality in this context excludes non-Western philosophies and ideas about reasonable decision making. Further, as Lloyd (1984, p. 11) points out the Baconian association of women with nature: “and nature as knowable” feeds into Western Christianity and the idea that male has dominion over female. A pregnant woman so obviously ‘natural’ is placed in a position of deference to the cultural scientific and medical enterprise, most usually represented in forms whose practices are gendered as masculine (see Pitt, 1997, pp. 220-229). It has been argued that it is not only traditional medicine and science that operates within a peculiarly disembodied approach to the patient, both in practice and theory (Reiff, 1979). Morgan and Scott (1993, p. 27) assert that within the tradition of social theorising generally: “the body if not irrational, is seen as non-rational.”

In drawing the threads of the chapter together there are a number of overlapping power networks within which women negotiate and make decisions in relation to pregnancy. What makes these regimes of truth powerful is not that they are completely successful as ideal types of the impoverished model of rationality or even that they are imperialistic in terms of the “Baconian program” but that they can and do present themselves as disinterested, selflessly pursuing a heroic quest for the benefit of all pregnant women and their babies. It is not the privileging of a particular impoverished model of rationality that is
the entire problem, it is the coupling of this with ideas about how this is ideally
demonstrated in terms of decision making and pregnancy conduct.

To make this a little clearer I will refer back to the example I gave earlier in relation to
some general practitioners utilising alternative therapies or at least recommending them to
their patients in certain situations. The general practitioner has been trained within the
tradition of medicine that is clearly based on an “older model” or impoverished rationality,
yet individual general practitioners for one reason or another choose to work outside these
parameters. Their practice therefore belies at times what they have been taught
theoretically. Perversely this does not seem to happen with main stream health promoters.
Although main stream health promoters are trained and theorise about the social contexts
within which they work, they fail to translate this theory into their campaigns or the
responses they recognise as valid to them. One of the reasons this happens I would
speculate is because there is a sense that they are poor cousins to ‘real’ health practitioners
and must demonstrate the authenticity and rigour of their practice, align their ‘soft’ science
with the ‘hard’ science of medicine and establish what Williams (2002, p. 343) refers to as:
“domains of practice” (see also Chapter 1). However, this is not the only reason - it is also
because of the emphasis in health promotion that is given to health literacy as a strategy, a
literacy that is similarly impoverished because it only includes information that is
sanctioned by main stream health promoters.

The emphasis on health literacy and an assumption of resultant empowerment is itself
problematical because in practice it fails to circumvent a traditionally rationalist
framework. The tendency to do this cuts across different health care models and in other areas of social inquiry and critique, but is particularly prominent in health promotion because health promotion clings to the “older” or impoverished model of rationality. Health literacy reflects its rationalist base; it is an abstract and masculine form of knowledge, privileged over other less static and linear forms of knowledge such as anecdote, discussion, psychological and bodily experience. The privileging of health literacy over other modes of knowing can similarly be critiqued on the grounds of cultural bias. The notion that a health literate person has the ability to gain access to and use information is based on Western ideas about sovereign individuals and their right to act autonomously. Literacy is understood to be an individual’s ability to read and understand written text as well as the ability to communicate by writing. The Health Promotion Journal of Australia (King, 1996, pp.160-164) and The Journal of the American Medical Association (Bresolin, 1999, p. 554) define health literacy in terms of an individual’s ability to seek out, read and understand health promotion and use it by responding positively to its instruction as a rational, learning subject. It is asserted that in doctor’s consultations educational literature is instrumental in “improving compliance” and “deterring litigation” (King, 1996, p. 161) and that: “those with the lowest reading skills had poorer physical and psychological health than those with better reading skills” (Bresolin, 1999, p. 554). Despite the latter study stating that “confounding sociodemographic factors” were taken into account, health literacy was attributed as the most significant factor in enabling the health of individuals (Bresolin, 1999, p. 554). Given the discussion above in relation to what is excluded from the impoverished model of rationality women who do not comply or comply only partially with health promotion campaigns would seem to be in a disempowered rather than
empowered position. Health literacy is it seems something apart from the everyday social contexts of individual’s lives (whilst this also applies to health promotion targeting men, the stakes for pregnant women are much higher due to their ‘responsibility’ for the health of the foetus).

There is another problem with this heavy reliance and emphasis on health literacy, as it fails to acknowledge that even women who are English speaking and comparatively well educated are nonetheless positioned in particular ways. English speaking Western women unlike English speaking Western men have been less visible as literary, learned and rational subjects. These exclusions, whether privileging ideas about mind over body, or what constitutes a citizen who can act in the public world, have relegated women to the less than rational and literate in many areas of their lives (Hekman 1995; Lloyd 1984; Tuana 1992). The consideration of this legacy begs the question about how women are able to demonstrate their health literacy in relation to pregnancy and birth in terms other than those dictated by main stream health promotion. Here the philosophical dichotomies intersect the pregnant and birthing body with the reasoning mind. These ideas have been explored by Thiele (1994) and Young (1990) and the possibility of “thinking” through the body raised.

It appears that there is a blurring of distinctions of a different kind in relation to women and health promotion campaigns. There seems an expectation, albeit limited, that reproductive women do have the ability to act as rational subjects. Health literacy as defined by health promoters relies on the ability of an individual to reason in a logically cognitive fashion. However, the rationality accorded to women seems to repeat the traditional pattern noted by
Code (1993), Lloyd (1984) and Tuana (1992): that is, it is a lesser form. Women are only rational if they read the right information (health promotion information) and comply with it in its entirety. Responses based on a different kind of literate reasoning process, or those that incorporate bodily experience, anecdote, spirituality and so on, that result in non or only partial compliance are considered to be the consequence not of an irrational person necessarily, but certainly one who is exhibiting a lesser form of rationality and are constructed as problematical by main stream health promoters.

Nicholson’s (1999) work suggests at least some tentative steps that may enable decision making to be more pragmatic or enriched, without throwing away all that is useful and even necessary in the impoverished model of rationality. This view is supported by Sagasti (2000) who describes the legacies of the Baconian age as limited in a number of ways. He advocates for less emphasis to be put on the exclusivity: “of our rational faculties” in terms of strategising for the future well being of humankind by: “putting ethical, emotional and aesthetic questions - that is, feelings - on an equal footing with reason, integrating all of them into the design of a new program” (Sagasti, 2000, p. 599). Both Nicholson (1999) and Sagasti (2000), acknowledge the usefulness of aspects of the impoverished model of rationality, or what Sagasti (2000) more globally describes as the “Baconian program.” There must be some kind of framework that enables us to make decisions about what is good or bad, or what is a better or worse decision. How this can work in terms of health promotion practice is a much bigger question and will be discussed in the concluding chapters of the thesis.
In light of the above it would appear that there are good grounds for questioning mainstream health promoters’ irrational insistence on particular kinds of decision making and ways of demonstrating rational behaviour. The privileging and colonisation by a particular circumscribed idea of rationality, which flows on to ideas about what constitutes health literacy and responsible decision making, would appear to be less than useful in terms of health promotion theory and practice, especially in its stated objectives to move away from individual approaches and to empower its target audience. It could also be argued that while these points are important in terms of mainstream health promotion generally, they are particularly pertinent for pregnant women because the processes of decision making are imbued with an intensification of responsibility and the very real existence of severe social and legal censure.

My main points have been that mainstream health promoter’s aim to empower the objects of health promotion will remain rhetorical as long as health promotion research and campaigns are conceived and conducted in ways that do not recognise difference as other than a problem. Health promotion strategies based on context independent or abstracted ideals about good pregnancy behaviour and an over reliance on health literacy as a tool for good decision making may not be the most productive ways to empower pregnant women.

My concern with how decision making is framed in relation to mainstream health promotion also relates to the overall health and well-being of women and their babies. If mainstream health promoters refuse to acknowledge the validity of different ways of decision making as well as knowing about pregnancy, the processes of pregnant women
will be fraught with unnecessary anxiety and stress. The second part of the thesis that engages with the interview material will draw this point out more clearly as well as explore the myriad of decision making processes and the pluralities of rationality used by the women interviewed for the study.
The Women

The first part of the thesis has provided the theoretical context and textual analysis for this study. It has outlined how pregnant women in Western Australia are constructed as health subjects by mainstream health promotion campaigns and a range of health discourses, including medical models of health and the alternatives or variations of these. The second part of the thesis will deal in a more direct way with the women interviewed, as the educated, middle class subjects of the mainstream health promotion campaigns referred to earlier. Here, a closer look is taken of the ways in which those women have interacted with, and responded to, mainstream health promotion information as well as a range of other information.

This chapter will begin this exploration by outlining the methods used for interviewing the women, how they were selected and the ethical and research issues that presented along the way. It will also outline the two models of care in relation to pregnancy and birth used by the women for this study. In this study I have interviewed those women who chose a more medically oriented path, consulting a doctor or obstetrician for the pregnancy and birth, and women who chose home birth as part of a community based midwifery program. Although many of the home birth women consulted a doctor in the initial stages and are legally required to have one on standby, most of their pregnancy and birth care was by community midwives. When I refer to midwives in this thesis it is to those that are community based
rather than hospital or privately based\textsuperscript{1}. I have included a discussion of these for a number of reasons.

Firstly, to outline the broad philosophical differences and practices of each model, including the different ways in which doctors and midwives interact with pregnant women. Secondly, I will argue that women may be subject to stereotypes depending on which model they have chosen. For example, women who choose a hospital birth are often constructed as being dupes of the medical system, more compliant and less critical of mainstream health information. On the other hand, women who choose a home birth on a community midwifery program can be constructed in different ways as ‘alternative’ and irrationally critical of anything remotely medical or mainstream. I want to shift the analysis from inevitably constructing women who choose hospital births as victims of medical discourse and women who choose home births as victims of a naturalist one.

\textbf{Why interview?}

When I first began to think about this project I had no intention of interviewing women at all. There seemed to be a great deal of textual information and analysis in the area that I could use without needing to interview. With the wisdom of hindsight this is somewhat ironic given that because I interviewed I approached the textual analysis in the first half of the thesis very differently. It enabled me to critique the approaches of mainstream health promotion in diverse, more fluid and insightful ways that I would otherwise have done. The interviewing process also assisted in unsettling and disturbing many of my own
assumptions and presumptions about mainstream health promotion and how pregnant women engage with it. This said there were also equally valid reasons for the feelings of tentativeness about the interviewing experience.

I was concerned about a number of issues in relation to interviewing, from the dilemmas and difficulties surrounding representativeness (who am I speaking for) to ways in which I might inadvertently contribute to women worrying about the management of their pregnancy or birth. There were also more routine questions like how I was to conduct the interviews, how I would get to them in my then unreliable thirty year old car and most importantly, what was the best way I could do justice to women who agreed to take time out of their busy lives to talk to me. Another major factor in my reluctance to interview was because I felt it was something I had not been formally ‘trained’ to do, that is it was not a skill I had developed. The issue of a researcher presenting as professional or expert when they feel uncomfortable or tentative about claiming this status, has not received very much attention in the research literature. While there are many texts about methods, including feminist methods of interviewing (see Oakley, 1992; Reinharz, 1992; Smith 1987) the issue of presenting myself as ‘professional’ or ‘expert’ interviewer, when I had never done it before was for me a worrying one. I will come back to this later on as the actual interviews did present with one particular situation where I did in fact feel somewhat uncomfortable about how to represent myself.

It was this feeling of discomfort and the other reasons mentioned that eventuated in my not seriously considering interviewing until after a year into the study when this slowly began
to change. I became aware that whenever I answered questions about the topic of the thesis or discussed my interests with other women, they were very interested in hearing more and would often share their own pregnancy and birth stories with me. I was struck especially by older women, some of whom had given birth twenty or thirty years ago who remembered how they made decisions in relation to pregnancy management and birth in great detail. Perhaps, most importantly it was the enthusiastic and animated way in which women spoke to me about their experiences that first began to alert me to the advantages in speaking to women more directly about their responses to mainstream health promotion. Their stories were all so interesting and different that I decided talking directly to women about their individual experiences would both enhance and enliven the study, especially if I arranged the interviews so that they were more conversational and interactive.

The importance of including women’s voices in research has been articulated by others. As Wyn et al. (1996) assert:

“It is in the conduct of research into the way in which women negotiate vulnerable periods in their lives that women’s health researchers can make an important contribution, focusing on the implications of relations and discourses of power for women” (p. 167).

My own approach to the research methodology has then been based on an idea that the women’s voices would be central to the directions of the thesis and that my interview methods will assist in this objective. I understand this study to be a project where: “a
relatively unstructured research method can be used” (Wyn, et al. 1996, p. 168). By this I mean that the questions I have asked have invited detailed, in-depth stories, rather than shorter, survey style responses.

The Women

Twenty women were interviewed for this study and of these ten intended to or had already given birth at a hospital at the time of interviewing. The other ten intended or had already given birth on the community based midwifery program mentioned above.

At the time of interviewing, the women were experiencing or had experienced in the last six months their first, second or third pregnancy to come to term. There were nine first time pregnancies, six second and five third. Six women were pregnant at the time of interview, while fourteen had already given birth in the previous six months. The reason for selecting women who had given birth in the previous six months was because I wanted to capture the immediacy of their pregnancy experiences in relation to contemporary main stream health promotion campaigns. My reason for choosing a mix in terms of whether women were experiencing a first or subsequent pregnancy was in order to ascertain whether first time mothers were more conscientious than or used different decision making processes to, women who had more than one child.

All of the women interviewed spoke English as their first language. Just under half of the women had been born in countries other than Australia but were still of an English
speaking background such as New Zealand or the United Kingdom. There was a diverse occupation range from academic, barmaid, chemist, florist, home makers, librarians, students, midwives, catering manager, teacher, social worker and general clerical and office workers. The women’s ages ranged from twenty-seven to thirty-eight.

While other studies have drawn a correlation between professional women and the likelihood of home birth this was not the case for this study (Morison, Hauck, Percival, McMurray, 1998, p. 235). Both professional and non-professional women had home and hospital births: professional women constituted about 30 per cent of both home and hospital birth category. This may also have something to do with the fact that I was interviewing women who had chosen home birth by way of a community based program, rather than those women who were privately insured and may have chosen a privately practicing midwife. The program provides free births to eligible women and has stated in a petition to the Western Australian government that community midwifery: “services should not be seen to be elite or available only to certain people, but should be available to all women who chose not to be part of the hospital based system” (Western Australian Legislative Council, 1999, p. 20).

As I have mentioned in the introduction to this thesis and in passing in other chapters, and despite the qualification mentioned above in terms of professional status, the women I interviewed could as a group be broadly categorised as ‘middle class.’ The construction of poor or ethnic women by main stream health promoters as a problem is an issue that I acknowledge, however, my reason for choosing an articulate and middle class group is
because I want to question the notion of compliance that is most usually associated with this group. I use the term middle class with some qualification, and the way I use it is certainly not in a purely economic sense. Some women lived in more elite suburbs than did others, some in older run down houses, others in newer, larger houses. The women I interviewed are then defined as middle class for the purpose of this study in the sense that they were all articulate, relatively well educated and their first language was English. Seven of them had completed or embarked on university or tertiary education and all of them had completed their high school studies to at least year 12 (the final year of study in Australian schools). My use of the term ‘middle class’ does denote an assumption, that I expected this group to read and inform themselves about pregnancy and birth, as they would in other areas of life. Women like those I interviewed are a group who are likely to read up, not only to inform themselves directly but also so that they have questions to ask of their doctors and midwives. They can be described generally as a group who are informed, literate and articulate. They are also a group who are considered ideal candidates for main stream health promotion by main stream health promoters.

Middle class women are as a group assumed to be most likely to seek out, read and comply with expert health information (Bower, Blum, Watson, Stanley, 1997; Torvaldsen, Kurinczuk, Bower, Parsons, Robertson, 1999). As mentioned in the introduction, part of the reason I am doing this thesis is because I am suspicious of the assumption that classifies educated, middle class women as uncritically compliant. I want to demonstrate the diversity of opinion, philosophical outlooks and responses to main stream health information within this seemingly homogenous group.
How the women were selected

My initial plan of action in relation to selecting women for the study was to write a short article outlining my study for a local community newspaper. In this way I hoped to access a reasonable diversity of women who lived in both older, more established areas, as well as the newer and more isolated suburbs. The home birth women were those who had been part of the community midwifery program in Fremantle and other areas South East of the city centre. Twenty were sent letters inviting them to participate in the study. Again the women were selected from a range of suburbs and occupational backgrounds. Initially I did not consider using two separate processes in order to attract women who had both hospital and home births as I had assumed that both groups would contact me. This was not the case and given the low percentage of women who choose home birth in Western Australia I needed to devise other ways of selecting these women. Two of the women I interviewed (both hospital birth) were accessed by way of the ‘snowballing technique’ that is they were not anonymously selected or self-selecting rather they were people I knew of, who had given birth within the previous six months.

While my aim was to interview relatively well educated and articulate women from a diversity of occupational backgrounds, I do not claim that my techniques for selecting women for interviewing were devised in order to maintain distance or objectivity. The women were neither chosen randomly nor by a mathematically generated attempt at representativeness. My aim was quite modest in that I wanted to interview by way of a
qualitative, semi-structured, in-depth technique, a group of women who were reasonably well educated, articulate and actively involved in keeping themselves and their babies healthy.

More women responded to my invitation to participate in the study that I could use given my time constraints and the scope of the thesis. I sorted through these by checking that the women who responded had given birth within the last six months, and by trying not to duplicate by way of occupational status or suburb.

I selected a group of women I felt were the most appropriate to interview in terms of the objectives of this study, that is, to ascertain the differences in engagement with mainstream health promotion from an articulate and middle class group of women who had chosen both hospital and home birth. Following on from this I sent out consent forms, a letter outlining the ways in which I intended to assure their rights to confidentiality, as well as the right to not participate in any part of the study or questions they felt uncomfortable with. The letters were informed by the ethical guidelines of Murdoch University as well as my own knowledge of feminist research methods and ethics gleaned from feminist and sociological texts (see Daly, 1996; Kellehear, 1993; Roberts, 1981). I also informed the women that I would be taping the interview. I provided the women with a brief overview of the sorts of questions I would be asking them. These ranged from asking them how they had felt about their pregnancies; what they considered were good things to do for themselves when pregnant; what they considered were good things to do for the baby when pregnant; to whether they had planned their pregnancy or considered pre-natal testing and how they
engaged with and made decisions in relation to the diversity of information (specifically main stream health promotion) they were presented with when pregnant (the actual questions used are attached in Appendix 3).

I will raise the issue of preserving anonymity in the research later, as this raised an ethical issue for me in relation to the women I interviewed, although not one that would ordinarily be anticipated.

The interview method I used has been described as semi-structured, in-depth and qualitative. I was informed about these methods from both feminist and qualitative research methods text books (see Daly, 1996; Roberts, 1981). This means that although I had a set of specific questions they were open-ended and broad, inviting a story-telling rather than a closed response (see Appendix 3).

The interviews were all conducted, audio taped and transcribed by myself. Once I had transcribed each interview I sent a copy of the transcript to each woman involved inviting any further comments or qualifications they felt were necessary. With hindsight I am not sure of the usefulness of this process, given the myriad of ways in which verbatim quotes can be interpreted and used in the final research. In terms of integrity I can only claim that I have attempted to honour the women’s voices by contextualising their responses within each interview situation.
As I have discussed in a subsequent conference paper presented with a colleague the aim was to engage and identify with the women concerned. The interviews were carried out in the women’s homes, often with a cup of tea and freshly baked cake. They were discussing at times very personal and deep felt issues. When doing semi-structured interviews women will often, at the end of a story, invite engagement from the interviewer and confirmation with “you know what I mean?” (Davies & Dodd, 2002, p. 283). The women I interviewed invited and expected this kind of understanding much like any other social exchange. I also do not claim to, nor did I try to remain distant or objective. Many of the issues raised by the women were ones I was either familiar with or had experienced myself as a mother of two children.

The contributions the interviews have made to the thesis have been profound, even personally confronting and unsettling for me on occasion. They have challenged a number of assumptions I had made about how women responded to health information and the ways in which they make decisions. The interviewing process contributed to some major points of interest, such as the ways in which women made decisions, how they described their feelings, differences and similarities between and within home birth and hospital birth women, as well as a number of interesting paradoxes and surprises. The contribution that the interviews have made to the thesis has resulted in a more interactive and flexible approach to the theoretical issues. Rather than being constrained by the somewhat static process of textual analysis, I have responded to the transcript material in a way that I hope assists in the women’s voices being central to the thesis. It is their voices that have informed the major directions of the thesis. Even though I do not directly quote any of the
women I interviewed in the first part of the thesis they are there in my recollections, informing the theoretical turns I have chosen to take. In the remainder of the thesis I turn directly to their voices. Where I directly quote I have allocated each woman with their own number (1-10) followed by an abbreviation of ‘hmb’ (for home birth) and ‘hosp’ (for hospital birth).

Methodological Issues

One of the most crucial issues that arose in terms of this thesis was the belated inclusion of home birth women. When I originally advertised for women to interview I was struck by the fact that not one of the women who had responded had given birth outside a hospital setting. Only one was planning to give birth at a birthing centre attached to the major teaching hospital in Perth. As I was interested in the decision making processes of women in relation to pregnancy and birth I thought the study should include some women who had chosen an alternative to a main stream medical path. These were, according to what I had read, still middle class women but yet had chosen against the dominant medically managed model of birth and pregnancy (Morison, et al. 1998). While I was aware that for many women home birth did perhaps not figure as a choice, I did expect a few women to respond that had considered this option, or at the very least, midwife led care in a birthing centre.

The overwhelming response by hospital birth women can be explained by the fact that for a number of reasons, home birth is really not an option for most women, representing less than 1 percent of the total births in Western Australia every year (Gee, 1998). It is not
covered by the government insurance system (Medicare) and up until recent years has only been available privately to a very few women. Fortunately this situation would appear to be slowly changing with government funding having since been made available to expand the Community Midwifery Program. In addition the option of home birth is rarely mentioned as an option when a woman first presents at a doctor’s office. Similarly a number of birthing centres attached to suburban hospitals have been closed down in metropolitan Perth. Although women may choose this option the criteria under which they may be considered is very strict and many end up in the main stream hospital system despite their ‘choice.’

While I have been concerned to include both home birth and hospital birth women and have in a sense ‘over represented’ home birth women this is not in order to necessarily create an oppositional discourse in terms of the two models of care. I want to state at the outset, that although it has become clear from the interviews that home birth can be an important and empowering experience for the women involved, I do not in any way wish to denigrate the experience of women who have given birth in hospital. I concur with the comments of others that there may be benefits for those women considering their options, if main stream obstetrics and midwife discourses were not constructed and perceived as “oppositional” (Campbell & Porter, 1997).

