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# 'Nobody in a Maternity Hospital Really Talks to You': Socialist Legacies and Consumerism in Czech Women's Childbirth Narratives\*

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**Abstract:** This article aims to show how eight women, most of them with higher education, experienced, perceived, and understood birth care in the context of the post-socialist transformation in the Czech Republic. It is based on narrative interviews and a thematic analysis of them. From a description of women's birth-care experiences the author finds that women are most critical of the behaviour of health-care workers and the lack of communication provided by the system. Discussing the narrators' birth-care requirements she notes the strategies women use to attain the form of care they wished. Finally, the author observes that the women she interviewed exhibit diverse understandings of birth care, on which basis the author identifies five distinct notions of birth care that differ in three key aspects: (1) women's attitudes to medical interventions; (2) their awareness of birth care; (3) their subjectivity and position in relation to birth-care providers. These ranged from complete acceptance of the way in which birth care is provided, to notions that are critical but accepting of medicalised care, to a rejection of the medical model of birth care and the assumption of 'a responsible consumer' subjectivity. The article in particular looks at women's disillusionment with birth care and interprets it in relation to clashing ideas about the relationship between birth-care provider and user associated on one hand with the socialist past and on the other with neo-liberal discourses on health.

**Keywords:** birth care, neo-liberalism, post-socialist, paternalism, Czech Republic

*Sociologický časopis/Czech Sociological Review, 2014, Vol. 50, No. 6: 961–985*

DOI: <http://dx.doi.org/10.13060/00380288.2014.50.6.150>

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\*\* Acknowledgements: This study is part of work on a research project (GAČR P404/11/P089) funded by the Czech Science Foundation, for whose support I am grateful. Partial support was also received from the University of West Bohemia's Motivational System under its POSTDOC10 section. I thank all the women who agreed to participate in my research. I would also like to thank Monash University in Australia and the Group of Eight for awarding me the Go8 European Fellowship, which allowed me to complete the final revisions of this paper. Empirical findings presented in this paper also appeared in

## **Introduction**

Since the 1990s most post-communist countries in Central and Eastern Europe (CEE) implemented market-driven reforms in their health-care systems. Although there were significant differences across the region in the particular nature of these reforms, the post-socialist states and their citizens largely adopted the commercialisation or 'marketisation' of health-care services and the idea of consumerism. These concepts mean different things across this region [Nemec and Kolisnichenko 2006; *cf.*, e.g., Mishtal 2010; Temkina and Zdravomyslova 2008; Rivkin-Fish 2005; Schecter 2011]. This text deals with the perception and impacts of changes related to the post-socialist reforms of the birth-care system on provider-receiver interactions in one country of the region—the Czech Republic. I focus on birth care because it constitutes a special domain in health-care systems; its users are mostly healthy people—pregnant and birthing women and their newborns, who as such have a greater capacity to pursue their health-care-related consumer demands than sick patients do [Hřešánová 2008; Hřešánová and Hasmanová Marhánková 2008].

My previous research dealt with shifts in birth-care practices and the views of health-care providers in two maternity hospitals [Hřešánová 2008; Hřešánová 2007]. Building on ethnographic research in two hospitals, I described how maternity hospitals adopted consumer-friendly rhetoric to attract more clients, rebuilt maternity wards into an attractive home-like environment, and increasingly commercialised some of their services to deal with financial cuts in the health-care system. Still, both health-care facilities suffered from a shortage of employees while facing at the same time an increasing consumer demand for individualised care [ibid.].

This article looks at birthing women's perspectives. I employ constructivist theoretical approaches of interpretative sociology of health and illness to explore how Czech women experience, perceive, and understand birth care. I ask what birthing women, who have increasingly turned into 'clients' of birth care services, actually want and what their priorities in birth care are. Drawing on narrative interviews with eight women, I examine problematic aspects of birth care. I argue that these women's criticisms are on one hand closely linked to their expectations, resulting from the various ways in which they understand and conceptualise birth care; in this regard the diversity of their approaches and understandings of birth care reflect wider societal changes in the post-socialist Czech Republic as well as more global trends typical for postmodern societies and neo-liberal economies. On the other hand, the negative aspects of birth care conveyed in these birth narratives also mirror wider structural matters. Specifically, I demon-

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a paper written in Czech [Hřešánová 2011]. Last but not least, I would like to thank two anonymous reviewers for their helpful comments and Robin Cassling for careful proof-reading of this text.

strate that the ideas about birth care provider-receiver relations associated with the socialist legacy clash with those shaped by the ideas of consumerism and neoliberalism that have been promoted as part of the post-socialist reforms.

