

REPRODUCTION & SOCIAL CLASS

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WHAT IS SOCIAL CLASS?

Sociologists use the term social stratification to describe the stable structures of inequality that persist within any given society and the term 'social class' describes the type of stratification that exists within modern Britain. Although sociologists disagree on how social class should be defined, in general terms, social class refers to material circumstances - a person's income and wealth - as well as social status - a person's social wealth and prestige.

Social class is measured using the National Statistics Socio-economic Classification (NS-SEC). In the most commonly used version of this classification, there are eight classes, the first of which is sub-divided [see Table 1]. The NS-SEC takes into account an individual's employment status, as well as their occupation.

Table 1 The National Statistics Socio-economic Classification

1.	Higher managerial & professional occupations
1.1	Large employers & higher managerial occupations
1.2	Higher professional occupations
2.	Lower managerial & professional occupations
3.	Intermediate occupations
4.	Small employers & own account workers
5.	Lower supervisory & technical occupations
6.	Semi routine occupations
7.	Routine occupations
8.	Never worked & long-term unemployed

There are several competing explanations to account for the persistence of class differences in reproduction, and health more generally. Materialist/structuralist explanations and cultural/behavioural explanations are currently two of the most influential.

Materialist/structural explanations

Materialist or structural explanations focus on the *material* causes of inequality and difference between social groups; for example, working conditions, housing and environment. These inequalities are seen as arising from the social structure, that is, the way in which society is organised. The poorest in society are seen to lack the material resources required to sustain health and maintain a healthy lifestyle. The 'inverse care law' (Hart, 1971) also suggests that those in the lowest socio-economic groups,

who are often in the greatest need of health care, often receive it later and in lower amounts than those who are more affluent, but in the least need.

Cultural/behavioural explanations

Cultural theories explain class differences in reproductive health by reference to the social processes that create and reinforce *cultural* differences in attitudes and behaviour. The emphasis is often on lifestyle and 'risky' health behaviours. The poorest individuals and families are seen as engaging in behaviours that are not conducive to the maintenance of good health. However, O'Donnell (2004) warns against this approach arguing that '*losing sight of the unequal social structure whilst working on what socially excluded and materially deprived communities can do for themselves may be a subtle form of victim blaming*' which health professionals need to avoid.

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Early pregnancy and motherhood

The UK has one of the highest rates of teenage pregnancy (and teenage motherhood) in Europe. Arai (2003) suggests that there are multiple, and complex, reasons for early childbearing but common explanations include: poor access to contraception; inadequate sex education in schools and at home; and the inability of young people to negotiate safe, protected sex.

Whatever the 'true' explanation might be, it is important to recognise that teenage pregnancy is strongly associated with social class; young women who experience poverty and social exclusion are far more likely to become pregnant than those who do not. However, early pregnancy and motherhood is both a cause and a consequence of social exclusion (Social Exclusion Unit, 1999).

It is important to recognise that within many societies, becoming a mother is an important rite of passage for women, and motherhood an important social status. Indeed, Coward (1992: 49) argues that pregnancy brings status and that 'The less social status women have in public .. the more likely they are to feel that pregnancy confers status'. It is easy to see how in a society where some young people lack education, employment and other opportunities, pregnancy, childbirth and motherhood can be perceived as important personal and social achievements.

Approximately 50 per cent of teenage pregnancies end in abortion (Tabberer *et al.*, 2000) and although prevention is widely regarded as the best response, a significant number of young women continue with their pregnancies. A recent study of pregnancy and early motherhood in Coventry (Letherby *et al.*, 2002) suggests that young women's experiences of pregnancy, childbirth and motherhood are shaped by a dominant discourse which labels all such pregnancies as a 'social problem'. Whilst many health professionals are aware that they must not fall into this trap,

this study also identified considerable prejudice in the care given to young women.

Choice in childbirth

Changing Childbirth (DoH 1993) stressed the importance of informed choice during pregnancy and childbirth, as a key feature of the philosophy of 'woman-centred care', in attempt to promote greater control for childbearing women. Much debate has centred on the fact that services do not appear to support this philosophy. However, genuine choice does not appear to be limited by services and resources alone. Assumptions made upon social classification has led to the development of stereotypes of women using the maternity services (Green et al., 1990), which highlights issues of prejudice and discrimination (Bowler 1993; Bharj and Cooper 2003).

Whilst choice may be secondary to women who are struggling with issues of poverty, it is becoming clear that women who are socially excluded or 'materially deprived', may receive less information, due to midwives' assumptions of the correlation between women's social class and education base. As Kirkham et al., (2002: 510) argue:

Materially deprived women were less likely to be made aware of choices available to them and were liable to be given fewer information leaflets and less verbal information than more advantaged women. Hence, when midwives made

stereotyping assumptions about materially deprived women's literacy levels and desire for information, these had a direct and negative impact upon their care.

Whilst the relationship between aspects of infant mortality and lower social class is clear, it should not be considered as a reason for limiting choice for these women, and support medical control over childbirth. Choice should be equitably distributed based on women's needs and expectations, although it appears that not all women start from the position of equity.

Infant feeding

It is widely acknowledged that breastfeeding has biopsychosocial advantages for babies and women. However, the UK has one of the lowest breastfeeding rates in the developed world and certainly the lowest in Europe (WHO 1999; 2000). Moreover, breastfeeding is strongly associated with social class. Middle class women are far more likely to both initiate and maintain breastfeeding than working class women. Indeed, the breastfeeding rates amongst women in Social Class I rivals those of other industrialised countries. It is worth noting that breastfeeding is also strongly associated with geographical location. For example, there is a considerable difference in rates of breastfeeding between 'affluent' and 'poorer' neighbourhoods.

Although breastfeeding carries hidden and largely unrecognised costs (Earle 2003), it is mostly free and therefore it is difficult to see how material disadvantage could explain such stark variations in breastfeeding. In order to understand class differences in infant feeding it is necessary to consider cultural explanations. Recent research has highlighted the following factors:

- infant feeding decisions are often made before or soon after conception (Murphy 1999);
- women who formula feed seem to know as much about the benefits of breastfeeding as women who breastfeed (Murphy 1999; Earle 2003);
- men's attitude towards infant feeding, fatherhood and mothering can be an important factor in women's decision making patterns (Freed and Fraley 1993; Earle 2000; 2002; 2003);
- feelings about breasts, sexuality and motherhood can impact on infant feeding decisions (Carter 1995).

Implications for midwives in practice

1. Midwives should not 'stereotype' individual clients but they should recognise that there may be **differences in health needs and expectations** between different social groups.
2. It is important to recognise that there may be both **material and cultural explanations** for differences in health behaviours and outcomes.
3. Midwives, managers, and others should recognise that midwives have a major role in tackling socio-economic inequalities through **public health strategies**.
4. Midwives should examine their own **beliefs and values** in relation to their knowledge and practice, to enable them to address the individualised needs of women in their care irrespective of their social class.

Useful reading

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