The politics of home and hospital births is vitally important in terms of choices and options available to women and will be addressed inevitably, in some part, within the thesis. However, the main focus of this study is a little different. It is how do women, whether
they had a home or hospital birth, use, reject and interpret main stream and other health information? How do they navigate and weave their way through multiple and competing discourses and what is the social and cultural milieu in which they do this? While there are indeed differences between home and hospital birth women these are not always inevitable and there are some surprising differences within each of the groups.

My need to be flexible and responsive in relation to the women I interviewed further confirmed my decision that my interview method needed to be qualitative, semi-structured and in-depth. I needed to understand the social and cultural contexts within which the women I interviewed made decisions. As Bryman (1984) asserts:

“Qualitative research is deemed to be much more fluid and flexible than quantitative research in that it emphasises discovering novel or unanticipated findings and the possibility of altering research plans in response to such serendipitous occurrences” (p. 78).

The flexible and responsive nature of qualitative research methods is also important in terms of similarly understanding ethics in relation to social research.

**Ethics and scope**

When I initially set out to do the interviews for this research I was most concerned with main stream health promotion and how women made decisions when pregnant. I was not
interested in the birth at this stage as I felt there had already been a lot of work done in this area and for me it was more useful to change the focus somewhat. I began the interviews by asking the women to only speak about their pregnancy. This approach seemed to be working quite well with the first ten women I interviewed (who had all given birth in hospital). When they did mention the birth it was usually only in passing and very briefly described.

The interview process with the home birth women turned out to be quite different. Emphasising once again that I was primarily interested in how they managed their pregnancy I found it somewhat disconcerting that they seemed to persist in talking about the experience of their birth in great detail.

After the first few interviews with home birth women I realised it was impossible to keep the birth story out of the interview. I also found I needed to reconsider my aim to contain the scope of the research within the original ‘pregnancy only’ boundaries. I began to have the uneasy feeling that if I persisted in this approach I was in fact being unethical as a feminist researcher. Essential to the role of the feminist researcher is to my mind, enabling and facilitating the voice of the submerged and marginal. To be ethical in this circumstance was to be less not more rigid in my research boundaries, to enable the women I was interviewing to tell their pregnancy stories in their own way. My sense of ethics in this regard was not informed by a “set of universal and absolute principles” or purely by “deductive and calculative reasoning” (Charlesworth, 1996, p. 11). Rather it sought to attain the flexible and contextual approaches that other researchers have advocated as
useful when the “objects’ of study” are either a vulnerable, marginalised, or silenced group (Charlesworth, 1996, p. 11; Roberts, 1981). My methods were informed by a belief that in qualitative research a sense of “empathy and imagination” rather than abstracted and universal ideals about what constitutes ‘ethical’ conduct, should be incorporated (Charlesworth, 1998, p. 13). Furthermore, given that home birth women represent a very small percentage of the total women who give birth it seemed even more pressing they were given the opportunity to articulate their experiences in a way that had most meaning for them. Also very importantly in terms of the direction of the thesis I realised that birth choice and the information used provided some interesting material in terms of overall decision making, questions of rationality and how the pregnancy was managed. The birth story actually became central to questions about the use of mainstream health promotion. While this will be the subject of a later chapter I have raised it here because although I felt comfortable with the reasoning for changing my approaches to the home birth interviews, I was then presented with another dilemma.

I already had transcripts detailing birth experiences for half of the group of women, but very little for the other half who had given birth in hospital. I addressed this in a partial way (and this was a compromise and by no means ideal) by going back to the hospital birth women I had interviewed and asking them to tell me the story about their birth as well. I was aware that it was difficult for women to take ‘time out’ with young babies and often many other responsibilities and so did need to compromise by ‘making do’ with a telephone interview.
Eight of the hospital birth women agreed to a telephone interview in relation to their birth or intended birth choice. In terms of those women who had already given birth I found it difficult to obtain the detailed stories I had so enthusiastically been given by the home birth women. This may have been partly due to my asking women questions by telephone; but may also have been a consequence of their being less involved in the decision making processes of giving birth and this is an issue that will be addressed in more detail later, as it has very real implications in terms of decision making in other areas as well. The actual process of preparing for and giving birth was described more in terms of something to be got out of the way and as something that needed to be done. The birth was then not the peak experience it was for many home birth women. It may also have been because birth did not symbolise choice for these women the way it did for home birth women. They were not choosing against something else but rather just negotiating in terms of how they would manage a hospital birth. None of the women I consequently interviewed had even considered a home birth. These points are raised briefly here to highlight that in relation to both ethical concerns and research directions, this change in methodology was significant. Neither was this the only issue I needed to respond to.

There was another significant issue in relation to demarcation of research boundaries. One of the other limits I initially set was to ask women to focus only on their most recent or current pregnancy. This proved as difficult to insist upon as the previous example. While I was interviewing women who had experienced more than one pregnancy, they inevitably made comparisons between different pregnancies and many compared their experiences with those of relatives and friends. Again, what appeared initially to be a problem with
boundaries turned out to be vital in terms of enriching the thesis. An example of this is that some of the women had unfortunately experienced a miscarriage in previous pregnancies and this affected the way in which they made decisions in relation to health information in later pregnancies. Again, I will come back to this in the chapter that deals more directly with these interactions.

Generally, women’s stories were complex, woven and intertwined with memories of previous pregnancies and comparisons with others, such as mothers, family members and friends. Although I was initially rather concerned about how this would muddy the waters for me, I quickly learned to let go of the notion that I was going to attain a ‘pure’ and untainted story. I realised my own propensity to be rationalist in the ‘older’ or impoverished sense. If I had insisted that the women ‘keep on track’ with my set questions and leave out their previous experiences, I would have missed out on a whole lot of pertinent information about how women made decisions in relation to pregnancy and birth. Another researcher summarises it in the following way: “the aim is not to produce an ‘objective’ account, but to allow expression to notions which have a reality of their own” (Pitt, 1997, p. 221). In terms of how I intended to critique the conventional notions of rationality the information I gained in this way was crucial to my overall thesis.

I now want to pick up on a point I raised earlier about the issue of presenting oneself as a ‘professional’ interviewer. I think this is a very important concern because whether one explicitly or consciously presents as professional or not, the women who are being interviewed often assume that a social researcher undertaking a doctorate is an expert. I was
very concerned that while interviewing I was complicit in presenting a facade or edifice of the ‘expert interviewer.’ I also became very much aware of how my own frameworks of knowledge could be thoroughly unsettled during the interview, and how it was somewhat difficult to present an altogether unruffled façade.

To provide an illustration of one situation where this was particularly apparent I will refer to an interview where the points I have raised became real issues. This particular situation occurred toward the end of an interview. The woman interviewed had throughout the interview stated she was emphatically against ‘the state’ and any main stream services, not just in the realm of health, but also in education, production of goods and services, government and so on. She lived in a semi-rural setting, where recycling, permaculture, organic food and homoeopathic medicine were the norm. Her bookshelves were full of anarchist books and she declared herself and her family to be non materialist. Although I assumed that I already knew how she would respond to a question about planning a pregnancy I still asked, as I had all the other women, whether she had planned her pregnancy. She did answer no, as predicted, but not for the reasons I had imagined.

*Interviewer:* “*Because we have been discussing women’s use of main stream health promotion information I am interested in asking women if they planned their pregnancies. Can you tell me did you plan yours?*”

“No, neither of them were. But we sort of decided..... not to take any precautions at all throughout the marriage. Probably because I am a Catholic and I do not want
The woman’s response to this question did surprise me and I am sure that my ‘expert’ composure would have been at least momentarily dislodged. It was not just that it was unusual for someone styling themselves as an anarchist to claim a strong belief in a mainstream religion, but that it presented a challenge to my assumption that if she was an anarchist she could not possibly be a practising Catholic. This was an example of where researchers can be confronted with their own concepts of subjectivity and the rational, unified self. It made me realise that when participants in interviews respond to questions that challenge frameworks of knowledge deeply held by the researcher it can be difficult to present the composed, professional facade of the ‘expert’ interviewer. I responded to this by remaining silent and moving on to the next question, however, I am sure that my face would have betrayed a look of surprise. While others have argued that maintaining a professional pose creates a sense of trust in the interview situation (see Smith 1987) perhaps it might be more ethical to admit to being less than expert in these situations (Davies & Dodd 1999). It may be just as useful to build trust on this basis rather than on a facade of the professional expert.

On the subject of trust I have also been led to question the insistence on complete anonymity because of my own experience interviewing women for this study. As I mentioned earlier, I had carefully worded consent forms for women to sign before the interviews where I assured them of anonymity. Once again at the beginning of each
interview I would assure women that their real names would not be used in the final thesis or any resulting publications. Many of the women were quite disappointed about this process claiming they would be happy for their names to be used. Some felt very strongly that this was one of the few occasions where they were asked for their opinion and it was for them a political act to be named. While I have chosen to preserve anonymity as required by the university ethical guidelines this is again an issue that requires more debate. There are research situations where articulate and politicised participants do in fact want to make a strong statement about an issue and furthermore want to clearly put their name to it.

Before I turn more directly to the interview material, I will conclude this chapter by providing some additional context of the different models of care in relation to pregnancy and birth care and provide a general overview of the philosophical positions adopted by both medical professionals and the women interviewed. This is important to provide the contextual background in which women negotiate with health professionals, purvey a range of literature and make decisions in relation to a range of health information.

Models and philosophies of care

I have in the previous section raised the issue of the absence of a ‘positive’ or ‘peak’ experience in the birth stories of the hospital birth women. The interview transcripts also alerted me to the differences in communication styles and ways of imparting information and advice between doctors and midwives. As a feminist researcher I am particularly interested in situations where women’s choices are optimised and more importantly, that
these choices can be acted upon within supportive contexts and infrastructure. I have asserted that in this thesis I do not want to write about hospital and home birth women in terms of opposing discourses, thus constructing all home birth women as in control and hospital birth women as passive dupes. There are very real structural, economic and institutional impediments confronting women in relation to making choices and about what they can expect in relation to pregnancy and birth. For example, many of the hospital birth women I interviewed lived in the outer northern suburbs of Perth, Western Australia, often isolated by distance and lack of amenities and services. Even if they came across alternative or home birth literature during their pregnancy it is unlikely that would have met or moved in the same circles as people who knew of or had experienced home or ‘natural’ births.

At the time of interviewing there was no community midwifery program in the Northern Suburbs. The structural barriers confining these women’s choices to a hospital birth in the public system if they were not privately insured (or if they were, to ‘who is the best specialist,’ or, ‘which is the best private hospital I can go to?’) are not an indictment of them as victims, but more of the homogenising tendencies of the main stream health system, that has become increasingly privatised. This homogenisation does not only occur in relation to middle class women’s birth choices Aboriginal and Ethnic women’s needs are also smothered by similar tendencies (Julian, 2002, p. 135).

Ideas about birth options are slowly beginning to change, in part due to the wide range of literature available and women’s propensity to read widely, especially for a first pregnancy.
Some of the hospital birth women I interviewed questioned the routine intervention of episiotomies, while others were critical of induced birth and vacuum extraction. Apart from a few exceptions, they all mentioned the frustration of being rushed through medical appointments and their less than satisfactory interactions with obstetricians who only had five or ten minutes to spare them (cf. Broom, 1998; Hildingsson & Haggstrom, 1999; Morison, et al. 1998). Main stream publications of health statistics are also publicising and raising questions about the high and in many situations, increased rates of caesareans and other interventions (Gee, 1998).

What I found common in most of the hospital birth stories was the desire for more realistic information and support. Women may not have desired or even considered a home or ‘natural’ birth, but they did find it frustrating that their obstetricians seemed to have so little time to discuss issues with them. They felt disconnected from the process and articulated this as a frustration. They could not as a group be categorised as being inevitably or ‘naturally’ more compliant, or in awe of the medical system than women who chose differently. Unable to connect on a personal level with a doctor, midwife or obstetrician meant they did not have the kind of long-term interaction that may enable feelings of involvement in the process, the kind of confidence building and discussion of ideas that home birth women have experienced with community midwives (see Dodd & Reibel 2000; Morison et al. 1998).

This experience did not seem to vary much in relation to whether the hospital birth women were privately insured or not. In the private health system although women may have had
the advantage of choosing their own obstetrician, there still did not appear to have been much time for discussion or connection. Hospital birth women frequently mentioned the difficulty in thinking about and asking questions of the obstetrician when they knew ‘he was so busy’ and when appointments were seldom for longer than ten minutes.

Having your own obstetrician was also something of a status symbol for two women who had experienced previous births in England under the National Health Service. For them the fact that they could afford private health insurance, a private hospital room and their ‘own’ obstetrician was a seen as a privileged choice. A ‘good’ obstetrician was chosen for their reputation in terms of safely delivering friends’ and acquaintances’ babies.

The emphasis that is put on safety also affects the kinds of stories women tell in relation to birth. Hospital birth women mentioned they felt reluctant to add to the ‘horror’ stories and, even in cases of relatively straightforward and uncomplicated births felt hesitant about claiming a birth story for themselves. A birth that is without event ‘danger’ seemed a non-event so to speak; hardly worth mentioning because it was not really anything special. These stories contrast with the home birth women where commonly held negative perceptions about ‘safety’ and ‘responsibility’ contribute toward them describing experiences of birth that challenge these. Home birth stories may in this sense be more than personal, they are also political. Hospital birth women are also less likely to be encouraged to tell stories or have long discussions. The different communication processes of doctors compared to midwives may have contributed to this silence. Midwives encourage story
telling and emphasise that each woman’s birth is unique and special regardless of whether it meets expectations or not (Hildingsson & Haggstrom, 1999; Morison, et al. 1998).

While it would appear that hospital birth women are more likely to be subjected to a greater number of medical and technological interventions and may not feel as comfortable as home birth women about articulating their birth experiences, home birth women are not immune from issues of authority and control. As Williams (1997, p. 243) points out, all birthing women are caught in: “the circulating strands of obstetric power.” Williams (1997, p. 243) asserts: “that by using natural childbirth techniques a woman submits to a panoptic regime of control.” What this means is that in some ways home birth women are more visibly monitored in terms of being expected to articulate their emotions, thoughts and hopes. The ‘peak’ experience of birth is described in detail throughout the pregnancy and some women may feel pressured to conform to the rules of their group, to ‘confess’ in appropriate ways. Some of the women interviewed for this study provided examples of where this occurred. For instance, one home birth woman stated that she had really wanted some form of conventional pain relief, but that her partner and midwife were quite adamant that she could manage without it. Another example was a woman mentioning that although overall she was very satisfied with the care from her midwife; during labour and birth she was sceptical of some of the intuitive expressions of her midwife and wanted more structured information.

Other home birth women mentioned a support group, which tied ideas of giving birth ‘naturally’ to women firmly entrenched in a traditional family setting. Although some
women were positive about this kind of philosophy, women who had paid work outside the home were particularly critical of the tendency to collapse giving birth naturally, to breastfeeding for more than six months and devoting oneself to staying at home long term to care for the baby.

I have contextualised these models of care to illustrate that there is not an ‘ideal’ model of care for all women and also to question the assumption that hospital birth women are more likely to be compliant in terms of mainstream health information. Hospital birth women are not necessarily any more compliant or victims of ‘the system’ than are home birth women, however, it may be more difficult for them to articulate or challenge mainstream health information because it is more authoritarian in delivery and because they feel disconnected from decision making due to the communication processes of many medical doctors and obstetricians.

There have been a number of studies undertaken about the differences between doctor and midwife processes (Fleming, 1998; Morison, et al. 1998; Pitt, 1997; Williams, 1997). One in particular I found useful in terms of this thesis because the researcher had interviewed both doctors and community midwives about how they assist women giving birth, and it illustrates the different philosophical and practical approaches to women that result from the different models of care.

The doctors that the researcher interviewed were able to sum up the processes of how women gave birth in a few words or sentences. For example, when asked: “what position
did you prefer to deliver women in?” a doctor replied: “on the back in the lithotomy position, it was easy” (Pitt, 1997, p. 226). However, for midwives the same question elicited a very different response. They would find it difficult to answer the same question is such a direct manner; their processes were far more complex, describing how women moved and how it depended on each individual situation. Words alone were not sufficient to answer the question midwives would actually move their bodies into different positions to demonstrate the strategies they used to enable women to give birth (Pitt, 1997, pp. 226-27). The researcher also reported that the midwives were more holistically involved than the doctors with the women from the beginning of the pregnancy. They would listen to and be guided by what the women told them about their bodies during pregnancy, labour and the birth (Pitt, 1997). Women in this situation were enabled to speak authoritatively about their own experience and for this to be given some validity.

I will now return to William’s (1997) observations as they are useful in terms of finding a way to straddle the dichotomy. I observed in my own study that although home birth women were as hospital birth women, subject to certain rules guiding approaches to pregnancy and birth especially, they described their experiences in a more positive way. As Williams (1997) points out, the processes of:

“involving the woman, judging each labour individually and assisting only when something is known to be wrong, is still governed by panoptic control but the authoritarian power of the discourses within it are less rigid. The woman is an active
participant in her own birth experience; if help is needed, she does not feel so disappointed or cheated, she has been allowed to have a go” (p. 245).

I think this is a crucial point in relation to the women I interviewed, not only were the home birth women “allowed to have a go” the strategies and processes of the midwives were a vital factor in the attainment of this. In terms of communication skills and encouraging discussion of issues, the processes of midwives are often quite different from those of doctors and obstetricians and this does have implications for how women feel in relation to decision making about a range of mainstream health information. This point will be developed in more detail in the next chapter.

There is some criticism that the discourse used by some midwives, terms such as “natural” and “drug-free” birth set some women up for failure (Griffith, 1992, p. 63; Michie & Cahn, 1997, p. 49). The use of the term “natural” to describe non-medicalised birth is evident in a number of popular pregnancy and birth texts (Kitzinger, 1994, p. 176; Kitzinger, 1996, p. 3; Odent, 1994). Griffith, (1992, p. 63) asserts that if women are “set up” to achieve the “natural” “perfect” birth and this does not eventuate they will feel they have failed in some way. I previously questioned the assumption that because a woman chooses a hospital birth she is necessarily a ‘victim’ or suffering from ‘false-consciousness.’

Describing particular birth practices as “natural” may be problematic, that is, what is considered “natural” is always contextual and may vary historically and culturally, (Griffith, 1992, p.60; Michie & Cahn, 1997, p. 49). However, acknowledging that the term
‘natural’ should be used in a qualified way should not detract from attempts to de-
medicalise the pregnancy and birth experience for women. In relation to birth, the home
birth women I interviewed for this study were not all caught up with idealised notions about
what ‘natural’ birthing entailed. That is, they did not accept ‘natural’ methods as
unmediated by their particular and individual values and circumstances. In general terms
the home birth women were hopeful that they would give birth without the need for
medical intervention or drugs for pain, however, they were at the same time very flexible
about how they would respond if this were not possible. They would nearly always qualify
their ideas about a ‘perfect’ birth with a pragmatic consideration of how uncertain the
processes of giving birth were. As one home birth woman stated: “Take what you need, if
you need a caesarean you take it, if you need drugs, you use them” (5: hmb).

The difference between home birth and hospital birth women in relation to this was that
rather than expecting interventions or medicalisation of birth to be inevitable; these things
were there to assist as a last resort. It was not a case of having ‘failed’ but rather an
acknowledgment that birth cannot be safely predicted to go this way or that. This
acceptance of ‘uncertainty’ is very important in terms of decision making processes not just
in relation to birth but also pregnancy and will be raised again in more detail in the next
chapter. The acknowledgement of uncertainty also has implications for the ways in which
information is presented by main stream health promoters, and the acceptable responses to
it, are framed (see Chapters 1 and 7).
To put the ‘natural’ discourses in some context it seems that the interaction of women with these is informed and mediated by their own previous experiences, experiences of friends and family members, and their midwives experiences, thus ensuring that women’s take up of these ideas is always only partial. The more explicitly holistic knowledge of home birth women incorporating embodied knowledge, anecdote and experience is, unlike that of hospital birth women, accorded authenticity by community midwives. While hospital birth women do not, generally speaking, enjoy an acknowledgment of these kinds of knowledges by their doctors and obstetricians they too use these as strategies to inform their decision making. Thus ‘embodied’ knowledge can in this instance been seen as more than just an adjunct to natural discourse. Both groups of women used embodied, anecdotal and experiential knowledge as a changing and shifting mediation of both ‘natural’ and medical discourses.

Another issue that was raised and was common to both groups of women was a desire for there to be more ‘middle of the road’ information and more pragmatic approaches to pregnancy and birth. For the women interviewed the philosophical differences between doctors and midwives, or ‘natural’ and medical approaches to pregnancy and birth were often not clear cut. Criticisms were made by both groups in relation to what they felt were often entrenched attitudes and processes by both doctors and midwives. For example, one home birth woman I interviewed had been very upset at her midwife ‘telling her off’ for having more than one ultrasound. I must emphasise that this response was unusual, but it does indicate that the clash of natural versus medical can cause unnecessary stress for some women. There were also hospital birth women who were interested in natural and
homoeopathic remedies for a range of minor pregnancy ailments, such as piles, varicose veins as well as for pain relief during labour. These too needed to be accepted and acknowledged by those working in mainstream settings. Women (and people generally) are crossing over the medical versus natural divide, “taking what they need” and indeed these processes are encouraged by professional experts in a number of areas (Siahpush, 1999). (I have mentioned previously some medical doctors are using or referring their patients to alternatives). However, these cross-border transgressions seem more fraught for women in relation to pregnancy and birth choices. Once again it seems that differences are intensified in relation to pregnancy and birth and there is more insistent justification of positions on either side of the medical/natural divide.

Women’s use of embodied, anecdotal and experiential knowledge creates another conundrum in terms of theoretical directions. While my critique of rationality and consequently the decision making processes that flow from this incorporates poststructuralist perspectives and conceives of a fragmented or at least complex non-unitary self, the women themselves often used modernist discourses in their descriptions of the body. These are also used by the women in a way that does subvert and challenge mainstream discourses and I will discuss some of these paradoxes in the next chapter. I will also demonstrate how the women I interviewed, both home and hospital birth use ‘embodied knowledge’ politically and strategically in similar ways in their interaction with a range of information pertaining to pregnancy and birth. Here the differences in their decision making are not so clear cut or a consequence of either a ‘natural’ or medical model.
This chapter has outlined some of the major methodological and ethical issues raised in the process of interviewing a group of middle class women. I have also devoted some time to outlining the different models of birth, doctors, community midwives and women’s philosophical positions and attitudes in relation to these. I have demonstrated that within the sample of middle class women that I have interviewed there was a diversity of expectations in relation to giving birth. In the next chapter I will return to a focus on pregnancy and examine how these expectations influenced approaches to pregnancy, mainstream health promotion information and women’s decision making processes.