The first part of this paper depicts the Czech birth care system and its transformations from the socialist into the post-socialist era, thus showing a wider structural context surrounding the birth experience of my informants. I then describe the research methodology I used. My findings are structured into three parts: first, I discuss women's birth experiences; then I focus on their strategies and requirements; and finally I outline the different notions of birth care that I identified among my participants.

### **The Czech birth-care system from the socialist to post-socialist era**

The central pillars of today's system of birth-care in the Czech Republic were founded after the Second World War, when the whole health-care system underwent a profound reorganisation and became state-funded, centralised, and integrated.<sup>1</sup> Universal social and health insurance were introduced so that health care could be free to all citizens at the point of provision. Health-care services were provided within a person's residential district. The system generally emphasised the importance of prevention, and new sites of district and regional facilities were built to promote it. These included new hospitals with maternity wards and new antenatal clinics across the country [Heitlinger 1987: 75; Štembera 2004]. Child-birth was increasingly moved into the hospital and by the mid-1950s 92.6% of all births took place in a hospital setting [Štembera 2004: 67].

Women were urged to visit antenatal clinics. Heitlinger [1987: 106] points out that free antenatal care had a 'strong controlling effect on pregnant women', as they did not have the real option of refusing it, unless they wanted to subject themselves to close monitoring from social workers. On the other hand, women did not accept medical authority uncritically and exercised what Heitlinger calls 'medical scepticism'. They frequently did not follow or even ignored the doctor's opinion and recommendations, instead favouring advice from their relatives, friends, and co-workers. In Heitlinger's view this demonstrates the limitations to medical professional power in relation to individual women who—especially if they are healthy—do not really adopt the role of 'patient'.

The socialist health-care reforms strengthened the position of gynaecologists and obstetricians, who became key antenatal and birth care providers during the

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<sup>1</sup> This transformation primarily followed the Nedvěď Plan, created by Dr. Miloš Nedvěď during the Second World War. In many aspects it resembled the Semashko Model of health care, and the communist regime passed it off as inspired by the Soviet model. However, Mášová [2005] shows that the reconstruction of the Czechoslovak health care system implemented concepts that had actually been invented in pre-war Czechoslovakia.

1950s and thereafter, while the independent midwifery profession was abolished and midwives were turned into obstetrical nurses subordinate to obstetricians within the hospital hierarchy [Štembera 2004: 44; Hrešanová 2008: 130–131]. In this regard it is significant that obstetrics has to date remained a male-dominated profession in Czechoslovakia and the Czech Republic [Hrešanová 2008: 151–155; ŮZIS 2013: 181], unlike in other countries in the region, such as Russia [see, e.g., Rivkin-Fish 2005] or Poland [Mishtal 2010: 63]. Reproductive medicine on the whole was a prominent medical field owing to its importance for the political regime, which aimed to prolong the life span by nurturing the overall mental and physical health of the youngest generations [Heitlinger 1987: 77]. The political system prioritised the special needs of industrial workers and expectant mothers and their children in the health-care system to secure ‘industrial development and population replacement’ [ibid.: 76–77].

However, the political regime generally ‘acted to lower the status’ of medicine and physicians, who in the pre-war era had belonged to the cultural and intellectual elite of the society [Křížová 2006: 108]. Doctors were all turned into state employees, their salaries were flattened to equal those of other occupations, their professional association was dissolved, and they lost their right to self-regulation [Štembera 2004: 44; Křížová 2006: 111].<sup>2</sup> As a result, there was a profound weakening of the sense of professional identity and solidarity among physicians. Hoffmann [1997 in Křížová 2006: 114] even argues that these changes led to wide-scale moral erosion that negatively affected doctor-patient relationships. However, according to Křížová [2006: 114] the loss of professional integrity led to a more heterogeneous performance, as the profession was not able to exercise control over cases of professional misconduct to the same extent as before. At the same time, Křížová [2006: 113] observes that ‘in the totalitarian society of powerless citizens’ doctors, who represented a form of superior expert knowledge, could still enjoy an authoritative position. Rivkin-Fish [2005] offers a different interpretation of the paternalism Soviet doctors exercised over their patients, as she associates it with the disempowerment of the medical profession in the organisational and political context of socialist health care.