The Community Based Midwifery Program Inc is a community based non-profit organisation that hosts the Community Midwifery Program and Pregnancy and Childbirth Information and Resource Centres.
5

The complexity of decision making

I have argued in the first part of the thesis that pregnant women in Western developed countries are expected to demonstrate a particular kind of health literacy informed by expert mainstream health information. This health literacy is considered important not only by health professionals, but the women themselves, in terms of framing questions they ask before and during pregnancy. I have asserted that the decision making processes of pregnant women are particularly intensified in terms of what is expected not only by health professionals, but also by the women’s family and friends and the wider community. Previous chapters have outlined how mainstream health promotion campaigns and the biomedical model of health construct women as moral and rational only if they comply with the information provided in entirety.

In this study I have not sought to chart the extent of compliance with specific campaigns. Instead the main purpose of the study was to demonstrate that the decision making processes of the women in relation to these is contextualised and is of a complex nature. This said it is still the case that some observations can be made about what was commonly shared amongst the women, in relation to how they responded to the range of mainstream health promotion information.
For all the women interviewed being healthy was given a high priority. Eating healthily, looking after themselves, moderating or ceasing alcohol and caffeine intake were all important considerations. Cigarette smoking and the consumption of illegal drugs was similarly avoided or limited by nearly all of the women interviewed. The importance of main stream health promotion advice in relation to folate and listeria was given slightly more emphasis by the hospital birth women. For the two hospital birth women who had previously experienced a miscarriage, listeria was given much more emphasis. Home birth women, who were all aware of the folate and listeria campaigns, did not so strictly adhere to exact health promotion directives as did hospital birth women. Most of them did, however, acknowledge that the messages were important, although there were a few exceptions in both groups. There were only two out of the twenty women interviewed who did not comply with either campaign. One was a home birth and the other a hospital birth woman, and the reasons for their non-compliance are outlined later in the chapter. The thesis does to a certain extent emphasise these exceptions because they most clearly illustrate the importance of including the context within which women make decisions. A concentration on the statistical analysis of how many women have complied with different aspects of health information does not illustrate the diversity and richness of women’s decision making or the complexity of why they may choose partial or non-compliance.

This chapter and the two that follow are concerned with the contexts within which women make decisions. This is contrasted with the myth of a context free rationality, the disembodied, autonomous subject and the decision making processes that are assumed to flow on from these. By using the women’s voices in the second part of the thesis, the
crucial point about context will ‘colour in’ support and develop the theoretical issues raised in the first. By focussing on the women’s interactions with the listeria and folate health promotion campaigns and a range of other main stream health promotion information, the chapter will provide additional support for the theoretical critique of a context free rationality and particular ways of decision making already raised. I want to reclaim, by giving voice and substance to the: “strangely disembodied figure unbounded by any constraints to her agency” (Keane, 1996, p. 265). In this case I emphasise the voices of the women I interviewed within their particular social contexts. This emphasis not only illustrates the broader contexts, such as social class and so on, but also the day-to-day contexts within which individual women make decisions, based on how they feel at that particular time.

Selfishly accommodating women:

Main stream health promotion campaigns targeting pregnant women focus on the current and future health of the foetus. Many of the health promotion campaigns aimed at pregnant women render the presence of the woman as a whole person, invisible. A number of the critiques of main stream health promotion have analysed the invisible woman of pregnancy (see Duden, 1993; Keane, 1996). I have argued in a previous chapter that pregnant women are constructed as selfish if they consider their own needs before those of the foetus and that these are particularly imbued with moralistic overtones (Hammerman, Lavie, Kombluth, Rabinson, 1998). However, there has been other work that demonstrates the fluidity and complexity of women’s decision making and how they consider the needs of
the foetus and themselves. In an article emphasising the dietary choices of pregnant women Markens, Browner, Press (1997) explore the ways in which women consider both their own needs and that of the foetus. While the foetus is constructed as separate by biomedical models of health it is at the same time deemed utterly dependent on the woman. In contrast the researchers found that women themselves see the: “woman-fetus relationship...as very fluid” (Markens, et al. 1997, p. 368). The women in that study deployed a number of strategies that assisted in their decision making in relation to diet. These included accommodation to the needs of the foetus as spelled out by mainstream information provided by health professionals, as well as consideration of other discourses which were centrally concerned with women’s own needs. For example, the authors point out that the directives about how much weight women should ideally gain when pregnant coincide with the concerns many women have about gaining weight generally (Markens et al. 1997, p. 368). For many women the strict directives of the campaigns are not realistically incorporated into their everyday lives. They heed the messages but at the same time water them down in consideration of their own needs. This occurred for the women I interviewed in this study particularly in relation to the listeria and folate campaigns. For example a hospital birth woman commented:

“I don’t take too much notice of listeria. I mean I know about it but just use my common sense. I haven’t been scared off soft cheese and processed foods, but if I do eat them I make absolutely sure they are really fresh. I do take folate - I take the supplement just in case my diet does not supply what I need” (7: hosp).
A home birth woman similarly was conscious of the listeria and folate campaigns but again accommodated the directives of the campaigns to her own situation:

“Yes...well... with Listeria I kept away from the cold meats. I don’t eat salami anyway. I do eat ham, but made sure it was really, really fresh. I also made sure I ate lots of green vegetables for the folate. I didn’t take a supplement. I had a blood test at 20 weeks and my levels were really, really, good” (3: hmb).

These quotes illustrate the way in which women respond to main stream health promotion campaigns in terms of a negotiation and mediation, an acknowledgment of the underlying message is there but the ways in which the women respond to it are less exacting, more flexible, than the strict directives of the campaigns. This balancing and mediation of multiple demands and knowledge informed by other than main stream health promotion is similarly noted by Markens, et al. (1997) in relation to their study as: “pregnant women actively negotiate a complex web of intersecting demands” (p. 368). So while strict adherence to the main stream health promotion campaigns did not always occur in every instance it was evident that women were very mindful and caring about the health of their foetus.

Another one of the ways that the women I interviewed found a space to challenge main stream health promotion and other pregnancy information was to articulate their processes
in terms of ‘moderation.’ A hospital birth woman described how she had adapted her lifestyle in consideration of her pregnancy:

“I did change some aspects of my lifestyle. I definitely changed what I ate and drank less [wine], although did not give it up completely. I carried on exercising until about six weeks before the birth and then stopped going to the gym. I was getting a bit of exercise right to the end. I took vitamins throughout and didn’t go around anyone who was smoking. I gave up work and then went back on a casual basis until about five weeks before the birth. I was working in a chemistry lab so had to be a bit careful. I don’t think you can become too paranoid, otherwise you’d just stay home and never go out. I just think moderation... and perhaps be a little more careful than you would normally”

(4: hosp).

This woman was aware of the range of mainstream health promotion advice in relation to pregnancy and responded to it within the context of her pre-pregnancy physically active and health conscious lifestyle. A home birth woman similarly describes taking account of everything and then balancing this against her own needs and lifestyle:

“\textit{I mean I just tried to take everything into account and then tried to find a balance or something that was reasonable. I would change something if I had to, if I thought it was important enough. But you know - moderation is the key, be sensible}” (1: hmb).
While it could be argued that moderation in this context is used as a justifying rhetoric by the women interviewed for partial or non-compliance, it can also be argued that it is a rational assessment of their situation. Moderation is what enables a negotiation through the voluminous quantities and ‘mish mash’ of contradictory and competing information they are presented with. While health promoters might only view strict adherence to the correct information (theirs) and for all women to have access to and understand this information as empowering, for the women themselves, moderating and considering both their own and the baby’s needs is what makes the management of their pregnancy workable. The following section details how women consider their own and their baby’s needs in response to two questions about what they thought were good things to do for themselves and their baby during pregnancy.

**Good for me: Good for the baby**

The article referred to in the previous section (Markens, et al. 1997) emphasised how the women interviewed for that study balanced competing demands and the needs of themselves and their babies. This was typical of women’s responses to questions I asked them about what were good things to do for themselves, and then for their babies. While some women did at times emphasise their own needs and at others the needs of the foetus there was a general understanding that what was ‘good’ for them was also ‘good’ for the baby. For example a hospital birth woman stated:
"I think that when you’re pregnant and you maintain a healthy lifestyle and perhaps even try and improve on it - well - it’s good for you and the baby isn’t it? I think the healthier you are the better for the pregnancy and the birth”

(8: hosp).

Their responses to the two questions I asked about what was good for them and what was good for their baby during pregnancy, were informative about a number of things. The example given above illustrates the way in which nearly all of the women responded to the two separate questions I asked. At the beginning of the interview I asked women, ‘What they thought were good things to do for themselves while they were pregnant,’ then the next question asked ‘What they thought were good things to do for their babies while they were pregnant?’ The women almost without exception had already considered the needs of the baby when answering the first question about themselves, and would often say when I asked them the second question, that they had already answered, typically: “what is good for me is good for the baby and vice versa” (8: hmb).

This kind of statement did not necessarily translate into women complying in entirety with main stream health information, their understanding of what was ‘good’ incorporated much more than main stream health promotion directives. Interestingly while I asked “what was good?” the women often replied in terms of “being good” such as in this example from a home birth woman:
“I think sort of - what is good for the baby is good for me in a way. You know what I mean? If I knew I was being good for the baby it was good for me as well. It works hand in hand” (2: hmb).

In this way they did not distance themselves just describing what they thought was good but immediately related to their own pregnancy experience and behaviour as ‘good’ in an interactive and contextualised way. Being ‘good’ often included in addition to the usual diet, exercise and relaxation directives a range of other factors such as emotional, psychological and spiritual well-being. For example a home birth woman relates:

“With both pregnancies I swam with dolphins and I do a lot of snorkelling on the reefs and that - just getting out. Water is the most terrific feeling, it is such a relief” (6: hmb).

While for a hospital birth woman:

‘Be happy, socialise, go out all day. I’m just happy doing... you know? Living life” (3: hosp).

The consideration of the needs of the foetus or the ‘baby’ as the women themselves described it was a high priority but was not their only consideration. In terms of considering the foetus in relation to the main stream health information, women utilised a number of strategies and articulated different justifications for both compliance and partial
or non-compliance with its instruction. A hospital birth woman describes her reasoning for her partial compliance with the folate campaign for her second pregnancy:

“Again I sort of think, well they keep finding out these new things and it takes me back to what I’ve always said. My mum had six kids and she never knew about that [folate and listeria], and you know there are a lot of things you are told. I took folate after I found out I was pregnant for the first one and was told, you should have been taking that before. This time, well we’re trying for another one and I’m sort of taking it when I remember. I eat X breakfast cereal which I think has folate in it. I take supplements when I remember. But I sort of think there is no history in my family [of disability or deformity], which is quite large we’ve none of us had any problems. There’s not enough information really about why you should take it” (5: hosp).

Another hospital birth woman describes her careful compliance with the folate campaign; again it is the context of her life situation that informs her decision making:

“I had heard of folate and I did take it religiously for the two or three months before I got pregnant. I think it was something someone gave me advice about a long time ago. I was probably most aware of it because I have a disabled sibling and so tended to kind of find out information about these sorts of things” (1: hosp).

On the other side, non-compliance with the folate campaign was because:
"I didn’t really pay much attention - people mentioned it [folate], my doctor didn’t say anything (although I think he is very nice). I recall hearing about it vaguely and just not paying attention. I get tired of all this worry, worry about everything. I already had two babies, never did any of that [take folate] and they were both really healthy" (9: hmb).

Women not only described their decision making processes as ‘balancing’ but also in terms of what was realistically possible for them at the time. Many of the women would respond to each question with a response similar to this from a hospital birth mother:

“I mean I just tried to consider everything and balance it out. I would change if I thought something was important. But ... hmmm, yeah, I was not too hard on myself. There is that much information, you think well - which is right? What do I believe. I think you just take on what you can fit in with, you know? Mmmm, like I knew I should rest but I found it very hard. I just wanted to fight it [feeling tired]. I don’t know if that is good or bad, but it is just the way I felt at the time” (5: hosp).

The use of the word ‘try’ is an interesting one that came up in a number of the responses. There seems to be a tacit acknowledgment that many of the main stream health promotion directives are unrealistic when they are placed within the context of real, everyday lives. Even before women had given me any detail about how they made decisions and how they managed their pregnancy there was already an assumption that they could only ‘try’ to
comply with the ideal pregnancy behaviours. There was an acknowledgment, not always directly or critically stated, that complete compliance with the information was somewhat unrealistic. For example:

“Try to get healthy - try to have everything ready for the baby and have my mother here so that I could really enjoy the baby when she first came” (4: hmb).

“Lots of pampering, lots of yoga, lots of eating, and always try to eat the right foods - but sometimes the cravings weren’t the right foods” (Laughter) (10: hmb).

However, when mentioning what was good for themselves and their babies both home and hospital birth women would mention much more than diet as this response from a home birth woman illustrates:

“Good things to do for yourself during pregnancy? Good things are looking after yourself and health. I mean in terms of nutrition and exercise, do things that make you feel good. Like I enjoy swimming so I’ve always swum. Good things to do are - yoga and meditation and things like that, so you can focus on what is growing inside you. So you can try and have a bond with the baby before the baby is born. Have time out I think. Have a rest during the day towards the end. A girlfriend of mine used to have a bath, a bath every afternoon. For her that’s time out and
meditation so that she can really connect with the baby in the bath. I found it easier to have naps, naps during the day when I could. Whatever makes you feel good. Like I enjoyed working as well. I didn’t work full time but on a part time basis and that was really good for me as well. I think whatever makes you feel good. But you have to be conscious of the fact that you’re pregnant and don’t go boozing” (3: hmb).

It is evident from this woman’s response that the management of her pregnancy incorporates a notion that pregnancy can be a time for self pampering and pleasure while at the same time the needs of the baby are also considered a high priority. In other words, what she enjoys, her own needs are considered an integral part of managing her pregnancy. What she enjoys however, is not selfish in the sense that her desire for pleasure has its limits. She enjoys working but would not “go boozing.” For many of the women I interviewed pregnancy was often the ‘excuse’ they seemed to need in order to feel justified about relaxing and ‘taking time out.’ What many of them described as ‘pampering’ themselves is quite different to the utilitarian view of main stream health promotion, where women are purely leading healthy lifestyles for the sake of the baby.

A hospital birth woman commented that having a baby gives added motivation for a healthy lifestyle, and that pregnancy is also a good reason to slow down, ‘take time out’ and relax:
“Be really healthy, there is an added incentive, made easier by the fact you are pregnant. Slowing down and being more reflective. Be reflective in the sense that this is a transitory period. So it’s all entirely selfish I wanted to enjoy being pregnant and I decided that being pregnant would be a opportunity for me to do all these things that I keep telling myself that I should do” (1: hosp).

It is something of a paradox that even when women are incorporating main stream health advice into how they manage their pregnancy and this includes healthy diets, relaxation and exercise, many women still view the adoption of this lifestyle for themselves as ‘selfish.’ Perhaps too, it is indicative of how difficult it is for women when they are not pregnant to do the things recommended by main stream health promoters to enable a healthier lifestyle. For many women taking ‘time out’ for exercise or leisure activities may be fraught with a number of concerns, including limited time, finances and a lack of child care and other social support (see Dodd & Reibel, 1999). Pregnancy was often the first time for many of the women interviewed in this study that they could justify having a nap in the afternoon, or to take time to exercise or meditate. In some cases pregnancy was also the time women felt they could legitimately cease paid work or study, as for this hospital birth woman:

“Well I wasn’t working while I was pregnant, I finished study. I basically just thought it was really important to relax and so I was just making things for the baby and that sort of thing” (6: hosp).
And for a home birth woman who was unwell before pregnancy but felt she could not spend time or money on herself until she was pregnant:

“I made sure I had everything I wanted. I wanted it [the baby] at home. I wanted my mother there. I was sick, but this time I actually went and spent the money and looked after myself - natural therapists, herbalists and homoeopaths and really looked after myself. And to get rest I suppose. Think I tend to...tended to feel I had to do things and was being lazy if I rested, things like that. I suppose rest” (10: hmb).

While many women found it difficult to be ‘selfish’ in pregnancy in terms of resting or relaxing, others found the issue of smoking and drinking alcohol in pregnancy to be particularly fraught. As I have outlined in a previous chapter, main stream health promoters and the general public are particularly moralistic about women who drink alcohol or smoke during pregnancy (see Keane 1996; Oakley 1989). Complete abstention from these substances is frequently cited as the ideal, both in main stream health promotion campaigns and many of the popular pregnancy books and magazines (Health Department of Western Australia, 1997; Shuttleworth, 1993/94; Stoppard 1994). Many of the women complied with these directives but there was a significant minority who did not.
**Drinking and smoking:**

Many of the women’s responses to mainstream health information incorporated compliant strategies in relation to drinking alcohol and smoking but at the same time there was also a critical edge to much of their response. Women’s agency was demonstrated by an active questioning and critique of mainstream health information although this may often have been tempered by a qualifying statement. In addition their responses would often reflect the values of mainstream pregnancy information as well as awareness of potential social censure. For example, a hospital birth woman describing what she thought about moderate alcohol drinking and smoking during pregnancy, commented:

“The medical profession have got the message across so good [about no alcohol drinking and smoking in pregnancy] and now everyone is in on it and you’re paranoid to do anything, because everyone knows” (4: hosp)

What was even more interesting about this woman’s comment was that although she recognised the influential nature of mainstream health discourse and was aware of the potential for social censure her own doctor did not advocate complete abstention from alcohol:

“Wasn’t told not to drink, just to cut down to a glass every now and again” (4: hosp).
In relation to diet and drinking alcohol a hospital birth woman, for whom it was a first pregnancy, relates:

“For three months I couldn’t face meat, so I didn’t eat much meat, but then I made up for it later. Apart from the cold meats and soft cheeses, I didn’t eat take away. But we still went out to dinner and that sort of thing, and when we did I had the odd wine and kind of wasn’t so conscious of what I ate” (1: hosp).

The balancing processes noted in the study mentioned earlier (see Markens, et al. 1997) is evident here, the lack of meat in the woman’s diet in early pregnancy ‘made up for’ in the later stages, the avoidance of cold meats, soft cheeses and take aways balanced with going out to dinner and being less concerned with what was eaten. The issue of drinking alcohol while pregnant is also raised by the following woman. In this situation the main stream health information that recommends that women drink no alcohol at all during pregnancy is not only balanced but also the subject of a qualified critique:

“Drinking I know is bad. But I would often have the odd drink especially toward the end. I mean they’re sort of saying, don’t drink when you’re pregnant, but they don’t actually know for certain what it can do to the baby. I know it can affect in the early stages” (10: hosp).

The quote again demonstrates the sort of accommodation to both the baby’s and the woman’s own needs noted in the other research. In addition to the discourse about not
drinking alcohol during pregnancy there is also one (particularly in popular pregnancy books) that advocates relaxation and avoidance of stress (see Kitzinger, 1994; Shuttleworth, 1993/1994; Stoppard, 1994). For many women a ‘glass or two of wine’ at the end of a tiring day was part of relaxing, ‘time out’ from stress which is, as many of them pointed out, also an important consideration in the management of pregnancy. It was also considered part of a pleasurable lifestyle. This may reflect the discourses that advocate that pregnancy and birth experiences should be rich and pleasurable. There is an expectation that pregnancy and birth should be peak experiences, birth is in particular emphasised in much of the home and natural birth literature. Griffith (1992) and Scheper-Hughes (1992) argue that women in Western countries are more likely to heavily invest in these experiences because pregnancy happens less often than in the past and many are ‘wanted’ and ‘planned’ rather than an inevitability due to lack of contraception or poverty. Survival rates for both mothers and babies have also increased significantly in Western industrialised countries in recent history.

This discourse of pleasure in pregnancy does however operate simultaneously with others, for example, about pesticides and the environment, and about responsibility and guilt. A hospital birth woman interviewed was very aware of the potential for social censure especially in relation to smoking and alcohol, yet was nonetheless quite critical of the emphasis put on an individual pregnant woman’s behaviour and pointed out that there were environmental issues beyond an individual woman’s control:
'Don’t drink, [it is] more the social thing of people looking at you, thinking ‘bad mother.’ I don’t drink, don’t feel comfortable with it. I wouldn’t recommend you went off and got blind [drunk] somewhere. I think that would affect the baby. Smoking? Don’t know, think it’s up to the individual. Hard to say whether [it is] better to give up smoking and be stressed or to have a couple. I don’t smoke - so don’t have that problem. You do worry about what people are thinking if you are relaxing and it takes a glass of wine or cigarette. Everyone is tutting and looking. If you go out for dinner at a restaurant … don’t know if people are looking at you, or you just think they will notice. [They] May think ‘that’s terrible’ because they’ve heard it from the adverts. If it relaxes you and helps you cope with it all. It is quite a demanding thing being pregnant. [So] if a couple of cigarettes or a glass of wine help you relax, can’t see how it hurts that much, compared with what is in the air and in the ground and all the pesticides” (2: hosp).

This comment also demonstrates that while women may be knowledgeable about mainstream health promotion information and understand it, they also contextualise it not only in terms of the realities of their daily lives but also within other expert discourses. So for this woman her equally well informed grasp of environmental issues enabled her to critique the emphasis put on individual women’s behaviour. Her point that “a couple of cigarettes or a glass of wine” might help women to relax is also informed by mainstream health discourse that advocates emotional tranquillity for populations generally and for pregnant women in particular. This woman is an example of someone who demonstrates the kind of health literacy advocated by mainstream health promoters, but who is, at the same time
informed by other expert discourses that enable her to be aware of and reflect on what she sees as an unfair emphasis on the individual behaviour of pregnant women.

The complexity of the decision making processes of all the women interviewed for this study was also evident in the different ways in which they made judgements about the mainstream health information with which they felt it was absolutely imperative to comply, and that which they felt less compelled to take on board. This occurred in a number of areas. Most notably while alcohol and smoking were considered ‘bad’ things to do by most of the women; some would pick one or the other as ‘worse.’ A hospital birth woman gives an example of this:

“You should definitely stop smoking. I don’t smoke. Carry on exercising, try and stop drinking, although the odd glass of wine is not too bad” (9: hosp).

In terms of the listeria and folate campaigns women would again often comply more with one than the other and gave a variety of reasons and justification for their none or only partial compliance. A home birth woman comments:

“Listeria - yeah, well I sort of... the first one [pregnancy] I didn’t even hear about it and supposedly ate all the wrong things and never had a problem. The second time I did know about, [listeria] but I didn’t go out of the way to avoid certain foods. Folate was sort of on my mind. Folate I feel is more important [than listeria]
the evidence seems clearer. I took the supplements before [pregnancy] and for the first three months anyway” (6: hmb).

Women also mentioned inconsistencies in terms of expectations between the textual advice available from mainstream health promoters and pregnancy books and what their doctors or midwives advised them. Markens, et al. (1997) also raise the issue of inconsistency in biomedical advice, in relation to dietary practices they point out that on the one hand pregnant women are told not to consume alcohol or caffeine, but on the other their doctors: “will at times give them permission to occasionally indulge” (Markens, et al. 1997, p. 367).

A hospital birth woman describes how she makes decisions in relation to the range of mainstream health information:

“There is an awful lot of stuff [information] out there, plus everyone has their little say don’t they? I know that certain things are bad, you know like smoking and drinking - and you should be careful about listeria and take your folic acid and iron and so on. But you know my doctor is really relaxed about the whole thing, he says everything in moderation. I got into a bit of a panic about having the odd cigarette and a glass of wine or two at the end of the day and he said ‘don’t worry.’ [I think] It’s better to be relaxed and happy, just as long as you don’t go berserk, you know - boozing and taking loads of drugs” (4: hosp).

Markens et al. (1997) assert that this, in addition to the contradictory medical research into consumption of these substances: “helps explain women’s inconsistent accommodation to
biomedical authority while verbally asserting its importance” (p. 367). While I would agree that the existence of contradictory medical advice does play a part in women’s decision making processes, for the women I interviewed there were many other factors that influenced their decision making. One of these was the way in which women felt guilty about none or partial compliance with mainstream health promotion directives. They would also on many occasions comply with mainstream health promotion even though they were sceptical of some of its claims because they claimed they would feel guilty otherwise.

Hospital and home birth women both described feeling guilty about a range of issues. These included none or partial compliance with advice about smoking and drinking, folate and listeria, dietary and exercise recommendations, failing to plan a pregnancy and not bonding with their baby. However, there were differences between the two groups in terms of what it was they felt guilty about. It was not only the mainstream health information that engendered feelings of guilt, alternative or more holistic information could also contribute to women feeling as though they had not quite attained the status of the ideal pregnant person. The inclusion and greater emphasis on psychological and emotional health described by the home birth women resulted in some of them reflecting on their perceived shortcomings as spiritually, emotionally or psychologically whole. Shuttleworth (1993/1994, p. 40) similarly notes this development in her critique and how the issue of being relaxed or stress free extends from pregnancy and birth to breastfeeding. Hospital birth women were more likely to feel guilty about smoking or drinking moderately as is the case for this woman:
“I do smoke and drink alcohol with this pregnancy. I know it’s not good or right... but I’ve read conflicting information on the subject. Some can drink a little and it can affect the foetus, others a lot and nothing happens. I do think I should give it [smoking and alcohol] up. I do have doubts, it is a bit scary. If something was wrong with the baby I would have to face up to the guilt. But I feel this is where I am with this pregnancy. I am aware of the risks. But I’ve read so much conflicting information and I enjoy smoking and drinking in moderation, it’s part of my normal lifestyle” (4: hosp).

This woman’s response is also interesting because she states that: “this is where I’m at with this pregnancy” so she is not ruling out the possibility that for another pregnancy or in a different time she may have responded differently. Once again it is the current context within which she is making decisions that is most important.

Home birth women spoke of guilt in terms of whether or not they were adequately emotionally prepared for birth and parenting. Home birth women were also more likely to describe bonding with the baby, or feeling positive in terms of the position of the foetus to enable the birthing process. For example, this home birth woman related how she felt guilty about not bonding with her baby:

“‘I think it’s good to just spend time with your baby and focussing on your baby is good as well, which I found very hard to do with the third one [pregnancy]. Found I
was half way through my [third] pregnancy before I really, really accepted I was pregnant. Whereas with the first one it’s like a daily thing, wow I’m pregnant! The third one - you sort of forget for days at a time - until you’re about half way through [the pregnancy] and feel it moving. I felt really guilty that I didn’t spend any time [bonding] with the baby while I was pregnant. I was busy with the other two [children]” (3: hmb).

This response reflected an acceptance of the main stream and alternative discourse about the importance of bonding as a prerequisite for motherhood. It demonstrates how the foetus is already constructed as a member of the family as someone the unselfish mother should consider. It contrasted with the woman’s stated scepticism about much of the other main stream health information. Her none or partial compliance with other main stream health directives which she does not appear to feel guilty about (an example of which will follow later), contrasts with her feelings of guilt about not bonding with her baby. For this woman her perception that she did not spend enough time connecting with her baby is more important than her less than ideal compliance with dietary and other main stream health promotion directives.

Despite her feelings of guilt in relation to bonding this woman’s reaction to the range of pregnancy advice offered by main stream health informers was generally more pragmatic than for the women interviewed for whom it was a first pregnancy. In addition to feeling guilty she also feels resentment at the loss of pleasure in pregnancy. For example, in response to my question about what she thought were ‘good’ things to do for herself while
pregnant her responses to mainstream health promotion could be seen as only partially compliant. Consideration of the baby is there but her concern about the loss of pleasure in her third pregnancy is quite apparent:

“Good things I should do. (Laughter). You should ask my husband. Good things I did. Ideally I think you should give up smoking, if you can, it’s hard, but I think you should watch your diet but not go overboard. I’ve met lots of ladies who don’t have sugar, who don’t have any coffee, who don’t have a doughnut, and I think that in some regards that can make you a bit miserable. Whereas I think everything in moderation and you will be happy and healthy - than everything should be okay. I think you can start [questioning every time you have] a coffee or a glass of wine and then if you do and something goes wrong at the end you’ll always look back and maybe blame the coffee or glass of wine or something. I think there’s so much focus on health that it’s [pregnancy] become so regimented that a lot of women don’t enjoy it, you know, so yeah, I just think everything in moderation. If you don’t exercise - so long as you’re happy within yourself and don’t try to live up to everybody’s expectations about what you should do” (3: hmb).

While a mainstream health promotion response to this woman’s decision making processes might be to re-educate her, or to construct her as selfish or irresponsible, her responses can also be read as reflecting a realistic appraisal of her life and work situation with two small children and a busy job. Her comments about the regimentation and emphasis on health in pregnancy also mark a very insightful observation about the loss of pleasure in pregnancy.
Many of the women interviewed stressed the importance of enjoying pregnancy and felt this was for both their own and the foetus’s benefit. Here the main stream health promotion discourse is challenged by women’s reading and understanding of other expert discourses. The consideration of psychological well being even if it means being only partially compliant with other main stream health advice takes precedence, and is perhaps an indication that some of the more holistic or alternative advice in relation to pregnancy may be more palatable to both hospital and home birth women than the rather more austere and utilitarian advice from main stream health promotion.

It is these complexities that, as Markens et al. (1997, p. 369) assert, confound simplistic and reductionist models of the relationship between woman and foetus as purely a biomedically based health issue. It also confounds a simplistic and reductionist view of decision making informed by an impoverished notion of rationality. By considering the contexts within which women make decisions about none or partial compliance with main stream health promotion it is less easily attributed to being a consequence of misinformation, irrationality or defective decision making processes. I have argued that pleasure, selfishness and desire all take on different hues when the responses of individual women are interrogated. Acknowledgments of women’s own needs are not necessarily antithetical to ‘good’ decision making as defined by main stream health promoters. A richer and less utilitarian view of the management of pregnancy may be possible. There are a range of other factors that influence women’s decision making processes that have not been discussed in this chapter. It is to a consideration of the complex interplay between
rationality and the use of other forms of knowledge such as embodiment that the next chapter turns.
I have argued in a previous chapter that main stream health promoters narrowly constitute a decision making process that is informed by a prescribed notion of what constitutes health literacy. I proposed in the first part of the thesis that main stream health promoters and other health professionals need to move beyond the expectation that pregnant women who make decisions as subjects do so as a “substantive inner core” or essence that pre-exists and can be abstracted from the social (Keane, 1996, p. 266). The assumption that this ‘inner core’ is the centre of rational thought and action and only needs educating or re-educating to act appropriately in relation to pregnancy behaviour also needs to be unsettled. I have argued throughout, that consideration of the contexts within which women make decisions is crucial in understanding the complexity of decision making. I have also discussed in some part, the importance of other strategies that women include in their decision making processes, such as previous experiences of pregnancy and embodied knowledge. This chapter focuses on embodied knowledge in more detail and I will first discuss how I understand embodied knowledge as it relates to the women I interviewed.

When I refer to embodied knowledge I am talking about the ways in which the women I interviewed described their own and others’ bodily experiences of either their current or past pregnancies. I will not be debating in detail the various theories about the body other than to note that there are a number of social theorists who have outlined a diversity of understandings and definitions about the importance of the body. For example, Turner’s
work on the nature and culture divide, Martin’s (1989) feminist and cultural analysis of reproduction, Butler’s (1993) theorising on the discursive body as performance and Grosz’s (1994) work that attempts to imagine beyond the dichotomous definitions of the body. My focus on what the body means for the pregnant women interviewed for this study is quite selective and relatively simple. I view women’s descriptions of how they make decisions based on bodily knowledge as part of the context that needs to be acknowledged as valid, positive and real by mainstream health promoters. Young (1990, p. 160) points out that when talking about pregnancy it is difficult to ascertain whether one body and subject are being experienced or two. I will analyse how women use their past as well as current experiences of pregnancy and sensations of the body to inform their decision making, their sense of self and their sense of others. I am in agreement with Marshall (1996, p. 255) that whilst there is much theoretical work in relation to our understandings of the body and how to avoid or transform dualistic notions of a mind/body split there has been less attention paid to: “the lived experiences and data.”

As Oakley (1998, p. 137) argues there are many compelling reasons to pay heed to the post modern theorising that argues: “there is no unmediated natural truth of the body.” However, she also asserts there are as many reasons to argue for: “a practical feminism that will engage productively with debates about women’s bodies, minds, and lives and what is considered ‘scientific’ knowledge” (Oakley, 1998, p. 137). Her point is that whilst there is a place for academic and esoteric feminist theorising about the body, practical feminism is needed to address the: “practical problems faced by millions of women everyday with the
cultural construction of womanhood through the discourses of medical science” (Oakley, 1998, p. 137).

The reproductive bodily experiences of women have been examined by feminist theorists such as Duden (1993), Martin (1987), Sutton, (1996), Thiele (1994) and Young (1990), however, much of the other social theory has tended to focus on extreme or unusual experiences of the body such as anorexia or phantom limb (Marshall, 1996, p. 256). I want to focus on the “ordinary” experience of pregnancy to illustrate Marshall’s (1996, p. 256) point that: “the study of the ordinary body offers glimpses of power relations with a moral immediacy sometimes lacking in work elsewhere.” I also want to avoid what I see as the overplayed hand of some theoretical accounts of the body that see it as an oppressive, eternal construction of discourse, or as an external surface that is inscribed (see Grosz, 1994; Butler 1999). Although as Butler when interviewed by (Costera Meijer & Prins 1998, p. 275) importantly qualifies: “to claim that the body is an elusive referent is not the same as claiming that it is only and always constructed.” I acknowledge that the latter theoretical developments are useful in terms of moving away from the dualist mind/body split, or the essential body, from which there is no escape especially if you are a woman as Marshall (1996, p. 256) notes.

My tentativeness in relation to these accounts does not mean that I do not consider them useful in terms of analysing what it means to be a pregnant woman. That many of the sensations of the body, or feelings about bodily knowledge in pregnancy are mediated by discourse is not in dispute. However I do question the argument that these discourses may
construct a pregnant subject who is forever watchful of her body and bodily signals as has been illustrated by Mitchell and Georges (1997). In their study they describe how a woman: “must learn to read her moods and bodily symptoms as evidence of fetal signals for nutritious food, rest, and regular medical care” (Mitchell & Georges, 1997, p. 393). They further claim that this results in the construction of the baby as: “the fetus-as-agent” (Mitchell & Georges, 1997, p. 393). My problem with the emphasis of social constructionist accounts like this one is that the pregnant woman as an active and critical agent is still rendered passive or trapped. She escapes an essentialist body only to be captured by a discursive one. The woman’s understandings of her body and its sensations can never escape a rather pessimistic construction of discourse.

While essentialist accounts capture the women as always prisoner of a certain kind of biological body; social constructionist accounts may construct a subject who is always a prisoner of discourse. While these theories have contributed to more diverse understandings of the body such as disrupting the mind/body split they still construct the body and understandings of it as a problem in terms of decision making and empowerment. By focussing on the empirical accounts of the women interviewed for this study I want to demonstrate how neither the disembodied woman of main stream health promotion, nor the woman as carrier of the “fetus-as-agent” tells the whole story. Apart from the ways in which women use embodied knowledge the women I interviewed used other discourses strategically and actively, some of which do not relate to pregnancy or birth at all, but are nonetheless influential in the choices made. For example, pregnant women may consider
the needs of others, their role as a ‘good partner’ or mother to other children, and pleasure when making decisions. As a hospital birth woman explained to me:

“Well I enjoy a ciggie or two and a glass of wine at the end of the day after we’ve [herself and partner] put the kids to bed. It’s time you know, our time to be together. I figure what is the use of giving it all up [moderate smoking and drinking wine] just because I’m pregnant - if it means I’m stressed. I’ve got to keep up my relationship with my husband and the other kids. You know it’s pretty hard work being pregnant” (5: hosp).

There is a further problem that results in the woman being a captive of discourse. The women in this study used phenomenological (sensory) accounts of the body in their decision making to inform compliance with mainstream health promotion campaigns in the way that Mitchell and Georges (1997) note. However, they also used them in different ways to inform partial compliance and non-compliance with mainstream health information. I would argue that the “fetus-as-agent” is sometimes a benevolent, understanding and flexible dictator. In addition, although descriptions and understandings of the essentialist body may be problematical for some social theorists, pregnant women in this study often used them in more positive ways and some examples of these will follow.

In general terms the women I interviewed used a combination of decision making processes. These were context dependent and may or may not have, incorporated notions of themselves as a ‘rational core’ ‘essentialist body’ or a more fluid, fragmented, multifaceted
articulation of self as thinking and body. Marshall’s (1996, p. 257) personal account of her own experience of pregnancy reflects some of this as she describes her experience as: “not an on-going unified pregnancy, but of a self living in the usual fragmented way, with pregnancy as one of the fragments.” So it is the use of embodied knowledge not as a privileged form of knowledge but simply as a valid and positive strategy in some of the women’s decision making that I wish to draw out in this section. Embodied knowledge can be used as a mechanism that sometimes enables women to question and feel more confident and comfortable about both compliance and non compliance with main stream health information.

There is a potentially treacherous line to tread here. I am not arguing that all of the women I interviewed used embodied knowledge either all or some of the time. The issues that were raised by the interviewing process for this study demonstrate that the decision making processes of the women and their interactions with main stream health promotion and health professionals were diverse and complex in nature. Neither is it only some of the women I interviewed who used embodied knowledge. Health professionals including community midwives and doctors similarly may use embodied knowledge (see Morison, Hauck, McMurray, 1998; Pitt, 1997) and a specific example of where a doctor does is described in the next section. There are also many occasions where the women I interviewed used decision making processes informed by modernist notions of a ‘rational inner-core’ and an essential body in simultaneous and interactive ways, that made them feel at times, confident and at ease with their decision making, and at others, critical and even angry about the rigours of main stream health advice. These complexities of the decision
making processes are difficult to unravel and analyse coherently. A focus on the interview transcripts of the women does help to illustrate this complex kind of decision making and interaction with the bio-medical model and one of these is outlined in more detail in the following discussion.

The Embodied Anecdote

Although I have questioned the use of abnormal or extreme descriptions of the body in other work in order to arrive at understandings of the importance of embodied knowledge the following example is unusual. Not so much in terms of this woman’s bodily functions or her experience of her pregnant body being abnormal; but that her experience of her pregnant body was unusual in comparison to the other women interviewed. Her response or rather her lack of response to main stream health campaigns is quite marked and strongly informed by her unusually extreme experience of ‘morning sickness’ and years as a supposedly infertile woman. Here her experience of her body is extremely influential in the decisions she makes in relation to pregnancy.

This hospital birth woman responded to my question about what she thought were good things to do for herself during pregnancy quite differently from many other women. She did not refer to being healthy, diet, exercise, alcohol or smoking at all, and instead responded in the following way:

“I do know what is bad, is when you’re sick in bed day after day and you’re not doing anything. You’re not getting up and you’re not cleaning up – you’re not
washing up. You could not be bothered even making a meal for yourself. Nobody
told me. I wasn’t expecting that sort of sickness [morning sickness]; you know [I]
just lay there day after day not coping. Not knowing what to do that’s bad. I think
its bad the doctors didn’t tell you [about severe morning sickness]” (3: hosp).

This woman had suffered from terrible ‘morning sickness’ throughout her pregnancy and
was vomiting or feeling nauseous for the best part of every day. For her, every day was a
struggle, keeping any food down was a challenge, and exercise was completely out of the
question. She mentioned that much of the information passed her by as she was just too
sick to engage with it. She claimed that what she needed was understanding and support for
her continuing nausea, some recognition that she was not the only person to have ever gone
through an experience of feeling sick for most of her pregnancy and not just for a few hours
in the morning. The woman’s experience was also an example of where all the information
and the advice about diet, exercise and stress, did not help her cope with the enormity of
facing every single day feeling sick for the best part of it. She wanted some recognition and
sympathy for her condition and on her next visit to her doctor explained: “I have been so
sick” (3: hosp). Hoping for some advice and understanding she instead found the response
to be somewhat judgemental:

(Doctor): “You don’t really want to take drugs do you? Well what do you want to
do about it? My wife had three children and she just had to go through with it
[morning sickness].”
(Woman): ‘Well of course I don’t bloody well want to take drugs, but it’s just his attitude - what a pig. That is no way to talk to someone who is feeling unwell and not knowing anything. It’s just no way to speak to someone - sitting six feet away and asking them ‘what do you want me to do?’’’ (3: hosp).

In this situation the doctor has used anecdotal information gleaned from his wife’s embodied experience of pregnancy and related it to his patient’s experience of ‘morning sickness.’ Rather than resulting in an empathy with his patient’s predicament, it has in this situation served to trivialise her experience. For most of the other women interviewed, issues in relation to diet, exercise, smoking, alcohol, caffeine, listeria and folate were most often mentioned. For this woman her ‘morning sickness’ was such an overpowering experience that her major concern in relation to what she ate and drank was what she could keep down. For her the ‘right’ food was that which did not contribute to her vomiting. This is also an example of where the popular pregnancy discourse and mainstream health promotion information constructs ‘morning sickness’ as a temporary and minor inconvenience. This woman’s embodied experience of it as something extremely debilitating stands in strong contrast to the general knowledge about how best to deal with it. The difficulty she has in articulating the helplessness she feels falls on deaf ears. She is defined as a woman who is out of control and unreasonably demanding, she needs to just “go through with it”’ (3: hosp).

Many women would explain that they did not drink alcohol, smoke or eat the ‘wrong’ foods while pregnant because their ‘body’ would tell them and these bodily signals would
coincide with the main stream health information. Some of the women commented that smoking, drinking alcohol and eating fatty or spicy foods did for example make them feel nauseous and so they did not eat them. For example a hospital birth woman and first time mother, comments:

“With alcohol, you actually don’t want to drink in the first three months anyway, it makes you feel a bit queasy” (1: hosp).

While it could be argued that this is a situation where the woman was listening to her body in a “fetus-as-agent” fashion it did not prevent her from drinking alcohol moderately in later pregnancy. Listening to bodily signals or the baby did not, however, always result in compliance with main stream health information and this was especially the case for women for whom it was a second or subsequent pregnancy.

For women who had experienced previous pregnancies and the birth of babies who were healthy, the reliance on the ‘embodied’ rather than expert and textual information was even more important. Confidence in their bodies to produce a healthy baby, even given the odd cigarette or occasional glass of wine was much higher than for those women for whom it was a first pregnancy. A woman I interviewed who was pregnant for the second time discussed her first pregnancy in terms of: “not wanting to bugger it up the first time” (5: hosp) and for the second:
“Well millions of women have babies, and they don’t have any problems, why should I? I enjoy going out to dinner and having a glass or two of wine” (5: hosp).

While for another hospital birth woman ‘listening to her body’ and ‘listening to the baby’ was very important for what was her third pregnancy:

“A good thing to do while pregnant is mainly listen to the body. Just listen to what it’s saying to you before anyone else. If the baby does not like it he will soon let you know. Don’t get stressed, it is the third [pregnancy], it is so much easier. The first pregnancy is a bit more scary because you are not sure what is going to happen” (4: hosp).

These examples illustrate the point made earlier that women’s use of embodied knowledge may be empowering, the second pregnancy less ‘scary’ than the first pregnancy. The experience of a previous pregnancy especially one that has been successful in terms of producing a healthy baby enables a confidence about the body to replicate this experience a second or subsequent time. In these situations the “fetus-as agent” is not necessarily a tyrant insisting on self-policing as described by Mitchell and Georges (1997) but rather a reassuring and knowledgeable presence. Here paying attention to bodily signals enables women to question main stream health promotion as well as providing them with cues in relation to compliance. The woman quoted above smoked and drank wine moderately throughout this her third pregnancy as she had with previous pregnancies. Confident about her ability to produce healthy children her emphasis on her body and the baby inside her is
a result of her growing scepticism about main stream health information which itself is informed by two other pregnancies.

The use of embodied knowledge by women in this study seemed to most often inform partial compliance. However, the following example details how a woman has used embodied knowledge, previous experience, and at the same time, a thorough knowledge of medical information to inform her non-compliance with the folate campaign. This once again demonstrates the complexity of the decision making processes used by women in pregnancy. Here the woman is using her knowledge not only of her body but also of other main stream health discourses to refute the folate campaign. This hospital birth woman was an exception because she was the only person who purposely did not follow the instruction of the folate health promotion campaign. This was because:

“When I was trying to fall pregnant, before [this pregnancy], I knew about folic acid. Because it constipated me so bad I stopped taking it. I tried so many years to fall pregnant and it didn’t work so bugger the folic acid” (3: hosp).