These conditions had fundamental impacts on birth-care provision in hospitals. Hospital birth care was frequently criticised for being too depersonalised and unfriendly to women. Since the 1950s criticism of the way personnel treated birthing women had periodically surfaced on the pages of the major journal *Czechoslovak Gynaecology* [e.g. Vojta 1953: 101; Čepický 1984: 123]. But doctors were not the only health-care providers responsible for treating birthing women. According Benoit and Heitlinger [1998], Czechoslovakian obstetric nurses who were responsible for providing most of the care often failed to give their ‘patients’ adequate emotional support. Read [2007], however, argues that such practices

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<sup>2</sup> In its stead, the Revolutionary Trade Union (ROH), a body uniting all professional organisations, was established in 1948 [Štembera 2004: 44].

mirrored the key values of emotionless 'professionalism' and rationality in the socialist nursing. Health-care providers adhered to the dominant biological and physiological models of health and focused on the technical aspects of care [Read 2007: 206; Heitlinger 1987: 83].

Substantial changes in the institutional regimes of birth care were adopted especially in the early 1980s, when several hospitals relaxed their strict aseptic rules and allowed fathers to accompany their birthing partner in the delivery room; several hospitals adopted 'rooming-in' and allowed mothers to have their babies constantly with them [Heitlinger 1987]. But major shifts came with the fall of the communist regime. The reforms of the 1990s generally sought to increase the democratic participation of citizens in decision-making related to health policy [Háva and Mašková Hanušová 2009: 13] and to decentralise the health-care system [Rokosová et al. 2005: 25–28; Hrešanová and Hasmanová Marhánková 2008: 90]. The state introduced market-driven principles into the health-care system, as was typical in other countries of the CEE region. Most notably, independent health-insurance funds were established as public-service corporations, and the reforms promoted the autonomy of the medical profession and soon after an independent professional association was founded [Háva and Mašková Hanušová 2009: 13]. The district-based health clinics, offering only outpatient services, including in gynaecology, were privatised.

Subsequent health-care reforms adopted after 2000 turned health-insurance funds into private and profit-driven enterprises with decision-making powers [Háva and Mašková Hanušová 2009: 13]. Most hospitals (except university hospitals, for instance) were transformed into joint-stock companies and in later years some turned into profit-driven organisations that adhere to the principles of market logic, whereby the increased competition among health-care providers is meant to lead to a better quality of health care [Hrešanová and Hasmanová Marhánková 2008: 90–91].<sup>3</sup> This idea was further supported by the concept of consumerism, which presupposes that clients actively weigh the pros and cons of particular health-care facilities and make decisions based on what they consider to be to their best advantage [ibid.; Lupton 1997].<sup>4</sup>

Hašková [2001b: 29] has pointed out that these market-driven reforms led to the 'commercialisation' of health-care facilities in the Czech Republic and the introduction of the new idea of the 'client' into birth care. Maternity hospitals were supposed to 'fight' for clients in order to get more of the funding distributed through the health-insurance funds. At the same time, the fertility rate had remained low since the late 1990s. In an effort to attract as many birthing women as possible, hospital managements renovated the interiors of maternity wards into 'hotel-like' environments offering an intimate, 'homey' atmosphere. Deliv-

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<sup>3</sup> On the promotion of the same rationale in Russia, see Rivkin-Fish [2005: 68-sia].