I speculated how main stream health promoters would most likely respond to this comment. It would probably be suggested to the woman that the folic acid had nothing to do with her initial difficulty in conceiving. It might also be recommended that she should have tried another brand of folic acid because it is frequently combined with iron pills, and these may have caused the constipation. Main stream health promoters would also be likely to assume she had not read or understood the information about folate properly. They might consider
her response to their campaign as both irrational and a consequence of being an ‘illiterate’
health subject.

A different story can be told if the woman’s decision making processes are placed within
her life context. The text can by re-thought and re-written so that her response is interpreted
as both well informed and rational. This woman had attempted for over ten years to
conceive and had in fact tried for so long she had not used any form of contraception for
many years. Her pregnancy after this time was for her most unexpected and certainly not
planned, consequently it had not been possible for her to take the folate supplement
beforehand. She did start to take a folate supplement after she knew she was pregnant by
which time two months had elapsed. The folate pills made her feel unwell and not willing
to chance any possibility of jeopardising her pregnancy by feeling unwell, she stopped
taking them. The same woman also mentioned to me that her doctor was always busy and
became impatient with her questions, she did not, in other words want to: “bother him with
my constipation” (3: hosp). This example enables a questioning of what it is that
constitutes health literacy and proper decision making processes as far as main stream
health professionals are concerned. Their assumption that the contexts within which women
make decisions are all neutral or do not affect the ways in which women make decisions are
clearly misplaced. In this example the woman’s embodied experience is crucial in terms of
her rationale for not complying with a main stream health promotion campaign.

This woman’s understanding of her own health needs disrupts the abstracted and
disembodied boundaries of main stream health promotion’s construction of what
constitutes good pregnancy behaviour. Even though she did not comply with this particular folate campaign her knowledge about other health issues was extensive. For example, she demonstrated an extensive and in-depth knowledge about infertility and other health services that were available to assist in this. She also raised concerns about the quality of food available for people and pregnant women in particular. She was also very critical of the role her doctor played commenting that there was little use in being informed and asking questions if the doctor was too busy to respond. This comment was one made most frequently by hospital birth women and certainly contrasts with the ways in which community midwives provide information (and is a point that will be returned to in the next chapter). For now, this chapter will conclude with examples of how women’s decision making is suffused with a complex interplay of embodied and mainstream health knowledge within contexts that sometimes reflect different value systems to those of mainstream health promotion.

Beyond embodiment:

An interesting paradox is raised in relation to health professionals constructing pregnant women as representing the ideal, if they demonstrate that they are autonomous, literate subjects. Women are of course not only influenced by mainstream health literature there are also other expert discourses that advocate for individuals to be informed, decision making subjects. I have mentioned before how mainstream health promoters and other health professionals who construct subjects that are rational, empowered and knowledgeably health literate are fashioning themselves a double edged sword as far as
compliance with their own directives are concerned. Many of the women I interviewed were so confident in their own knowledge and ability to provide the optimum environment for their baby; they used this to subvert main stream health promotion and other expert health information. I am not speaking here solely of some kind of intuitive or embodied knowledge, but of a knowledge that while informed by these in some cases, was still very much the product of the kind of rational health literacy advocated by health professionals. For example, one woman I interviewed was confident that she was as healthy as possible and that even though she had been categorised by the biomedical model as an ‘at risk’ and ‘older’ mother (at thirty-five) she declined pre-natal tests to check for Downs Syndrome:

“I was offered [pre natal] tests for Mongoloid and amniocentesis and ultra sound. They [doctors] said there’s only a minor chance of abortion but couldn’t give 100 per cent... I felt healthy and I felt really good. I had an ultra sound and everything seemed to be okay. I saw one doctor and he went right through what all the tests were, and he said you have a 1 in 500 chance of having spina bifida or 1 in 1000 of Mongoloid. That sort of thing. They can give you rough estimates but that’s all. To cover their hide. [The doctors] said they weren’t accurate but if there were any definite signs they could pick it up. I did some research into it, read heaps of books and medical articles and I thought, oh well, its [pre-natal tests] not really worth it. With the amniocentesis by the time you get the results it’s past the time [to abort]. We’d have the baby anyway, whatever, there was no point” (10: hmb).
This woman used the rhetoric of being a health literate mother to justify her position in the following ways. Not only did she ‘feel healthy’ and had ensured that she ate the very best diet possible, she had also thoroughly researched the probability of having a Downs Syndrome child. She was quite prepared to accept, love and care for a Downs Syndrome child if that was what eventuated, although she considered this the remotest possibility. This is where the individualising of pregnancy behaviours and the construction of women as responsible in terms of producing a ‘perfect’ baby becomes interesting. Here was a woman who had thoroughly researched all aspects of pregnancy and birth, she had planned her pregnancy, ate a healthy diet, ensured she had adequate exercise and relaxation, abstained from any harmful substances. Yet she could still have been described as ‘irrational’ by health professionals in terms of her response to the possibility of a Downs Syndrome baby because of her refusal to utilise pre-natal tests. Furthermore she would not consider aborting the foetus if it were shown she was carrying a Downs child. Her own evaluation and acceptance of ‘risk’ would not have been recognised as rational because her value system is different to that shared by many mainstream health professionals whose desire, under the guise of ‘heroic medicine’ is to eliminate rather than mediate risk.

Pregnant women are inundated with information about Downs Syndrome and other things that can go wrong, but the sanctioned responses to imperfection are narrowly defined and women’s roles heavily scripted according to mainstream health orthodoxy. As Landsman (1998, p. 80) has asserted there is plenty of information about ‘what can go wrong’ but it is always written up in terms of what the individual woman can do about it. Notions of the essentialist body are used here by mainstream health professionals to suggest that
individual women have ultimate control over their bodies. There is rarely an acknowledgment that even if a woman does everything right there might still be complications. The paternalistic nature of the advice cannot admit to this fallibility, an acceptance of imperfection that may occur despite everything possible being done to prevent it.

As I have already asserted, the use of health literacy as a strategy is a double-edged sword for mainstream health promoters. The emphasis on healthy lifestyle and the construction of women as individually responsible works both ways. A woman who is confident she is health literate, has complied with the dietary and lifestyle instruction of mainstream health promotion, may feel that as a responsible and well informed individual, she does not need to comply with what she may see as the more invasive or intrusive aspects of pregnancy management such as pre-natal tests. After all, she is exercising her right to assess as an informed and supposedly autonomous subject. She is already doing everything she can as a sensible individual to ensure a ‘perfect’ baby. Once she has done this there seems to be an acknowledgment and arguably a realistic assessment that the rest is beyond her individual control. Her desire to control the pregnancy process has limits that contrast with that of mainstream health professionals where there seems there is no cut off point. Here the inclusion of the context within which pregnant women make decisions, their acceptance of ‘risk’ as a possibility they cannot ever completely eliminate, contrast with the abstract and disembodied nature of “heroic medicine” and the “armour of moral certainty” of mainstream health promotion on a quest to stamp out uncertainty and risk (see Moodie & Borthwick, 2001, p. 2; Sagasti, 2000).
Not all of the women who refused an amniocentesis test did so by using the health literate processes preferred by mainstream health promoters. One home birth woman describing amniocentesis responded that: “they stick a needle in your abdomen, and I find that disgusting” (7: hmb). For this woman her revulsion of the test was articulated in relation to issues of invasiveness into what was for her, a sacred space, her own womb. She also resented the assumption that after the test:

“They [the doctors] don’t even ask you what you want. They’ll give you the test and just leave you [with no discussion]. It’s like an assumption to abort [if the test is positive] is the best thing, it’s a moral assumption. By demeaning people to the cost they may be on the health system you’re [society is] ruining [the] potential [for people] to be so many things. People no matter what disability can give to society” (7: hmb).

This woman’s reluctance to undergo a test like amniocentesis was informed by different reasons than for the woman in the previous example. While not so easily categorised as ‘rational’ or health literate in the way it is narrowly prescribed by mainstream health professionals it does nonetheless illustrate equally valid, and it can be argued ‘rational,’ reasons that are informed by values not necessarily shared by mainstream health promoters. She recognises that she is pregnant in an environment where health dollars are scarce; in a society where a value or price is put on what is a worthwhile human life. This woman asserts her right to question these values and to hold different ones. Seen in this light it is
questionable as to why her decision making processes should be considered any less valid than one that recognises statistics should be viewed with scepticism. This woman also articulates a different morality to that of mainstream health promotion underpinned by an economically rationalist health system driven by healthism. Her reasons although different, and more importantly in disagreement, with the values that form the basis of what is considered a health literate person by mainstream health promoters, are nevertheless the result of rational decision making processes. Her bodily revulsion and the articulation of it is important in her decision making, but it is also the case that she is at the same time considering in a more abstract way the implications of pre-natal tests. Discourses and texts that espouse different values to that of mainstream health promoters inform her considerations. For her, priorities in decision making are linked to larger questions related to ethics and how quality of life is defined. What constitutes a worthwhile human life is a crucial question. Her decision making is placed within a context where ethics and values of a broad nature are considered.

In a previous chapter I cited an example of where women who had undergone pre-natal tests and who were about to give birth to less than perfect babies were judged negatively when they did not want heroic medicine to intervene. Women were described as intrinsically selfish for not wanting their babies to be subjected to aggressive medical treatment. However, a woman who chooses not to avail herself of pre-natal tests but who nonetheless is prepared to accept the consequences of a living ‘less-than-perfect’ baby is defined as irresponsible and irrational. In either case the only response by women that would be considered responsible would be one that incorporated biomedical intervention.
Much of the biomedical advice given to women in the shape of health promotion campaigns or advice from doctors and other health professionals was often described as useful and appropriate. However, it was equally well recognised that to do other than comply strictly with biomedical directives, was in fact a realistic and even ‘rational’ response to the complexity of managing health in pregnancy. The women I interviewed recognised that while there was an ‘ideal’ in relation to pregnancy information and behaviour that strict compliance with this ‘ideal’ was not always possible or in some cases even appropriate to their individual situation. In some cases an individual woman’s own philosophy about what were ‘good’ things to do departed quite dramatically from the more usual responses I have already described. The following example unsettled my own notions about what was a rational response to the question about ‘what was good’ and was markedly different from the other women I interviewed.

A home birth woman responded to my question about what she thought were ‘good’ things to do while pregnant in the following way:

“I think that swimming, being in the water helps in some sense. Especially with the dolphins. I guess because they [the dolphins] pick up the ultra sound. We swam with the dolphins at the weekend and he [the baby] really responded straight away to the dolphins. So for me it was being positive for him - plus the exercise. Being fit must surely help the pregnancy and to some extent the baby - also it is very relaxing” (6: hmb).
This woman’s response incorporates main stream ideas about being fit and relaxing during pregnancy, however, parts of her response challenged my own frameworks of knowledge. For example, her description of the baby responding to the ultra sound in this natural environment was seen as positive. This is in contrast with what other home birth women had described as the unnecessary intervention of ultra sounds when they took place within a medical setting; while most of the women interviewed either did not mention ultra sound or just considered it a routine of pregnancy management. However, one home birth woman had particularly strong views about ultra sound claiming:

“With the second baby I did have an ultra sound because I was suffering the same sort of pains I had with my previous pregnancy. I had one at fourteen weeks and the foetus showed distress. The radiologist stopped. I said it looks as though the foetus is getting disturbed? And he said yes, it’s quite funny, they often do that. And its like, the disturbance of the ultra sound does disturb them [the ultra sonographer] and that didn’t reassure me at all” (7: hmb).

The comparison of these two examples provides a salutary reminder of the limitations of an impoverished notion of rationality to explain adequately the different responses. While one woman’s baby’s response to the ultra sound of the dolphin is seen as positive the other that takes place in a clinical setting is viewed with suspicion. Whilst this might reflect to some extent the assumption that what is ‘natural’ is less invasive than the technological it illustrates the importance of context in terms of women’s decision making.
I had generally expected that home birth women would be more likely to incorporate holistic notions of health into the management of their pregnancy. In many cases this assumption was correct. For example, in relation to the folate campaign home birth women were more likely than hospital birth women to eat a diet of folate enriched vegetables, cereals and fruit rather than take a daily supplement. However, I was not prepared for a woman to say that swimming with dolphins was ‘good’ because the baby responded positively to the ultrasound. I had to acknowledge that the scepticism I felt about this woman’s foetus responding to the dolphins, and further what was ‘good’ about this in terms of health, was a product of particular definitions of rationality that I held. While I am critical of mainstream health promoters and what I see as their reliance on an impoverished rationality, I have to also acknowledge how, as a researcher, I am also bounded and constructed by the dominant notions of what constitute a ‘proper’ rationality. While I was prepared to accept eating vegetables rather than taking a supplement for folate was a rational response to mainstream health promotion I was not so sure where ‘swimming with the dolphins’ fitted in, or what made one ultrasound intrinsically good and another intrinsically bad.

I can only speculate that the absorption of the range of biomedical and naturalistic discourses into women’s decision making processes enable a much richer and more complex tapestry. It can also lead to a questioning of what is privileged by mainstream health promoters and what is important to their target populations. To speak of empowerment, and more importantly for mainstream health promoters to seriously ‘do’
empowerment, will require acknowledgment of the diverse contexts within which pregnant women make decisions in other than problematical terms. It will also require acknowledgment of difference in terms of values and perceptions. The woman who found ultra sounds (in a clinical setting) disturbing, similarly may be an exception and could also be categorised as falling outside of what may be considered a rational response. Her views also reflect other discourses that question and raise concerns about the routine use and affects of ultra sound (Duden, 1993; Petchesky, 1987). However, it is not the discourse but the embodied experience for this woman that is emphasised. Feeling her baby moving erratically inside her during the ultra sound most influenced her questioning of the routine use of ultra sound. This contrasts with the experiences of other women, who on ‘seeing’ the baby on the ultra sound image may be reassured and may even feel ‘really’ pregnant for the first time (Ihde, 1990; Petchesky, 1987). Both the examples cited above provide clues about how empowerment can be differently defined for pregnant women. For some women their embodied experiences in particular situations and times may be usefully deployed, while for others, knowledge of a range of discourses enables critique of ‘the routine.’ While mainstream health promotion is set in a hierarchically superior relationship to other forms of knowledge, whether it is embodied or the result of opposing or just different discourses, its aim of empowerment will remain rhetorical.

The next chapter further develops the argument of the thesis in terms of how women who are situated in the social context of their decision making are rendered other than strangely disembodied individuals. This is not only, as has already been discussed, in terms of how they use a complex mix of embodied and rational decision making processes to make
decisions, but also how they do not solely make decisions as the unitary individuals assumed by main stream health promoters. Women construct themselves as complex, fluid and interactive, as much more than isolated pregnant individuals who are connected to a foetus. They are also partners, mothers to other children, friends and work colleagues and members of a much wider community. While the developing foetus may be emphasised by main stream health promoters and other health professionals, many women are facing the reality of accommodating more than the needs of the foetus.

This chapter has demonstrated how women’s decision making processes are suffused by other than main stream health literature. The next chapter will focus on this in more detail, illustrating not only the wide range of textual information that women access but also the information gleaned from sources such as doctors, community midwives, various pregnancy and birth support groups, antenatal classes, family, friends and other individuals within women’s communities.
This thesis has been concerned with the decision making processes of two groups of women and describing how these are ongoing, complex and contextual. The information environment in which women make decisions is rich and varied and obviously encompasses more than just mainstream health promotion information. One of the main criticisms this thesis has made is that mainstream health promotion constructs responses to its advice in ways that privilege rationality and good decision making, and which render the contexts within which they are made invisible. I have argued that not only are the contexts in which women variously make decisions invisible, the decision making process is linked to ideas about health literacy that are static and tied to particular notions of what it means to be rational. Decision making processes within these contexts are also assumed to lead to an end, a singular conclusion. By this I mean decision making is not considered an ongoing and fluid process open to multiple influences and interpretations and subject to constant change, revision or diversity of responses. What I want to emphasise in this chapter is that, for the women I interviewed, decision making is not just fluid, but relational as well as individually cognitive.

To begin this complex unravelling I want to re-visit and discuss ideas about rationality and notions of autonomous individuals. This chapter will illustrate how women make decisions both as individuals, in more isolated or less social circumstances, as well as social beings interacting with a wide range of people. Both health promoters and their critics may
construct women as health promotion subjects who are little more than a consequence of what they read in terms of expert information and how much and how efficiently they take on board the advice offered. My argument is that whilst women do read and use expert information in this way they also engage with it critically and relate it to their own unique stages of life and circumstance. They also utilise a number of other strategies. I have argued that women are much more than passive constructs of discourse and can equally be viewed as interacting and choosing subjects influenced by a range of bodily and social experiences as well as by textual and expert discourses. I do not mean to assert that main stream health promoters and other health experts are ignorant of the existence of these alternatives to straightforward decision making, based on a narrow notion of health literacy. It is just that they are most often described in terms of being a problem or a barrier to rational decision making (as defined by health promoters), and are constructed as inferior and irrational or in need of improvement.

In addition, women are making decisions in an environment that expects them to consider risk and work toward certainty and control, in situations that are uncertain and cannot realistically be subjected to individual control. Whilst some of the women interviewed refer to this in terms of eating or being as healthy as they can and that this is something they can have ‘control’ over, most women accepted that pregnancy and particularly birth is often uncertain and that ‘control’ has its limits. Whilst many women accepted their responsibility in terms of controlling diet or ensuring they exercised; they acknowledged, for example, that they had little or no control over environmental pollutants such as insecticides used in food production.
The discourse of control is also turned against the experts at times as I have demonstrated earlier in the thesis. A hospital birth woman who had smoked cigarettes and drank moderately throughout three pregnancies cited the result of three perfectly healthy children as ‘evidence’ that moderate intake of both these substances had not harmed her babies. After the birth of her third child she wrote me a letter, quite some time after I had interviewed her in early pregnancy, describing how healthy that child was and her positive birth experience. She described being guided “by her body” and her “baby” stating: “if you are doing too much, or drinking or smoking too much, the baby will tell you, or your body will tell you” (4: hosp). Whilst main stream health promoters would view this as quite irrational and probably irresponsible, it is an example of a form of empirical knowledge that leads to an ‘essentialist’ conclusion informing women’s decision making. It also turns on its head social constructionist accounts of pregnant women listening to the “fetus-as agent.” Bodily cues were used in this case in a way that enabled a circumventing of strict adherence to main stream and popular pregnancy advice that preaches complete abstinence of both substances. Here the woman’s knowledge of her body and her baby’s responses gives here a sense of control and a feeling of confidence about moderate intake of alcohol and cigarette smoking. This woman’s general practitioner supported her decision in this, in contrast to the message of complete abstinence advised by main stream health promotion.

The notion that middle class, English speaking women are the ideal health promotion subjects in terms of compliance and unquestioning acceptance of advice has also been raised in the thesis. Not only has the diversity in decision making between home and
hospital birth women been discussed but the differences within these groups have also been
detailed. This process has resulted in a disruption of the categorising of hospital birth
women as inevitably less questioning of main stream health promotion advice because they
have chosen hospital birth. While home birth women were more likely to be critical of main
stream hospital birth this did not mean that they were immune from ideas about control or
that they did not pay attention to main stream health promotion advice albeit in alternative
ways. For example, the use of diet rather than supplements to ensure adequate folic acid
whilst more flexible does nonetheless demonstrate acceptance of the message that folic acid
intake prior to and during pregnancy is desirable. Whilst hospital birth women may be less
critical of hospital births (although this was not always the case) they were quite critical of
many aspects of main stream health promotion advice and frequently critical of the
responses or dismissal of their concerns by the general practitioners and obstetricians
involved in their care (see Chapter 4).

Although agency was demonstrated by both groups of women, the major difference
between home and hospital birth women was the greater opportunity for home birth women
to discuss and debate pregnancy and birth care with their midwives. This is important and
relevant to the question about how women make decisions in relation to health promotion
because the context of women’s every day lives is more likely to be considered and
discussed in these situations. It also illustrates the sociable nature of much of the decision
making processes of the women I interviewed. The emphasis health promoters place on
health literacy as proof of women’s rationality and ability to make the right decisions, does
not acknowledge the complexity and fluidity and every day nature of decision making
contexts, other than in a superficial way or in a way that negatively portrays these as contaminants or detractors from ‘proper’ decision making processes. It presupposes a rational individual making decisions largely in isolation after reading the ‘correct’ information (health promotion advice) rather than a social being interacting at least some of the time with questions and discussion about the advice that is presented such as this example:

“I did do some reading of stuff but not as much as the first time. [I’ve] just gone with the midwife - they are a great source of information. The best you can get really, because they come to your home and if there are any problems, [they are] very direct” (4: hmb).

Neither, does the emphasis on health literacy as I have argued throughout the thesis, contribute in a meaningful way to empowering women. Main stream health promotion’s use of social capital theory is similarly rhetorical as it does not translate into health promotion practice. That is, health promotion practice still emphasises the individual’s response rather than addressing some of the structural concerns raised by the women themselves. For example, the woman who voices concern over the quality of food generally, and others who mention environmental issues that as individuals they have little or no control over. That the individual is still emphasised in health promotion can be evidenced in relation to the two key texts recommended for health promotion students in Western Australia and one that claims to be useful for health promoters Australia wide (see Egger, Spark, Lawson, Donovan, 2002; Nutbeam & Harris, 1999; O’Connor-Fleming &
Parker, 2001). The difficulties and various conundrums faced by health promoters who may want to practice in the ways that social capital theory and empowerment principles recommend are discussed in some detail in the concluding chapter that follows. The emphasis on the cognitive importance of decision making in relation to social marketing and the use of media in mainstream health promotion will similarly be discussed.

This chapter will begin by demonstrating how enriched and complex decision making contexts are used strategically by women and how this can provide clues about how these can be constructed as other than a problem. It occurs to me that in emphasising the decision making processes of the women I interviewed and notions of what is considered rational decision making my focus has still been on the individual, a position I criticise when it is used by health promoters. However, I can balance this with the knowledge that if non or partial compliance is positioned as other than a consequence of irrationality or lack of the appropriate or ‘correct’ information, if it is differently constructed as other than a problem, the inclusion of complexity will draw in structural concerns and broaden the area of interest beyond the individual.

Before I provide examples of women’s decision making processes and how these support an argument for an enriched sense of what good decision making could exemplify, I want to devote some time to discussing notions of the ‘self.’ This is because the women I interviewed described themselves as both the ‘inner rational core’ the individual and isolated self constructed by mainstream health promoters, as well as the multiple, fluid,
fragmented, relational, interconnected and social selves described by a range of social theorists (Keane, 1996; Marshall, 1996; Oakley, 1992; Van der Plaat, 1999).

The ways in which different selves have been described and defined as ‘ideal types’ by social theorists, particularly anthropologists has been questioned in relation to what is described as: “the overly dichotomised view of Eastern sociocentric selves ‘versus’ Western individualistic selves” (Kusserow, 1999, p. 541). Kusserow (1999) asserts that notions about bounded individuals in the West have been due to an over reliance on particular philosophical texts and that there are a number of examples of self as multifaceted and interactive such as in the work of Goffman (1959) and social psychology theory. Kusserow (1999, p. 553) points out that behaviours and reactions are situational and not the consequence of some universally shared or modal personality trait. I will pick up on this observation and argue that the situatedness of decision making and women’s own descriptions of themselves as individual self and social selves maybe an important consideration, for not only main stream health promoters but also health promotion critics to note.

In relation to the women I interviewed for this study it is also the case that while there are many similarities in terms of philosophical positions in relation to pregnancy and birth that home birth women share, and that these as times differ quite markedly from those of hospital birth women, there are also many differences within each of the groups. Ways of making decisions and defining the self are also not simply attributed to one group or the other. I expected home birth women to be more ‘communal’ that is, utilise a wider range of
community and alternative resources, and for hospital birth women to be more ‘individual’ and isolated in their decision making and to use more mainstream services. While generally speaking this is what occurred in this study, a closer examination of the decision making processes of both groups of women demonstrates a number of complex reasons why this was so. Ways of making decisions were not solely due to particular kinds of essentialist or stereotypical personality types. For example, that all home birth women are vegetarian, left wing and communal (sociocentric) in orientation and all hospital birth women are conservative and individualistic in orientation. Many of the home birth women I interviewed mentioned feeling that they were stereotyped in this way: “people think you’re a ‘veggo’ [vegetarian], hippy type [alternative person]” (3: hmb) was one such comment and there were others that noted wryly that home birth was associated with ‘alternative’ or ‘hippy types’. While a hospital birth woman noted the need to: “justify my high-tech birth choice [hospital birth] to my more natural birth friends. All the equipment made me feel secure, it’s what I wanted.” She also questioned assuming individual responsibility for the birth stating: “you get a lot about what you’ve got to do, what your partner’s got to do. Well I want to know - what are the midwife and obstetrician going to do, where do they come in?” (1: hosp).

Kusserow (1999) asserts that:

“Perhaps it is time to acknowledge that in all groups, as in all individuals, both individualistic and sociocentric orientations exist, but in differing styles and ratios, depending on the local worlds they inhabit” (p. 553).
It is the local worlds inhabited by home and hospital birth women and the social relations they were embedded and immersed in, that form part of the contexts that main stream health promoters fail to acknowledge. Consideration of the contexts in which both groups of women make decisions makes for a more complex reading of their decision making processes.

I have asserted in previous chapters that notions of an essential self and an autonomous, isolated individual has been the subject of some considerable debate and critique, particularly in feminist, post structuralist and post modern theorising of main stream health promotion and other expert discourses (see Bunton, Nettleton, Burrows, 1995; Harris, 1994; Keane, 1996; Michie & Cahn, 1997; Oakley, 1992). I have previously stated that the women I interviewed did at times describe themselves, and their processes of decision making, in terms of being rational, health literate individuals. In Chapters 5 and 6, I provided some examples of where this occurred, and how in some cases these notions were used to justify rhetoric of non or partial compliance with main stream health promotion. I also noted how they were just as likely to be used as a justification for complete compliance with some elements of health promotion advice. Keane (1996, p. 273) similarly notes in her study on alcohol and pregnancy that the: “pregnant woman is embedded in social relations and discourses which both limit her behaviours and actions and make them possible.” I have discussed how the decision making processes of the women I have interviewed are complex and may vary depending on whether it is a first or subsequent pregnancy and so on. Social theorists may usefully interrogate definitions of rationality, self, the body and critique how these definitions have been used in a number of expert
discourses, however, they may be less useful in terms of understanding the actual processes of how pregnant women make decisions. Pregnant women read, respond and interact with a range of health information and health professionals and they may understand and use in positive ways both non essentialist and essentialist notions of self, body and rationality. My argument is that they do this in strategic ways, so as to transcend both a categorisation of them as middle class dupes and as simply social constructs of main stream health promotion discourse.

Expert discourses may construct subjects in particular ways but these constructions are not static. The women I interviewed were at times caught up in the construction of themselves as rational, health literate, disembodied subjects, but were also at the same time constantly re-constructing and re-negotiating themselves as other than this. Women’s engagement with main stream health promotion and other health information does not inevitably lead to a completely successful construction of a “disembodied, rational core subject” as described by Keane (1996, p. 265) for example. By focusing on the interview responses it becomes clear that in certain situations women make decisions based on individualistic notions of self while in others they are more sociocentric in orientation. In addition that whilst the ‘rational core subject’ is present so too are other subjects informed by body, previous experience and the experiences of others. For example this home birth woman discusses her decision making in terms of the birth and afterward:

“There were certain things that were really important to me from the start. I knew right from the start no matter how much anyone said... I knew that I wanted to try and have as natural a birth as possible. I had read all the stats [statistics] and knew the effects of medical intervention” (9: hmb).
In contrast to this more individual statement she describes how she is different after the birth:

“So while I was pregnant, I was reading a lot, and filtering out a lot of the stuff. I’m not the Caesar [elective caesarean birth] private hospital type, but I’m not that far over to the Left [non-conservative] either. I was quite sure about stuff when I was pregnant; that has changed since the baby. I’ve felt unsure since I’ve had the baby. Like if he’s not sleeping, I’m looking for the answer. I guess in many ways I probably ask too many people. Everyone has an opinion and maybe there isn’t an answer. I never get tired of listening to what people say about things like that you know, how to get baby to sleep, but I certainly wasn’t interested while I was pregnant, I knew what I wanted and that was that” (9: hmb).

They may also incorporate both individualistic and sociocentric decision making strategies in the same process as does this home birth woman describing her decision making processes in relation to pregnancy and birth:

“It’s a combination - reading, listening to what other people think and you just balance. You just go with what feels right sounds right, and like I talked to my midwife a lot and she was a very good source” (5: hmb).

Given both main stream health promoters and their critics’ concern with issues of empowerment, an examination of women’s decision making processes in terms of how they define ‘self’ and how they describe both the enabling and restricting factors that affect their decision making seems useful. As in the previous chapter it is the contexts within which these occur that is important. For example, for women for whom it was a second or subsequent pregnancy textual information and the advice of other people whether expert or not are far less important than their own previous experience:

“Guess you already know with the second one what you want to do yourself, anything you did the first time you thought you could have improved upon you think how you could do it better” (7: hosp).

It is possible too that reading as individual rational core selves is preferable for many first time mothers. A strategy to counteract respond to, or deal with, much of the uninvited commentary they experience. Many of the home and hospital birth women interviewed described how first time mothers are more likely to receive unsolicited advice from a range of expert and non expert sources. As this hospital birth woman describes:

“It’s worse your first time [pregnancy], because you’ve never done it before. So the first question people ask - ‘Is it your first?’ If you say first, they just tell you everything, do this, do that, and don’t do this” (7: hosp).

For second, subsequent or older mothers the advice was less forcefully put and also probably less likely to be given the same credence by the woman herself, as this home birth woman explains in relation to her choice of birth:
“Yes, you do get the unwanted advice. Not mentioning any names but sort of family. Everyone likes to comment about how it should be done. Although maybe because I’m a bit older and it’s my third, they realise I’m not going to change my mind. Nobody tried to talk me out of having a home birth. So I didn’t get very much [unsolicited advice]” (3: hmb).

In this instance this woman’s age and presentation of herself as experienced and confident about her decision making and ability to give birth (she has proof of two previous successful ones) means she is not only less reliant on textually based information, but also less likely to be questioned about her decisions in this regard. This contrasts quite markedly from the next example, where a hospital birth woman for whom it was a first baby, emphasised that textual information was very important to her decision making processes, and that rather than discussing issues with other people her approach is very individualist:

“I found out by reading, reading, reading. I went to the Family Planning Association and got anything they had that seemed useful. I bought a couple of books. I did heaps of research beforehand on what I should and shouldn’t do. There are lots of leaflets around. Folate and listeria are probably the real big ones. I think I had good access to information. I think my training ensures I get what information I need. I’ve probably only sought advice from other people since I’ve had the baby” (6: hosp).

This woman accepted that while there might be dissonance between what she read and experienced at times, this was ‘solved’ by further research and reading. She felt confident with her own ability to seek out and read the relevant information. For her feeling ‘empowered’ was having a handle on all the expert information. It was only once she had thoroughly researched an issue that she would then ask her doctor any questions. For her, listening to the anecdotal advice or experience of other people was confusing. For example, she found antenatal classes useful in terms of textual information, but less so in relation to the discussion of other people attending. Rather she found:

“Quite often in antenatal classes when we were talking different people [attending the class] would say different things. It was obvious not everyone had got
[understood] all of the information, different people saying different things, it was confusing. I prefer to find out for myself” (6: hosp).

While this woman could be described as quite individualist in terms of decisions she made about pregnancy and birth, she was more open to others in terms of child rearing. Once again her apparent individualism is situational not a consequence of what Kusserow (1999, p. 541) describes as a “modal personality” neither is it a consequence of her choosing hospital rather than home birth. It could be argued that her perception of herself as informed, is a consequence of being constructed thus by the material she reads and the expectations of main stream health experts. It may also be argued that she feels confident and more in control, with her own individual decision making due to her profession (related to information organisation and research) and that she relates this expertise to her pregnancy and birth. This woman had a sense of herself being a professional who was able to manipulate the textual information to her own ends. She did not however, extend this sense of self to all areas of her life. In terms of child rearing she read less and relied more on the experience of friends:

“Actually probably since I’ve had the baby - I listen to friends more and make comparisons and ask questions you know” (6: hosp).

Birth choice and decision making
I have stated previously that birth choice is a significant factor in terms of the kinds of information accessed and the social relations the women I interviewed were most likely to engage in. At the same time I have argued in this chapter that there are no simple or straightforward ‘types’ of women that are more likely to choose home or hospital birth, or that they will necessarily make decisions in a predictable way in relation to mainstream health promotion and other expert information because of this. However, in considering the contexts within which women make decisions birth choice is an important influencing factor. Not because of personality types but because of the philosophical and social contexts within which home and hospital births occur. Also whilst birth choice may seem unrelated to health promotion during pregnancy, an exploration of it provides clues about the complexity of decision making and how health literacy is tempered by previous experience. In addition, the women I interviewed (particularly the home birth) did not necessarily separate the pregnancy from the birth, they did not divide their decision making into two discrete categories ‘pregnancy’ and ‘birth’ (see Chapter 4). This supports my contention that the women I interviewed used processes of decision making that were ongoing and fluid. Furthermore, it is an important consideration in terms of what empowerment may mean for the women I interviewed and how this can translate into processes, rather than just be a rhetorical aim of health promotion. There is something about the continuity of care provided by a community midwife (evident in this study and others) that contributes towards women feeling empowered about both pregnancy and birth decisions, and it is for this reason that it is important to acknowledge women’s decision making processes in terms of birth choice (Lavendar, Walkinshaw, Walton, 1999; Morison, Hauck, McMurray, 1998). The ways in which home birth women described so much more
positively their feelings of uncertainty in relation to the management of their pregnancy, and how they should respond to a range of main stream health advice, provides some starting point in relation to considerations of how they might be empowered as other than the rhetorical subjects of health promoters.

I have previously stated that the one distinct difference between home and hospital birth women was the greater opportunity for home birth women under the care of community midwives to discuss their ongoing pregnancy care and birth options at some length. Issues of uncertainty could be discussed in-depth with midwives who dedicated real time to this (on average an hour compared to ten minutes for hospital birth women with obstetricians). In contrast the majority of the hospital birth women interviewed described feeling frustrated, or powerless, in terms of being able to discuss developments or uncertainties about their pregnancy care or impending birth. The following demonstrates how a home birth woman contrasts her most recent experience of pregnancy, with two previous ones that had resulted in hospital births. It also provides further support for my contention that women are strategic in how they use a range of information:

“Read up a whole lot and then contacted the Midwives Association and talked to a lady there, who put me onto a community midwife. She [the midwife] made me feel so excited and looking forward to the birth, rather than trepidation. I looked forward to looking after myself; it’s [pregnancy] really a delicious time. [I] Just felt happy, if I wasn’t too sure about something than I’d go to the library. Like with the
tests [pre-natal tests] I talked to the midwife about it and then read up about it to just check up on the average [risk].” (10: hmb).

Here the information gathering and decision making processes are fluid and interactive. This woman accesses the expert information in an individualistic way, but the confidence she gains from her positive relationship with her midwife enables her to feel comfortable with, rather than anxious about, the decisions she makes in relation to her pregnancy and birth. There is almost a symbiotic process between her reading and then asking questions of the midwife, each informs and feeds off the other in a productive and satisfying way. Importantly the experience is pleasurable for this woman, who describes her pregnancy as: “a delicious time” (10: hmb).

The next example of decision making also relates to a home birth woman. This one is interesting because this woman too reads extensively and uses her community of friends, support groups and antenatal classes in particularly strategic ways. In addition to reading a lot of information for this her first pregnancy, she also attended two sets of antenatal classes. One that was run by the community midwives and the other a hospital based one. She described the benefits to her, of both:

“The community midwife classes certainly talked about the stages of labour and what you could expect. She also talked about the birth expectations and the importance of thinking through - what you’re hoping the birth will be like and what you’re expecting, and talking to your partner about that. A lot more about the
emotional side of things ... we didn’t really talk about pain relief, even though some of the women were going to have hospital births. It was much more... I like the fact it was about the emotional side of things. We did go to some of the classes at the hospital, things like ‘about the first six weeks’ and the gear you need. Sometimes we sat there for hours and didn’t learn anything. My husband would say, why go to another class? But I learned, you know, not to talk to the baby and you shouldn’t turn the lights on at night to try and get the baby used to the fact that it’s time to sleep - it’s not time to play. I thought sitting there for three hours to learn that was valuable. I guess I never got tired listening to things, about what people had to say about, taking like little bits of it. Recognising it” (9: hmb).

While this woman used a variety of information sources, including books, her midwife, friends and ante natal classes, it is clear that she saw it as her individual responsibility to inform herself as comprehensively as possible. This would seem to support the argument that pregnant women, particularly middle class English speaking women, make decisions as the typically individual, neo-liberal subjects that are an inevitability of main stream health and other expert discourses. It may also seem, that even if this woman’s sociocentric tendencies are considered to be a contributor to the decision making, that the individual self can be still be set in a hierarchically superior relationship to the sociocentric self. Accordingly, even a woman who goes out as a sociocentric self and absorbs and sources information utilising various others and communities, does still at the end of the day deal with the information in an individually, rational, health literate way. However, her decision making processes as a ‘self’ can also be differently described as depending on the situation
and context. The individual self, works with the self in process and the self engaging with others. Others are used to both confirm and be critically aware of decisions she makes. For example, whilst her partner felt three hours in a class where one learned only one new thing was a waste of time, the woman herself found this useful, the one new thing was valuable even if it did take up three hours.

Others can both restrict and enable her decision making on a number of levels. Others also raise issues and experiences that she then goes back to read about, research and reflect upon, as an individual. She works at different, and sometimes at the same time, as both the individualistic and sociocentric self. Rather than being described as hierarchical, the relationship between individual and sociocentric self can also be defined as more fluid and interactive. For example:

“I guess just from reading things I’d get an idea about what I thought about certain things. It’s just like certain things I wouldn’t negotiate at all. I don’t want to hear. I’m not a rude person; I don’t tend to tell people off. But I just wouldn’t act on it. Like that X [family support] group, although I believe very much in more natural, I guess really holistic care, I don’t think, I’m not so far to the Left [non-conservative] as some. So while I was pregnant I was filtering out some of the stuff - it just seems a bit too...over the top” (9: hmb).

As a woman who could perhaps be easily stereotyped as a typical middle class, English speaking woman, her orientation toward expert information whether main stream or
alternative is qualified, she is careful to avoid (as she sees it) polar extremes on either side
of the philosophical divide. While she does the rational weighing up or “filtering” as she
describes it, she does so as an individual, who interacts with others on a number of levels.
Even her use of the word ‘filtering’ suggests she is working through an enormous amount
of information and that this comes from a variety of different sources. I am not suggesting
that she is the ‘autonomous’ subject (free to act rationally) presumed by main stream health
promoters. There are limits to what she can choose without being the subject of social
censure, or constructed as an irrational person but she is nonetheless able to negotiate a path
that feels comfortable for her. She is not a complete victim of expert discourse, her decision
making is importantly informed by social relations that both restrict and enable her. This
woman was for the most part compliant with main stream health promotion advice,
however, in response to my question about whether her pregnancy was planned or not, she
stated that it was not and described this in the following way:

“I guess I felt quite embarrassed about it [un-planned pregnancy]. People would
say so many times - ‘It’s the 90’s, how did that happen? You’re a smart woman.’
You know quite a few of my friends are trying to get pregnant at the moment or just
got pregnant and they [the pregnancies] were very planned. You sort of think, what
happened [with us]? This huge big decision. You know because neither my husband
nor myself are dummies or don’t know. It just happened. So it wasn’t planned” (9:
hmb).
Aware that her unplanned pregnancy had meant she had not taken her folate before pregnancy she stated:

“I guess that was a concern [folate], because I hadn’t planned to be pregnant, so I hadn’t been taking the folate before. So I was concerned about that so I did have the triple test. I guess being... I’m 36 now, I was 35 when I was pregnant, the chances increase [risk of something wrong] when you get older, so I was keen to have those tests. So that was a worry [not taking the folate]. I guess I felt better after the tests, knowing of course, it’s [the test] is not one hundred percent’ (9: hmb).

These responses illustrate the complexity of decision making and the woman who as ‘self’ is seemingly compliant and rational in relation to folate intake and pre-natal testing, is also the ‘self’ that does not plan in relation to pregnancy. Importantly she is also the ‘self’ that in the face of overwhelming societal and peer pressure chooses home over hospital birth. It is interesting that even though she feels embarrassed by her inability to plan her pregnancy and responds by having the triple test, she acknowledges at the same time that the tests are not “one hundred percent.” She accepts limits in how much she can control the outcomes of her pregnancy. Here the expectation by health professionals that I referred to earlier in the chapter that women do everything in their power to ‘control’ and ‘weigh up’ risk is acknowledged, but also tempered by the realisation that there is no way to ultimately control the outcome.
I have spent some time describing how the women I interviewed responded to main stream health promotion information and a range of other advice both sought and unsolicited in relation to pregnancy and birth. I have tended to concentrate on health promotion information in relation to pregnancy, however, I have also pointed out that during my interviews with women they frequently talked about their experiences and information needs in terms of pregnancy and birth. By focusing a little more closely on the way discussions about birth choice provide clues about the complexity of women’s decision making processes and the richness of the information environment in which they make decisions, ways of thinking about how health promotion can be more inclusive of women’s needs and opinions can be considered. Birth choice and the birthing experience may seem at first glance to have little to do with main stream health promotion. However, when I asked women what kinds of information they would have liked to access they did not restrict their answers to health promotion in pregnancy. Neither did they restrict health information needs to themselves, stating rather that other people required information such as partners, family and friends. This was particularly the case for home birth women who were often asked to justify their birth choice to other people. It was not only women’s immediate family or friends who required information many stated the need for medical professionals working in hospitals needing to be informed.

The following excerpts of interviews may seem removed from the usual territory of main stream health promotion, and I am not suggesting that main stream health promoters take over birth choice and birthing experiences as a new advice giving area. (Although arguably, if women are enabled to experience birth in ways that maximise autonomy, well being and
physical capability, and minimise unnecessary medical intervention and physical and emotional stress, it could and should be seen as a health promoting and empowering activity). I am suggesting, that in terms of thinking about health promotion in the broadest possible way (as empowering and community driven) that consideration of the infrastructure and contexts in which women give birth does demonstrate that pregnant women and those considering having children, desire information that is more than just about simple danger messages or risk assessments. It was also articulated by a number of home and hospital birth women that they should not be the sole targets of health promotion, health, pregnancy or birth information. A range of people were identified by home birth women in particular as needing information. One home birth woman who had a breech presentation and was transferred to hospital felt that hospital professionals required information about the benefits of a water birth for women:

“I really wish they [the hospital] would make water available. If they [hospital staff] knew the benefits of labouring and giving birth in water and make it available. If they had, that would have made it much easier for me to accept going there. Maybe the hospital needs more information about – coming from us about what we need. It can’t cost much money to put in a large size bath” (2: hmb).

Another home birth woman identified a number of other areas where information could be improved:
"Hospitals also need more information about being able to move during labour and also providing bigger beds with fold up flaps on the side. To make you feel more secure, you know when you feel so big on those narrow little beds" (10: hmb).

Aside from comments about hospital professionals requiring educating, home birth women identified partners, family and friends as needing to be informed about different birth options. Many of the women stated they were quite comfortable about their decision to have a home birth, but would have liked some accessible and succinct information to give to sceptical family members and friends. Apart from home birth information, some of the women also felt there should more information for male partners, presented in forms that were more accessible and appropriate to their needs. For example:

“I think short information for dads would be better than trying to show them things in books or getting them to read pamphlets. I think men are more visual. I loaned a video about births and water births from X library but it was about an hour long. It was too long. Maybe something that was about twenty minutes long would do the trick. You know, explaining the different parts of pregnancy, this is the emotional swings, the mood swings, this is labour, this is birth. I also think doctors should have more information in their offices for men. Even a list in their office of where to go for more information” (10: hmb).

It was not only home birth women who identified deficits in information provided by mainstream health professionals. A hospital birth woman related her experience:
“There was a lot of information about birth in magazines [that] I thought was pretty good. I thought the antenatal classes run by the hospitals were a joke. The midwife skirted around some of my questions. I asked her about vacuum extraction: the side effects I know can be major. She dismissed it [vacuum extraction] as a risk. She also didn’t explain how when you’re induced the labour can build up really quickly and you can go from no contraction to two minute contractions and it can be painful” (4: hosp).