<sup>4</sup> See also Shaw and Aldridge [2003] for the debate on the different meanings of consumerism.

ery rooms were equipped with new tools to ease the first and second stages of labour, such as birth balls, wall bars, artificial 'bush ropes', special bathtubs, and a sofa bed with TV and a fridge. And they also introduced new services, such as antenatal classes, or private family rooms that can be used for a fee [Hrešanová and Hasmanová Marhánková 2008: 96–97; Hrešanová 2008: 167–180]. These new services, however, mostly involved better materials and equipment, but not better *caregiving* in the sense of a personal one-on-one approach. O liker [2009: 109] defines caregiving as 'affect and actions that are responsive to an individual's needs and well-being within a face-to-face relationship'. As I found out during my ethnographic study of two maternity hospitals, health-care facilities have actually cut back on the number of personnel, while midwives, in short supply, struggled to meet increasing consumer demands [Hrešanová 2008: 131–136].

By the turn of the millennium, most women still preferred a medically managed childbirth. Hašková conducted a questionnaire-based study among 818 women with a child aged 1.5 years or under and three-quarters of respondents indicated that during their most recent childbirth they had just followed the instructions of their birth-care provider [Hašková 2001a: 25]. Nevertheless, one-quarter of her respondents with a child under one-and-a-half years indicated that they preferred childbirth with a minimum of medical interventions. Yet only one-third of these women met with health-care workers who complied with their wishes. The women, for instance, usually wanted to be in a position other than the lithotomic position with their legs in stirrups. Their wishes in most cases emerged out of a previous childbirth experience, as most of the women were multiparas [Hašková 2001a: 23–26]. Building on her findings, Hašková [ibid.: 25] concluded that Czech women preferred to have more birth-care alternatives to the active medical management of childbirth; nevertheless, they mostly thought about them in terms of the technical equipment of maternity units providing obstetrical care. Among her respondents, 15% of those who approved of home-birth had had a negative hospital experience in the past and complained about the unfriendly behaviour of health-care providers. Most women also complained about how hard it was for them to obtain important information about the care provided by the facility [ibid.: 26].

Health insurance has remained compulsory since the socialist period and health care was still provided completely free of charge up until 2008, when the then right-wing government set up small user fees for visiting a doctor (30 CZK, i.e. 1 EUR), hospital stays (100 CZK for a day, i.e. approx. 4 EUR), and pharmaceutical prescriptions, and introduced 'out-of-pocket payments' into the system [Kinkorová and Topolčan 2012: 3]. The new left-wing government cancelled the fees for hospital stays effective 1 January 2014 and some user groups were exempted from the fee requirement. In this regard, reforms in the Czech Republic 'commercialised' health care to a much lesser extent than, for instance, in Russia, where commercial reproductive health services became part of the system already in the 1990s and compulsory health insurance did not usually cover all forms

of medical care; thus, rich clients tended to take advantage of private and commercial health-insurance programmes [Temkina and Zdravomyslova 2008: 278]. Similarly, the early post-socialist reforms introduced by the Wałęsa government in Poland led to severe social welfare cuts, intense privatisation, decentralisation, and deregulation, which resulted in a mass exodus of health-care professionals abroad, the widespread practice of informal payments and bribery—particularly common in birth care—and the general impoverishment of the health system [Mishtal 2010: 57–58]. Comparing four post-socialist countries and their health-care reforms, Nemeč and Kolochisenko [2006] nevertheless observed that health-care systems in countries like Slovakia and the Czech Republic, which became members of the European Union, were ‘much better off’ than the countries of the former Soviet Union, where health-care systems almost collapsed [ibid.: 18]. Different kinds of problems stemming from the socialist legacy nonetheless remain.

## **Methodology**

The findings presented in this paper are part of a wider study on Czech birth care, in which I examine the birth-care experience and needs of various groups of women. In particular, it builds on the first phase of my study, comprising of eight narrative interviews with predominantly higher-educated women with recent childbirth experience. In the first phase of the project I continued to explore findings identified during previous ethnographic research I did in two maternity hospitals, during which I interviewed 32 postpartum women [Hrešanová 2008; see also Hrešanová 2011]. In the hospitals I had only limited opportunities to talk to the women whom midwives and obstetricians considered ‘over-clever’, in reference to their specific requirements for birth care and their high level of knowledge about birth care owing to their higher education [Hrešanová 2008: 48–57; cf. Hrešanová and Hasmanová Marhánková 2008]. Therefore, from July to August 2010, I interviewed eight women with recent childbirth experience who had at least a secondary school education and preferably had some form of higher education. Most of the participants were university graduates. Only two out of eight participants did not continue to university study after graduating from secondary school and one participant was still completing her university study. In all but two cases their partners had higher education, too.

I contacted these women through a circle of my friends and acquaintances using the ‘snowball’ technique to interview them about their childbirth experience and notions of birth care. All the interviewees, whose names have been changed here, had given birth for the first time, with the exception of one woman who had given birth for the second time. The woman with the most recent childbirth experience gave birth a month before the interview; the longest period since childbirth was fifteen months. These women were between the ages of 25 and 34, one-half of them were age 31. The women gave birth at four different maternity

hospitals, and six of them had experience from the same university clinic. Five of these eight women gave birth vaginally and the level of medical intervention they experienced varied. The three other women had a Caesarean section. What was interesting was that all eight women showed an active attitude to childbirth. In this respect, I should point out that neither their approach to childbirth, nor their evaluation of the birth care they received were criteria that led me to ask them to participate in my study. In five cases I had no information about their childbirth experience beforehand; nor did I know what their birth-care preferences were.

I used narrative interviews as a research technique, which seemed to be the best tool to identify key aspects of women's childbirth experience, and to grasp their subjectivity.<sup>5</sup> In this regard I was substantially inspired by Della Pollock who in her book *Telling Birth Stories* [1999] explored how women re-created their selves by narrating their birth stories [ibid.: 7]. After obtaining women's informed consent, I initiated their narratives by asking, 'please tell me about your childbirth and the birth care that you received'. My general interviewing strategy was inspired by the narrative approach in the sense that I became the active listener; I tried not to intervene in the woman's story and raised as few questions as possible [cf. Chase 2005: 661]. The narrative interviews lasted approximately two and a half hours; only two of them took 40 minutes due to time limitations on the side of the interviewees. I asked women to choose the appropriate interview setting; five interviews took place in their homes, one in a café, one in a park, and two other interviews in the office of someone we both knew. I conducted a thematic analysis of these interviews to identify key themes in women's descriptions of their birth experience and their perceptions of the care they received [Ezzy 2002: 86–88]. I used Atlas.ti software to facilitate this kind of qualitative data analysis.

### **The birth-care experiences of women**

The women's birth-care narratives mainly unfolded out of the particular physiological course of labour that they experienced. Five out of eight of my communication partners gave birth vaginally, the level of medical intervention varied between them, and all of them also had an episiotomy. Three other women had a Caesarean section: only Františka had emergency surgery performed under general anaesthesia. Alena had a C-section because her baby was in a breech position. In Eva's case, obstetricians performed a C-section when several attempts to induce labour failed and her baby's cardiocographic records suddenly worsened.

Fear was the most noticeable theme in the women's birth narratives. The women worried about various things. Other studies [Kringenland et al. 2010; Fisher et al. 2006] have similarly shown that fear related to childbirth is often

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<sup>5</sup> I understand *subjectivity* in terms of how people conceive of and recognise themselves and in line with the idea of the 'self as an acting agent' [Boon 2007: 48885].

a reflection of factors that are connected to both the personality of the woman and to the social dimension of the care provided. My informants mostly worried about their baby's health and about physical pain, but they were also concerned because they did not exactly know beforehand what was going to happen to them in a hospital setting, even though they were generally well-informed about birth care. Their biggest concerns were about the behaviour of health-care workers and particular medical interventions. Paradoxically, the women's worries turned out to be relatively legitimate, as all but one of them experienced some kind of negative incident with a health-care staff member during their hospital stay. While describing the birth care they received, they expressed feelings of frustration, depression, anger, desperation, helplessness, and powerlessness; and some of them had the feeling at the time that they should keep their emotions to themselves.