This hospital birth woman’s questioning of the information provided was informed by her own experience of induced labour and a vacuum extraction during the birth. For women who had previously given birth whether in hospital or home, there was some frustration that the information flow was directed downward and was seemingly impervious to the suggestion, knowledge and expertise of the births women themselves had experienced. Furthermore, women did not always expect doctors and midwives to present themselves as the consummate experts. A woman who had a caesarean birth but had attempted to have a home birth described this in the following way:

“I would like all the information I want to be freely accessible. In plain, black and white, in plain English. No huge medical terms, no rotten statistics and for it to be unbiased. If the doctor doesn’t know, or someone doesn’t know, whether it is the doctor or midwife – whatever the profession, if they don’t have the answer, just say so. If they don’t have the answer don’t be afraid to say, ‘I don’t know.’ I’m not
going to think them any less professional, in fact I’ll think them more professional if they say they don’t know the answer to a question but may have a colleague or someone else who knows. Or there may be a group who have experienced similar issues. Regardless of who it is, whether it be a medical person or a midwife. I like asking for information but I don’t always expect them to have a definitive answer. [There] definitely needs to be more honest information generally and for me, particularly about vaginal birth after caesarean” (2: hmb).

For other women, main stream health information whether in the form of printed materials, or advice from doctors and midwives, was less important than the ability to be around a broader community of women at different life stages, from which one could learn:

“Ideally if I had to do it [have a child] again, I think the best way to learn is by being around women, rather than doctors or nurses or whatever. Seeing the way they’re [other parents are] raising their children. And I think you’d probably gravitate toward a certain kind of parenting or birth. Probably you would learn a lot about their birth, their birthing process and their pregnancy. By being around people it’s better, people with similar ideas, learning from those people. There is a place for the printed stuff but it has to be factual not presented in a way that is biased. Less of the scare mongering, more emphasis on the emotional. I don’t think you can ignore the emotional – I suppose to look at it in a more holistic way [pregnancy, birth, parenting] it is not just a physical experience” (4: hmb).
This woman’s reflection about what she wants in terms of information indicates that there is a place for textual information, but that it needs to be within a supportive context. Within a community where she can check and interact with a tradition of anecdotal and experiential knowledge. She also questions the emphasis on the physical body. For her the literature plays a minor role, and being empowered means much more than wading through reams of information and making decisions as a health literate individual. She also does not define so neatly her ‘self’ or decision making in terms of separately being pregnant, giving birth or as a parent. Rather the process is less linear, ongoing, fluid and interactive. The limitations of textual information are similarly confirmed in an evaluative study of ante-natal screening programmes, where it is noted that: “the pamphlets supplied to women in the ante-natal period did not specify that women had a choice about ante-natal tests screening tests. Women are not given the right to refuse” (Searle, 1997, p. 268). The biased nature of the pamphlets is also noted; where perhaps what is most interesting is the information that is left out: “another feature of the high rate of screening shown by this study was the lack of accurate information about the reliability of routine ante-natal screening tests” (Searle, 1997, p. 273). Further that:

“Not all information during the ante-natal period was perceived as useful. Participants did, however, identify simple, instructive pamphlets given prior to ante-natal screening and support and time to ask questions as effective ways of providing information and choice about routine ante-natal screening” (Searle, 1997, p. 273).
In this chapter it is clear that women have been critical about main stream health information both in textual and other forms. Women have also identified the importance of doctors and midwives as gatekeepers of information. Most importantly, they have identified gaps in information that demonstrate one of the major problems of textual information is its static and inflexible nature. They have also clearly identified the importance of information being more than a downward flow from experts. The emphasis on birth choice has demonstrated how women generally do not necessarily separate the experience of pregnancy from that of giving birth, or being a parent. Women in different stages of their child bearing years may emphasise one or more of these, again complicating the contexts within which health promotion information is delivered and responded to.

Recent theoretical shifts in health promotion emphasise the importance of empowerment and the use of social capital theory in an attempt to move away from the individualist nature of health promotion, and this may seem to be a move in the right direction. The thesis will end on a discussion that considers the current state of play of health promotion in terms of its emphasis on social capital and empowerment in informing health promotion directions and will also discuss how pregnant women as health subjects might be re-supposed.
Conclusion

Toward Bare-foot Health Promoters

I have argued throughout this thesis that decision making as defined by mainstream health promotion is predicated on particular notions of rationality, health literacy and assumptions in relation to empowerment. I have criticised the automatic association of health literacy with empowerment, and the assumption that as long as information is provided, and women read and respond to it in particular ways, they are empowered. The second part of the thesis has focused particularly on the women I interviewed and illustrated the diversity of contexts and situations within which women make decisions. I have argued that the decision making processes deployed by the women interviewed are ongoing, fluid, complex, relational and contextual. I have described in the preceding chapter how women
make decisions as individual, and sociocentric selves, as well as the importance of the social context of decision making as being potentially empowering for women. Most importantly, I have argued that whether women use individualist, or more social and relational ways of making decisions, they use these processes strategically and in ways that demonstrate agency.

The thesis has also been concerned with the construction of women as particular kinds of subjects. I have interrogated the ways in which mainstream health promotion presupposes women as rational, health literate subjects, largely making decisions in individual isolation, and I have questioned some of the social constructionist writing that presupposes women as passive, middle class listeners to the “fetus-as-agent” (Mitchell & Georges, 1997, p. 374). I have been wary of the position that middle class English speaking women are inevitably more compliant with expert information, such as health promotion. Whilst Chapter 2 discussed the various ways in which health promoters single out specific minority groups of women, such as teenage mothers and women from non-English speaking backgrounds as problematic, it showed they were also perplexed by second time mothers generally, particularly those who seemed complacent in relation to the recommendations of the listeria campaign. Many of the critics of health promotion similarly are concerned with the inappropriateness and cultural relevance of mainstream health services and health promotion (Julian, 2002; Liampuutong Rice, 1996). However, I have argued that to claim that all well educated, middle class, English speaking women are more compliant is perhaps an overstatement. Although some groups of women may be better educated and potentially more health literate than other groups, this does not necessarily equate with
greater compliance. Increased literacy may act as a double edged sword that can be used to question main stream health promotion and other health discourses. By this I mean, that women are sufficiently literate to acknowledge the inconsistencies in much of the health information presented to them and use this to question health promotion orthodoxy. The middle class women I interviewed clearly unsettle this categorising of them as naturally compliant, and I have illustrated this throughout the thesis by focusing on the diverse ways in which they variously interact with health promotion and other expert information.

In this the concluding chapter, I want to revisit in more detail recent social theories that inform or influence health promotion practice. Health promoters, much like the women I interviewed, are not a homogenous group and despite the criticisms highlighted in the thesis in terms of the ways in which campaigns are theorised and delivered, some health promoters do critically reflect upon and write about their profession and its processes. This statement does need to be qualified, as whilst there are those that reflect critically on their profession, they are doing so from a place that is not central to the major policy thrusts of health promotion. Further, the critics within health promotion do so from a context (health policy and practice) where allied health professionals are not only the minority (less than 15 per cent of all health professionals) they are also less powerful (Williams, 2002, p. 361). As Williams (2002, p. 344) highlights, there is a dilemma faced by allied health professionals that in order to establish: “domains of practice” they may choose to align themselves with main stream medicine and its processes thereby: “largely neglecting to develop a culture that encourages criticism of their own development.”
Despite this observation, Williams (2002, p. 361) asserts that health promoters are in a better position to resist being subsumed by medical domination than some of the other allied health professionals, and certainly the existence of critique within some of the main stream health promotion literature including main stream health promotion journals, would seem to indicate that there is room for some optimism in this regard (Gleeson, 1999; Moodie & Borthwick, 2001; Seedhouse, 2001). This should not, however, lead to an underestimation of the significant tensions in relation to the processes that are adopted by health promoters in terms of establishing their own “domains of practice” and how, in turn, this affects their ability to empower health promotion subjects.

It is not only medical dominance, as discussed by Williams (2002) which may be a problem in this regard. The influence of economic theory within health promotion theory and practice has not abated over the years, and market values are prominent in the use of social marketing techniques that have been taken up by health promoters in recent years (Egger, Spark, Lawson, Donovan, 2002; Nutbeam & Harris 1999). These developments are discussed in more depth later as are the conditions of possibility for main stream health promotion to practice in ways that acknowledge, as other than a problem the complexity of situations and contexts within which women make decisions.

I have argued that current strategies lock women into little more than risk assessing roles and best guess scenarios. This is not to say that health promoters do not ponder the question of how to respond to health subjects in less proscriptive ways. Recent writing in the area clearly demonstrates that these issues are of concern to a number of health promoters. For example, the usefulness of social capital is debated, what it means to be an empowered
health subject is examined, as is the need for health promoters to be more accepting of uncertainty and ambiguity (Erben, Franzkowiak, Wenzel, 1999; Moodie & Borthwick, 2001; Van der Plaat, 1999). As I mentioned earlier, this does not mean that all health promoters are equally as reflective: Two of the key texts for Australian health promotion students do not address these issues in critical depth at all (see Egger et al. 2002; Nutbeam & Harris, 1999). The language used by health promoters may also construct health subjects in less than flattering terms, for example, describing those who do not take up health messages as “laggards” (Nutbeam & Harris, 1999, p. 45).

A range of health promotion writing has in recent years (particularly since 1999) reflected on the usefulness of social capital as an informing basis for health promotion practice (Erben, et al. 1999; Gleeson, 1999; Labonte, 1999; Leeder & Dominelo, 1999; O’Connor-Fleming & Parker, 2001). Social capital has become the new darling of social and political theory and has been taken up by those working in a range of government; community and health settings (see Cox, 1995; Government of Western Australia, 2001; Hampshire & Healy, 2000; Leeder & Dominelo 1999; Putnam, 1995; Winter, 2000). Public health and health promotion professionals have also begun to grapple with what social capital means for health promotion and the critique has spanned diverse positions (see Erben, et al. 1999; Gleeson, 1999; O’Connor-Fleming & Parker 2001, Labonte, 1999; Leeder & Dominelo 1999). Many note that it is still individualist in orientation and does not really grapple with the larger political and economic structural constraints which contribute to, or detract from, health and well-being. This criticism has been a long standing one and current health promotion initiatives would seem to indicate that there has been little real change in this
regard. However, the critique in relation to social capital that is most relevant to this thesis, concerns the observation by health promoters that the theories of social capital that are taken up by governments and policy makers, including those in the business of public health and health promotion, are inherently conservative, individualist and fail to recognise inequality in power relationships between and within different groups (Daly, 2000; O’Connor-Fleming & Parker, 2001, p. 194). There is also recognition that health promotion is practiced in political environments and institutions that are neo-liberal, individualist and economically rationalist (Gleeson, 1999; Labonte, 2001, p. 2).

Labonte (1999) questions whether social capital is anything new at all, seeing it rather as the latest repetition of a theme where previously community development, empowerment and capacity building were the key descriptors; rather it is a: “re-packaging of some very old ideas” (p. 430). Labonte (1999) asserts that public health strategies are delivered within a social context that has two competing visions, one that is about “market individualism” and the other that is about “communitarian justice” (p. 433). The question about how empowering health promotion can be, caught betwixt these two positions, is a complex question. This thesis cannot provide the solution to this problem, however, by focusing on the processes women already use, and the consideration of some other writing outside the area of health promotion, some possibilities may be raised about what empowerment means in terms of enabling and providing conditions of possibility for women as health subjects.

In relation to empowerment, concerns are raised about the implications of the more conservative elements of social capital theory (Daly, 2000, p. 8; Erben, et al. 1999). I have
discussed earlier the problematic nature of describing what empowerment is, and whether or not it is a useful term to use to signify the ways in which women may have agency with respect to health promotion campaigns. Acknowledging earlier that indeed the use of the term empowerment is problematical, I have chosen to retain it, but do so with an understanding of empowerment that is informed by Van der Plaat’s (1999) use and description of empowerment as relational. This understanding would construct individuals (the women in my study) as neither complete victims (in need of empowering) nor as health promoters (all powerful). Health promoters may also experience inequalities as discussed earlier, in terms of power relationships with other health professionals, for example (Williams, 2002). Whilst Van der Plaat’s (1999) work is concerned with social intervention and community development, she refers to health workers and her ideas are useful in relation to health promotion.

The women I interviewed often demonstrated a strategic agency in how they responded to health promotion campaigns, and clearly some health promoters recognise their inability and lack of success in being empowering agents. Neither should the role of being completely successful at individually empowering subjects be a state that health promoters should embrace. Rather Van der Plaat (1999, p. 775) argues that the process of empowerment is mutual. Too much emphasis on the ability of the expert to ‘give power’ and on the health promotion subject as the passive receiver of power and the categories remain intact. Whilst Van der Plaat (1999, p. 785) advocates that activists (whether health promoters or community development workers) should recognise themselves as: “part of the discursive community that gives meaning to social relations” and should harness
themselves to the realities of others everyday lives. Her position does still assume a mutuality that is symmetrical. Her use of the term relational does denote some equality between players, an assumption that health promotion and other experts can understand through self reflection and critical examination of their own processes, how to better empower the people they work with. These processes of relating may be more critically informed by the insights of Young (1997) and her ideas about asymmetrical reciprocity as well as others who write about the importance of empathy (Everingham, 1996) and deep listening (www.pinakarri.org.au, accessed October 2001) in terms of subverting impoverished notions of both rationality and empowerment. There are other complicating factors that mitigate health promoters being able to simply critically reflect on their processes, and I will return to a discussion of these later.

Young (1997, p. 341) argues that a “communicative ethics” recognises both difference and particularity, asserting that it is neither possible, nor morally desirable, to try and adopt another’s standpoint. The perplexity and concern evident in evaluations and writing about mainstream health promotion campaigns illustrates the futility of trying to attain some kind of mutual symmetrical understanding of the ‘other’ (in this context, the health promotion subject as pregnant woman). Van der Plaat (1999) is hopeful that through critical self examination, experts (including health promoters) can become aware of their own processes. Her assertion that users of expert information or services are not necessarily completely powerless, is a useful one as it does create the possibility of agency, however, it does not really deal with the problem of power relations that are unequal. By this I mean that the health promoter is always positioned as an authority in comparison to a pregnant
woman. Young’s (1997, p. 341) writing in relation to attaining a “communicative ethics” for those in positions of relative power, is more cautious and I think for this reason more useful, in terms of thinking about health promotion as a communication that requires more humility.

With regard to health promotion, Young’s (1997, p. 350) discussion about the usefulness of “moral humility” echoes the sentiments of many of the women interviewed for this study. That is, to admit to things that are not understood on a number of levels is not necessarily a bad thing for experts to do. However, rather than trying to understand and respond to this through “generalised principles that apply to all equally” it is better to follow through by listening with “specific expression” (Young, 1997, p. 347). It starts with the recognition that experts cannot put themselves in pregnant women’s shoes and that in some cases a “respectful distance” is more empowering for the “other” than attempting to “understand” their viewpoint from a purely symmetrical position (Young, 1997, p. 347). The result of symmetrical processes in relation to mainstream health promotion tends to be the assumption that all that is needed is the ‘right’ health promotion information or an intensified or better targeted campaign with the same information. Young (1997, p. 347) points out that even between individuals of the same gender, cultural or other groups, there are still differences, and this observation could equally be applied to the middle class, English speaking women interviewed for this study.

I have in this thesis related the experiences of home birth and hospital birth women, who are middle class, English speaking, educated and articulate. Whilst there were shared
experiences, there were also many differences both between and within each of the groups. Young’s (1997, p. 345) point about our inability to ever really “know” a person for whatever reasons (for example, shared history, life experiences, different physical and mental ability and so on) is a valid one in relation to pregnant women and health promotion. Efforts to try and understand where women are ‘coming from’ need to be informed by processes that practice humility and “enlarged thought” ones that celebrate and do not try to close off the differentiation between subjects. This does not mean there is nothing to work with, as Young (1997, p. 345) points out there are points of symmetry (common understanding) as well as asymmetry (different understanding). If health promoters ‘listen’ to women they may identify areas of common concern, however, their success in ‘listening’ will depend upon a “respectful distance” and a “moral humility” as advocated by Young (1997, p. 350). I think the process she is referring to here would relate to the women in this study in the following ways. Rather than mainstream health promoters attempting to rationalise women’s responses, they should accept the responses at face value as valid. The term ‘listening’ is an important one and more useful in relation to expert information and the subjects of this information than ‘understanding.’ It may not be possible to ever fully comprehend or ‘understand’ another’s viewpoint but to ‘listen’ with respect will mean that health promoter’s can respond to women in ways that do not necessarily always categorise women who are non or partially compliant with health promotion campaigns as irrational or ill informed.

There is usefulness in relation to Van der Plaat’s (1999) assertions that experts can reflect critically on their own processes. However, it is less useful in terms of how health
promoters can shift their responses from a symmetrical position that fails to address the issues of power inequalities. The symmetrical position within mainstream health promotion has become quite firmly established through its use of the mass media and social marketing techniques. Both these techniques have become increasingly popular as tools for the health promoter to use.

The strategies associated with mass health promotion construct audiences in particular ways and fail to acknowledge in a critical way how these perpetuate the construction of health promotion subjects as cognitive, potentially rational subjects who just need a nudge in the right direction by health promoters. For example the use of the term “pre-contemplative” which assumes that certain “segments” of the population have not even considered the change that health promoters are attempting to implement (see Egger, et al. 2002, pp. 96-97). Another example relates to the use of pamphlets, described as: “information transmission. Best where cognition rather than emotion is the desired outcome” (Egger, et al. 2002, p. 106). As the evaluative study by Searle (1997, p. 273) and this study found, pamphlets alone are not enough, women need: “support and time to ask questions.” Main stream health promoters seem to perceive the “public” as health promotion subjects who are passive; there is an assumption that the media “moulds” their opinions and that in order to implement health public policy the media should be used to this end (Nutbeam & Harris, 1999, pp. 69-72). Good (1994, p. 26) similarly raises this tendency by health experts and points out that: “members of society are not empty vessels waiting to be filled with whatever health knowledge is being advocated.”
The use of social marketing techniques is similarly adopted by Nutbeam & Harris (1999, pp. 69-72) in a way that does not render problematical, the construction of health promotion subjects as neo-liberal, free market consumers who will make rational choices. The assumption that experts ‘know best’ is similarly reflected in Egger, et al. (2002, p. 91) who justify their use of social marketing as both useful and different to commercial marketing techniques: “a basic distinction between social and commercial marketing is that social marketing usually is not based on needs experienced by consumers, but on needs identified by health experts.” This is then qualified with the assertion that: “however, messages must be delivered in accordance with consumers needs” (Egger, et al. 2002, p. 91). It is somewhat ironic, that the power relations inherent in the use of these strategies are not acknowledged as possibly being somewhat antithetical to the aims of empowering health promotion subjects. That is they do not unsettle the assumption that the expert knows what is best for the consumer and that the consumer only needs to be told what is best, and by accepting and complying with the message, can then demonstrate their rationality and responsibility by consuming health in the correct manner.

There is another problem with the use of social marketing techniques that relates to the way health promotion is practiced. Apart from the assumption that the expert (in this case the professional health promoter) knows best, there is a presumption that a fair and equal exchange is occurring. That is, that the health promoters are offering consumers (health promotion subjects) something of value. This concept of a reciprocal exchange is evident in the assertion by Egger, et al. (2002, p. 91) that: “social markets must offer something of value” and recognise the “outlays” of consumers. The assumption that the health message is
valuable is taken for granted, and whilst the ‘outlay’ of the consumer is recognised as being either something the consumer pays for in terms of a gym membership, or a change in lifestyle, it is constructed as a fair and equal bargain. It does not leave any space for the ‘consumer’ being dissatisfied or disgruntled. A rational consumer (health subject) will of course buy the product (health message) and use it as instructed. It is a straightforward and fair exchange, the kind of symmetrical communication that Young (1997) critiques as being less than empowering for the subjects of expert information. The “enlarged” thought that Young (1997, p. 350) advocates as necessary for an ethical communication is similarly missing in these descriptions of popular, mass health promotion strategies.

Despite the bleak picture painted above in relation to the use of media, social marketing and the ways in which main stream health promotion constructs health promotion audiences, there are some developments in main stream health promotion literature that indicate that not all health promoters are beyond the “enlarged thought” that Young (1997, p. 350) refers to. As I have mentioned before some health promotion theorising is grappling with the limits of health promotion practice. Moodie & Borthwick (2001) discuss the thorny issue of health equality and its relationship with the socioeconomic status of individuals, claiming that the: “minimalist view of health promotion sees causal chains as manageably short” they instead argue:

“the links between wider determinants of health and health effects at the individual level are inherently more complex. The same activity can have several different
effects, and a single outcome can be the result of several different sequences of influences” (p.1).

The authors argue that health promoters: “must be prepared to accept a more fluid conceptual structure, to cope with uncertainty and ambiguity, and to move hesitantly without certain knowledge” (Moodie & Borthwick, 2001, p. 2). Whilst they are talking about health promotion generally, the processes upon which they are reflecting could begin to provide the conditions for a health promotion that is more responsive to the needs of pregnant women. They are wrestling with some of the issues that both Young (1997) and Van der Plaat (1999) have identified as crucial in the process of enabling more equitable exchanges. The refrain that they: “must proceed without the armour of moral certainty. We must be less dogmatic, more open to doubt, and more tentative; and we may find this makes us better health promoters in other areas, too” (Moodie & Borthwick 2001, p. 2) departs from the usual critique about structural inequality versus individualism or the inherent conservatism of social capital theory. It does reflect on the actual processes and ways of thinking that individual health promoters may utilise.

This is not to say that the more general critique of health promotion theory in relation to structural determinants versus individual lifestyles, or the limitations of social capital have no place. In relation to this study and the women I interviewed, however, processes of health promotion that reflect upon and positively embrace uncertainty, ambiguity and are less morally judgemental, would seem to be more useful in terms of a meaningful empowerment for women. Everingham (1996) also advocates for more relational
approaches by experts, in particular empathy as a tool that is more attentive to the needs of women. The practice of these processes may construct women’s responses in more productive ways. In ways that do, for example, consider as other than deficits responses that are more than a straightforward engagement with information and whether women comply with health messages or do not. This may also result in a different view of empowerment, one that is not simply linked to the ability for women to read information and assess different sets of risks.

I have already discussed the part that social marketing plays in constructing health subjects as rational consumers of health promotion messages. The use of social marketing techniques by health promoters is also justified in terms of being able to respond to differences within populations. This is described by Egger, et al. (2002) as “segmentation” and the different “segments” within populations:

“often are described as risk factors (for example, smokers, the obese, the inactive, heavy drinkers, diabetics) or demographic groupings who epidemiologically appear at higher risk (for example, blue-collar groups, sedentary occupations, Aborigines, street kids)” (p. 96).