Health-care workers' behaviour generated particularly negative emotions among some of these women. Half of them found the birth-care providers to be unpleasant and unprofessional. Františka considered the term 'mommy', which the health-care providers used to address the birthing and/or postpartum women, as unprofessional itself. Similarly, Alena perceived the term as infantilising. While emphasising the need for respect and good manners in treating 'clients', Běta also found the approach of health-care providers to be largely unprofessional. A nurse by education, who had worked with drug addicts in a non-governmental organisation before her maternity leave, she contrasted the way health-care staff treated birthing women with the standards in her organisation, where ethical treatment of clients was considered essential; in her field, the ethical approach to clients was constantly discussed, observed, and nurtured through further education. Běta was therefore quite disillusioned by some midwives and obstetricians who had raised their voice to her, scolded her, and were rude to her, while—as she emphasised—she tried her best to be 'the perfect patient' with good manners and following all the instructions.

The birth narratives included repeated examples of rude and arrogant behaviour by birth-care providers; regardless of how the women evaluated the care they received, only one out of the eight interviews did not include any unpleasant incident with a birth-care provider. Four out of the eight women (Cecilie, Běta, Alena, Františka) said that they felt like they were 'bothering' the midwives in the postpartum ward, 'keeping them back from their work', and felt like they were 'begging for something'. Cecilie concluded that what she really missed in the maternity hospital was 'good, human behaviour'. Alena elaborates:

... a burst of hormones, then the baby, you're alone there, and now you expect that, you know, they are paid for it, and then you just have this feeling that they're doing you this big favour and that you have to beg them for something, and that they're doing something that it's not their duty to do. So you're in this position, oh, gosh, 'If I want something from them I must be a hysterical mother'. If just ... well, poor her, she's there, well two of them are there for the whole ward, and I understand that if

they were to dawdle over everybody like they do with me that there's no time for that here. I really had this feeling of guilt that I was bothering them. (Alena, 31, one child)

Similarly, Běta recalls:

From the emotional point of view, it was a really difficult period, you had the feeling you're bothering them all the time, and I felt like I couldn't afford to be hysterical because then I wouldn't be able to find out anything ... quickly [you had to become] a kind of toady. (Běta, 25, one child)

Běta's words suggest that health-care workers expect women to be sympathetic, docile, understanding, unselfish, submissive and kind, and not to assert their demands too much. On the other hand, the women feel like they have to behave in a way that prevents them from being judged as hysterical even though their exasperation may be a legitimate response to flaws in their care. The threat that they might be labelled hysterical has a strong disciplining effect on women. While this might be a characteristic of any subordinate position in a power relation, Karen Martin [2003] points to a gendered aspect of such behaviour, which has to conform to gender norms. In this regard she highlights the internalised technologies of gender adopted during gender socialisation, which, besides social institutions, discipline women in a way appropriate to their gender.

Cecilie, Alena and Běta believed that they were generally unlucky with midwives in the postpartum ward. Nevertheless, they mentioned several exceptions in the world of exhausted, unpleasant, overworked, and rude midwives working in this ward. For instance, Cecilie recalls a very kind midwife whom she met on the third day of her hospital stay;<sup>6</sup> she spoke to her nicely and showed her how to care for her baby, which nobody else to that point had done. She gave her 'such words of reassurance and support that I felt like I was talking to a creature from a fairy tale' (Cecilie, 31, one child). The women who gave birth at a university clinic also compared the midwives in the labour and the postpartum wards, and they perceived the midwives who helped them during labour and delivery as more sensitive, sympathetic, and nice. My participants also mentioned other health-care professionals who were kind to them, such as an anaesthesiologist (Alena), paediatricians (Cecilie), or an orderly (Gabriela). But generally, unpleasant incidents with several health-care providers negatively affected the first days after childbirth in five out of eight cases. Naturally, this influenced how the women evaluated the birth and postpartum care they received. At the same time, these

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<sup>6</sup> Most women stay in hospital for at least three days after a vaginal physiological childbirth without health complications. This practice complies with the binding recommendation of the Ministry of Health to provide postpartum and newborn care for at least 72 hours after the delivery [Ministry of Health 2013: 2].

women did not understand the incidents as a personal failure on the part of the individual health-care providers. Instead, they viewed them as the product of wider structural or system-related errors that cause maternity hospitals to be significantly understaffed and the remaining employees overworked and burnt out. Out of eight women, only two (Gabriela and Hana) did not question the conditions that they encountered at the maternity hospital.