I have discussed earlier how the ways in which health promotion is currently practiced may leave pregnant women with little more than a risk assessing role. Discussing the promotion of health in relation to families, Swadener and Lubceck (1995) discuss how the use of “risk” categories is:
“highly problematic and implicitly racist, classist, sexist and a 1990s version of the cultural deficit model which locates problems or ‘pathologies’ in individuals, families and communities rather than in institutions and structures that create and maintain inequality” (p. 3).

There is another aspect to the use of ‘risk’ that results in health promotion processes that are less useful for women. The use of risk assessing as a process is inherently negative and, as Hanvey (1996, p. 10) points out, focuses on: “weaknesses instead of strengths, limitations instead of abilities” resulting in people being perceived “at risk” as opposed to “promise” it is assumed there is something missing. This is an important point in relation to the women I interviewed and in terms of empowerment relates especially to their feelings of anxiety and worry. Whilst many of the women I interviewed felt generally positive about their pregnancy there was a backdrop of ‘worry’ that was articulated by many. It is hard to fathom how health promoters can enable empowerment with health subjects who are anxiously assessing risks many of which they can not possibly have any control over. As this woman relates:

“I mean they’re [health promotion campaigns/pamphlets] not telling you very much but they might be telling you something that will worry you for the rest of your pregnancy and that may not eventuate [failure to take folate]. I think they tell you things that could happen. I am a bit of a worrier, and I don’t necessarily want to
I referred earlier in the thesis to Sagasti’s (2000) critique of ‘heroic medicine’ with its utopian ideal of elimination of risk, as being unrealistically at odds with pregnant women’s more pragmatic stance of accepting and mediating risk. In relation to empowerment it would seem that a health promotion that considers the possibility of subjects that are promising rather than at risk may be a worthwhile position to consider. An empowerment that is linked to impoverished notions of rationality or simplistic risk assessment is a pale shadow of what might be achieved with an empowerment that re-configures promising health subjects and health promoters situated in diverse, complex contexts. Although in arguing for more relational or empathetic approaches there is always the danger as Everingham (1996, p. 163) points out that these are values associated with women and are therefore positioned as non-rational, if not irrational and therefore: “something to transcend.” Whilst acknowledging this point it is also the case that there are health promoters who are at least are beginning to question what Rapp (1998, p. 68) refers to as the: “scientific message of obligatory universality.”

I have argued throughout the thesis that women's interactions with and responses to health promotion campaigns are complex and diverse and importantly contextual in relation to life history, current circumstances and whether they are pregnant for the first or subsequent time. I have also argued that health promotion theory from the time of interviewing in the late 1990s, to the present, reiterates the same concerns with enabling empowerment and
producing health promotion strategies that more meaningfully engage with health subjects. 
I have teased out some of the impediments to this such as health promoters’ insistence on 
particular ways of making decisions, their reliance on health literacy and of their propensity 
to categorise women who either do not comply, or only comply partially with their 
directives, as irrational or in need of improved information.

To imagine the conditions of possibility for a health promotion that is more meaningful and 
useful to pregnant women it is not only important to examine the processes I have outlined 
above, and the recurrence of themes in ‘new’ health promotion and social theories, but also 
the ways in which health subjects are conceptualised within Western contexts that privilege 
a particular kind of rationality. What is counted as proper knowledge also needs to be 
subjected to “enlarged thought” as espoused by Young (1997, p. 350). This might enable 
health promoters to acknowledge the embodied knowledge of the women interviewed in 
this study, and more generally, in a more positive fashion. Similarly, the social 
constructionist theory that maintains pregnant women who listen to their babies or their 
bodies are passive constructs of discourse that result in governance by the ‘fetus-as-agent’ 
is also unduly negative. Modernist notions of the body can serve as important justifications 
for women’s responses to health promotion and more importantly, engender feelings of 
confidence and well-being, which would seem to positively contribute toward an 
empowerment that does not solely rely on health literacy, or knowledge, that is the 
consequence of an impoverished rationality.
My argument is not that women’s decision making processes or use of reasoning be recognised as always and inevitably superior to the methods used by mainstream health promoters, or that they do not ever make decisions as the rational subjects pre-supposed by mainstream health promoters. Merely that a less impoverished model of rationality, and an enriched sense of decision making processes, may have benefits for both mainstream health promoters and women. Decision making which incorporates other than a health literacy based on an impoverished model of rationality could be seen in a more positive light. Rather than as something to be fought against with protestations of an objective knowledge based on a superior rationality, perhaps it may allow some space where health promoters can engage with pregnant women as a diverse community, moving away from an emphasis on individual lifestyles circumscribed by narrow and unrealistic expectations. For example, in terms of health promotion the following example explains why in this pregnancy (but perhaps not in any future pregnancies) exercise is not possible:

“I don’t exercise as much as I’d like to. I’ve stopped walking the dog. It’s due to a lack of time, my father is ill [in hospital], I go to visit five to six days a week. It’s a two and half hour round trip. That also happening [father being ill] has changed my life, my father is very ill. I go over there [to the hospital] so much. I think I watch more television now than I ever used to” (4: hosp).

I am not advocating that health promotion embrace anarchy or a decline into some kind of relativist quagmire where anything a woman chooses to do while she is pregnant should be recognised as acceptable or rational. As Sagasti (2000, p. 599) asserts we can acknowledge
and incorporate diversity in our decision making and world view, while at the same time: “maintaining a firm and responsible ethical stand.” This does, however, require a shift away from always seeing difference - non or partial compliance with main stream health promotion advice - in other than problematical, irrational or judgemental terms. It should also be acknowledged that the vast majority of pregnant women are extremely conscientious about ensuring they have a healthy pregnancy and baby and are highly successful at this, despite at times their non or only partial compliance with main stream health promotion campaigns.

If health promotion was based on a rationality that is not utopian in this manner, or raised to what Ralston Saul (1997, p. 105) describes as a “state of divinity” this might enable a space for health promotion strategies that assist rather than impede pregnant women’s decision making as an empowering process. Health promotion that does not buy into the ‘heroic medicine’ quest or is not evangelical might enable different conditions of possibility. These could be real points of engagement that informed a reflexive and critical analysis for main stream health promoters to use in a productively relational way with pregnant women as advocated by Van Der Plaat (1999), whilst practicing the “enlargement of thought” and “asymmetrical reciprocity” outlined by (Young, 1997, p. 350).

How this might be implemented is always problematical and a major assumption that is being made in even considering a different set of possibilities, or conditions for the practice of health promotion, is that health promotion is a relevant and appropriate activity. Nearly all of the women I interviewed wanted health information, including health promotion
information, to be available and most did not have a problem with the extent of information available. Neither did they advocate at any stage for health promotion to be discarded. What does seem to be clearly articulated by the women I interviewed is that health promotion needs to move beyond straightforward messages about the risks associated with non compliance of campaigns such as those relating to listeria and folate. The suggestions of the twenty women I interviewed in terms of information they required, incorporated so much more than simple risk assessment (as discussed in the previous chapter). Women had concerns about the structural layout of hospitals, availability and attention of doctors and midwives, environmental and economic issues, psychological and emotional health. The critique of health promotion has also contributed to limiting the field in terms of imagining a health promotion enlarged by pregnant women’s contribution.

By this I mean the ongoing critique that asserts health promotion continues to be individualist rather than structural or communal in practice. Even the critique about the usefulness of social capital theory inevitably advocates a return to the Ottawa Charter and less individualist bases (Erben et al. 1999; Gleeson, 1999). Whilst of course these are valid critiques and I have criticised the emphasis on individual health behaviour myself, there is some space in the middle where individual and structural connect or interweave. Emphasising either individualistic strategies as the problem, or structural concerns as the solution, will not necessarily solve the dilemma of enabling health promotion to be more empowering, or less dismissive of pregnant women. Neither does the social construction of women as passive listeners of the ‘fetus-as-agent’ or merely mediations of discourse; particularly promise much in the way of acknowledging the agency of many women.
Perhaps one place to start is for health promoters to critically reflect on their status as professionals. I am not suggesting that they devalue their role, but recognise that health promotion work done outside the professional boundaries of health promotion may provide useful points in relation to enabling respectful, listening and responsive relationships with women as health promotion subjects. Health promotion work is done by an array of other people as health promoters themselves recognise, for example, doctors, nurses, midwives, teachers, community health and development workers, family members, friends, acquaintances of pregnant women and previously pregnant women themselves. I referred to an example in the previous chapter where a doctor advises the pregnant woman under his care to be moderate in her alcohol and tobacco intake, rather than advising that she stops altogether.

The community midwives referred to in this thesis similarly undertook much health promoting work; discussing at length issues of concern to the women they cared for. Perhaps health promotion should be less about pamphlets, and more interested about how to enable an ethical and empowering communication on the ground between women and the diversity of health workers they come into contact with. A critical examination of the settings within which health promotion is practiced might also be worthy of some attention by professional health promoters who work in bureaucratic policy settings. For example, both Baum (1999) and Broom (1998) assert that when people or women access doctors and other health professionals in community and women’s health centres they are much more likely to be given a longer time at appointments, and also more likely to be referred to other
health professionals (including health promoters) within close proximity. I have discussed in Chapter 7 how women responded positively to having the time with either their doctor, or community midwife to discuss in-depth, issues that were of concern to them. These kinds of relational processes ensure that women are cared for, and constructed in ways that reflect a holistic and promising configuration of them as health subjects, rather than as ‘segmented’ or ‘risk’ subjects, part of a potentially dangerous population. They are being related to in ways that enable discussion and debate. A health promotion that recognises and works with women’s ways of making decisions in relational and social ways might be better placed to be more, rather than less empowering (cf. Searle, 1997).

This thesis has illustrated that the ways in which women respond to, work with and against health promotion, and other health information, are various and combine both elements of acceptance and resistance. They incorporate in their strategies both individual and social and relational elements. Rather than working toward a health promotion utopia where all comply with the ‘right’ information health promoters might enable more empowering processes if they can accept unfinished business and decision making that does not attain the final solution (compliance) as valid, and perhaps even promising, responses. To empower health subjects health promoters perhaps can debate not only the different theories and orientations that inform their practice, but also the ways in which they construct women who do, or do not, comply with their advice. It would seem productive in this sense to also let go of the illusory certainty of an impoverished rationality, which promises compliance informed by health literacy and accept uncertainty and the vagaries of life with the same careful wisdom as the women I interviewed.
It would seem timely to accept as well, as Van Der Plaat (1999) outlines that it is not up to health promoters to assume the mantle of heroes whose ultimate quest is to empower women. The assumption that health promoters hold the key to empowering women seems implicitly arrogant. Constructing a health promotion that is more responsive to women’s needs also requires more than finding the right version of social capital theory or going back to their roots (Ottawa Charter) so that utopia will then present itself. Rather the words of caution by Moodie & Borthwick (2001, p.1) seem pertinent here: “to move hesitantly and without certain knowledge.” To work toward a health promotion that is more respectfully listening of women’s diverse responses (with workers on the ground) might be a more useful strategy than assuming what women need through the magic of mass health promotion strategies such as social marketing and improved pamphlet production (although of course these still have a use and a place).

The cultural imperialism and Western dominance that Sagasti (2000) refers to in terms of what are considered rational processes can also be re-thought through the processes of decision making and consultation that occur in other cultural settings. An example of this occurs within a culturally appropriate co-operative housing initiative for Aboriginal people in Perth. Here Aboriginal consultation with the experts emphasised the importance of: “Pinakarri, a Nyangamarta word, which means deep listening” (www.pinakarri.org.au, accessed October 2001). Respectful communication by experts was in this setting demonstrated through such deep and attentive listening, in other words something learned from the community by the experts. Respectful communication by experts was similarly
raised by the women interviewed for this study. For example, a hospital birth woman whose doctor kept her waiting so long that she:

“Had half forgotten what I wanted? When I start to ask things, they [the doctors] sort of push you off [are dismissive] and tell you they are a bit pushed [busy]. I have found that the whole time’ (3: hosp).

In contrast with discussions with family birthing centre midwives:

“They’re lovely there; they [the midwives] are so nice. As well, they have this section on the wall with all these pamphlets and she [the midwife] just told me to have a good look, take what I think I need and if I have any questions just to come and see her. You know... the way she spoke to me made me feel so much better. You know... she was very comforting, she really listened to me, she knew what I was saying” (3: hosp).

This shift to the importance of the relational and empathetic in my conclusion does not mean that I advocate these processes as overarching solutions. Rather my intention is a suggestion that there may be usefulness for main stream health promotion in achieving a more interesting mix in terms of processes and philosophies, an “enlargement” of thought as advocated by Young (1997, p 350). After all, this is what the women I interviewed seemed to find most useful such as this home birth woman:
“I found a support group. So that meant every second Friday and they had a lot of information, they had a library as well down in X where you could get books and magazines and videos. And you know we used to talk amongst each other [the participants of the support group]; through word of mouth. But I also did a lot of reading. So lots of books, did a lot of reading, and then the president of the support group, she has become a close friend and we talked about things all the time. And my doctor he explained different things - and my midwife - she was absolutely fantastic, just wonderful, and not intrusive. I talked things over with her, asked her loads of questions” (8: hmb).

It would seem that to ignore the relational and social nature of much of women’s decision making is to miss opportunities for women to feel confident and peaceful about their pregnancy and birth. It also suggests that if mainstream health promoters do not include the rich and varied information contexts within which women make decisions their evaluations of their own campaigns will be impoverished. I am suggesting that perhaps it is considerations such as those mentioned in the closing paragraphs that might hold some starting point in relation to mainstream health promoters pre-supposing women as decision makers, and women and their babies as health subjects, who are positively promising, rather than in need of relentless improvement.
Appendix 1: Streetwise Comic Strip
Appendix 2

OTTAWA CHARTER FOR HEALTH PROMOTION [copied from WHO web page].

First International Conference on Health Promotion, Ottawa, 21 November 1986
WHO/HPR/HEP/95.1
The first International Conference on Health Promotion, meeting in Ottawa this 21st day of November 1986, hereby presents this CHARTER for action to achieve Health for All by the year 2000 and beyond.

This conference was primarily a response to growing expectations for a new public health movement around the world. Discussions focused on the needs in industrialized countries, but took into account similar concerns in all other regions. It built on the progress made through the Declaration on Primary Health Care at Alma-Ata, the World Health Organization's Targets for Health for All document, and the recent debate at the World Health Assembly on intersectoral action for health.

Health Promotion
Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living. Health is a positive concept emphasizing social and personal resources, as well as physical capacities. Therefore, health promotion is not just the responsibility of the health sector, but goes beyond healthy life-styles to well-being.

Prerequisites for Health
The fundamental conditions and resources for health are:

- peace,
- shelter,
- education,
- food,
- income,
- a stable eco-system,
- sustainable resources,
- social justice, and equity.
- Improvement in health requires a secure foundation in these basic prerequisites.

**Advocate**

Good health is a major resource for social, economic and personal development and an important dimension of quality of life. Political, economic, social, cultural, environmental, behavioural and biological factors can all favour health or be harmful to it. Health promotion action aims at making these conditions favourable through advocacy for health.

**Enable**

Health promotion focuses on achieving equity in health. Health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential. This includes a secure foundation in a supportive environment, access to information, life skills and opportunities for making healthy choices. People cannot achieve their fullest health potential unless they are able to take control of those things which determine their health. This must apply equally to women and men.

**Mediate**

The prerequisites and prospects for health cannot be ensured by the health sector alone. More importantly, health promotion demands coordinated action by all concerned: by governments, by health and other social and economic sectors, by nongovernmental and voluntary organization, by local authorities, by industry and by the media. People in all walks of life are involved as individuals, families and communities. Professional and social groups and health personnel have a major responsibility to mediate between differing interests in society for the pursuit of health.

Health promotion strategies and programmes should be adapted to the local needs and possibilities of individual countries and regions to take into account differing social, cultural and economic systems.

**Health Promotion Action Means:**

**Build Healthy Public Policy**

Health promotion goes beyond health care. It puts health on the agenda of policy makers in all sectors and at all levels, directing them to be aware of the health consequences of their decisions and to accept their responsibilities for health.
Health promotion policy combines diverse but complementary approaches including legislation, fiscal measures, taxation and organizational change. It is coordinated action that leads to health, income and social policies that foster greater equity. Joint action contributes to ensuring safer and healthier goods and services, healthier public services, and cleaner, more enjoyable environments.

Health promotion policy requires the identification of obstacles to the adoption of healthy public policies in non-health sectors, and ways of removing them. The aim must be to make the healthier choice the easier choice for policy makers as well.

**Create Supportive Environments**
Our societies are complex and interrelated. Health cannot be separated from other goals. The inextricable links between people and their environment constitutes the basis for a socio-ecological approach to health. The overall guiding principle for the world, nations, regions and communities alike, is the need to encourage reciprocal maintenance - to take care of each other, our communities and our natural environment. The conservation of natural resources throughout the world should be emphasized as a global responsibility.

Changing patterns of life, work and leisure have a significant impact on health. Work and leisure should be a source of health for people. The way society organizes work should help create a healthy society. Health promotion generates living and working conditions that are safe, stimulating, satisfying and enjoyable.

Systematic assessment of the health impact of a rapidly changing environment - particularly in areas of technology, work, energy production and urbanization - is essential and must be followed by action to ensure positive benefit to the health of the public. The protection of the natural and built environments and the conservation of natural resources must be addressed in any health promotion strategy.

**Strengthen Community Actions**
Health promotion works through concrete and effective community action in setting priorities, making decisions, planning strategies and implementing them to achieve better health. At the heart of this process is the empowerment of communities - their ownership and control of their own endeavours and destinies.

Community development draws on existing human and material resources in the community to enhance self-help and social support, and to develop flexible systems for strengthening public participation in and direction of health matters. This requires full and continuous access to information, learning opportunities for health, as well as funding support.

**Develop Personal Skills**
Health promotion supports personal and social development through providing information, education for health, and enhancing life skills. By so doing, it increases the options
available to people to exercise more control over their own health and over their environments, and to make choices conducive to health.

Enabling people to learn, throughout life, to prepare themselves for all of its stages and to cope with chronic illness and injuries is essential. This has to be facilitated in school, home, work and community settings. Action is required through educational, professional, commercial and voluntary bodies, and within the institutions themselves.

**Reorient Health Services**

The responsibility for health promotion in health services is shared among individuals, community groups, health professionals, health service institutions and governments. They must work together towards a health care system which contributes to the pursuit of health.

The role of the health sector must move increasingly in a health promotion direction, beyond its responsibility for providing clinical and curative services. Health services need to embrace an expanded mandate which is sensitive and respects cultural needs. This mandate should support the needs of individuals and communities for a healthier life, and open channels between the health sector and broader social, political, economic and physical environmental components.

Reorienting health services also requires stronger attention to health research as well as changes in professional education and training. This must lead to a change of attitude and organization of health services which refocuses on the total needs of the individual as a whole person.

**Moving into the Future**

Health is created and lived by people within the settings of their everyday life; where they learn, work, play and love. Health is created by caring for oneself and others, by being able to take decisions and have control over one's life circumstances, and by ensuring that the society one lives in creates conditions that allow the attainment of health by all its members.

Caring, holism and ecology are essential issues in developing strategies for health promotion. Therefore, those involved should take as a guiding principle that, in each phase of planning, implementation and evaluation of health promotion activities, women and men should become equal partners.

**Commitment to Health Promotion**

The participants in this Conference pledge:

- to move into the arena of healthy public policy, and to advocate a clear political commitment to health and equity in all sectors;
- to counteract the pressures towards harmful products, resource depletion, unhealthy living conditions and environments, and bad nutrition; and to focus attention on
public health issues such as pollution, occupational hazards, housing and settlements;

• to respond to the health gap within and between societies, and to tackle the inequities in health produced by the rules and practices of these societies;
• to acknowledge people as the main health resource; to support and enable them to keep themselves, their families and friends healthy through financial and other means, and to accept the community as the essential voice in matters of its health, living conditions and well-being;
• to reorient health services and their resources towards the promotion of health; and to share power with other sectors, other disciplines and, most importantly, with people themselves;
• to recognize health and its maintenance as a major social investment and challenge; and to address the overall ecological issue of our ways of living.
• The Conference urges all concerned to join them in their commitment to a strong public health alliance.

Call for International Action
The Conference calls on the World Health Organization and other international organizations to advocate the promotion of health in all appropriate forums and to support countries in setting up strategies and programmes for health promotion.

The Conference is firmly convinced that if people in all walks of life, nongovernmental and voluntary organizations, governments, the World Health Organization and all other bodies concerned join forces in introducing strategies for health promotion, in line with the moral and social values that form the basis of this CHARTER, Health For All by the year 2000 will become a reality.

CHARTER ADOPTED AT AN INTERNATIONAL CONFERENCE ON HEALTH PROMOTION*
The move towards a new public health, November 17-21, 1986 Ottawa, Ontario, Canada

* Co-sponsored by the Canadian Public Health Association, Health and Welfare Canada, and the World Health Organization
Appendix 3.

Interview Questions:

1. Can you tell me about how you felt during pregnancy?
2. Was your pregnancy planned?
3. What are some of the good things to do for yourself while pregnant do you think?
4. What were some of the things you thought were good to do for the baby?
5. Did you know about folate and listeria while you were pregnant?
6. Did you have any pre natal tests and how were you told about them?
7. Could you tell me where you got most of your pregnancy information from? (Prompts: books, people, groups, pamphlets).
8. Did you get any unsolicited advice?
9. How did you sort through the information about the pregnancy?
10. How did you sort through the birth information and did you go to ante natal classes?
11. Were you given any information about what the birth would be like?
12. Was there anything you wished there had been any information on and how would you have liked to access it (pregnancy or birth)?

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**Bibliography**

**Books**


**Journals**


Reports


Western Australian Legislative Council (1999). 48th Report of the standing committee on constitutional affairs in relation to a petition requesting that community based midwifery be included in state health services. Perth, Western Australia: Legislative Council Western Australia.

Conference Papers, Unpublished Theses, Unpublished Manuscripts


**Newspapers and magazines**


Time International (1999). Big stink over smelly cheese. 153, p. 44.


**Brochures and Pamphlets**


Health Department of Western Australia. (1996). For all women an important message before pregnancy: If you want a baby start taking this pill. [Pamphlet]. Perth, Western Australia. Public Health Services.


**Web-sites and Abstracts**


Ottawa Charter for Health Promotion, First International Conference on Health Promotion, Ottawa, Canada, 17-21 November 1986. WHO Regional Office for Europe, updated 20 August 1996 - jfr@who.dk.