There were four women—three of whom gave birth at the same university hospital—who were more critical than the others of the care they received and regarded the way the midwives and ob-gyns communicated with them as especially problematic. For instance, Běta said:

It's really quite nice that maternity hospitals [are] super-modern, they are the most comfortable and the most modern in the world, but the way some of the doctors behave, it's really like from way back in the totalitarian era. (Běta, 25, one child)

Františka, who gave birth at a different facility, also referred to the impersonal system of socialist health-care, which she associates with a lack of respect for human dignity. Alena and Františka link such treatment by health-care workers to a lack of respect for a woman's right to make her own choices in birth care. In this regard, Františka mentioned that even asking just a simple question could provoke a hostile response from health-care providers. She told me:

And then you ask her [the doctor] about some things and she's so shocked that you dared to ask a question and she takes it like ... I don't know, worse than if you were taking drugs or something like that. (Františka, 31, one child)

Alena, Běta, Dana and Františka stressed that the health-care professionals in maternity wards generally did not talk to them. Dana explained:

Well, nobody in a maternity hospital really talks to you. Not at X [where she gave birth to her first child] nor at the university hospital, nobody says, 'we're going to give you a drip' and what it's for. No, it's just 'sit here', and that's how it is. Nobody consults with you on anything. It's simply, 'we're doing our job'. The only thing they asked me about was whether I wanted an enema or not, but that was it. (Dana, 28, two children)

In Dana's view, the main priority for health-care providers is to focus on the technical nature of birth care and to deal with women's birthing or postpartum bodies. This significantly affects the character of the care provided to women in a maternity hospital. In Alena and Běta's view, it actually ceases to be 'caregiving' in its true meaning, in the sense of looking after somebody and providing her with a psychological and emotional support [see Olikier 2009]. Instead, it turns into the technical skill of applying medical technologies to patients' bodies. Běta's

experience illustrates this. After her delivery the female obstetrician started to stitch her wounds, but Běta shrieked because she felt pain. The doctor snapped back that it could not hurt as she had been injected with 'a twenty of Mesocain'.<sup>7</sup> Běta, who was fortunate enough to understand what that meant due to her nursing education, nevertheless insisted that she felt real pain. The doctor then asked a nurse to hold Běta's hands so that '... she doesn't try to reach down here because I've a sterile environment here', is how she commented on Běta's vagina. Františka believes that this kind of treatment of women by health-care providers is the result of the 'reduction' of care to a pure technical skill. The midwives and ob-gyns in the hospital where she gave birth primarily 'collected information' instead of 'actively asking women questions and listening to them'.

Dana's words quoted above point to several key flaws in the way in which health-care providers communicated with women while at the same time revealing her ideas about ideal care. But other women, for instance Alena and Františka, also thought that they did not receive enough information and facts about birth care to make truly informed decisions. In this regard, Alena mentioned that individual obstetricians and various official leaflets distributed by the maternity hospital promoted the option of informed choice, but nobody gave her any specific information about her health, care, and the potentially harmful consequences of suggested medical interventions, information she needed to know in order to truly make informed decisions about her care.<sup>8</sup> This contradiction between what maternity hospitals officially proclaimed and what the care they provided was like in reality was the main source of disillusionment that many of my informants expressed. For that matter, my previous research revealed similar discrepancies between the official rhetoric of maternity hospitals and the hidden message about birth care communicated during the childbirth education classes that these hospitals held [Hrešanová 2008: 117–120].

The majority of my participants believed that the most essential thing was to get sufficient information about the care offered. My participants viewed this to be the basic element in being responsible for their state of health and for being able to make decisions about it. As Běta states:

In order to cooperate well and not to underestimate or overestimate things, and also not to look like a hysterical person, I—as a patient—need information. (Běta, 25, one child)

Běta's approach to birth care also reveals key features of her notion of health and health care, which reflect values of individualism and related notions of self-discipline, self-control, and personal responsibility. These are characteristic of

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<sup>7</sup> Mesocain is a type of local anaesthetic.

<sup>8</sup> In her case she needed such information to decide whether to give birth vaginally or go with the Caesarean section, as her baby was in a breech position.

the neo-liberal discourse in Western postmodern or late modern societies [see Bryant et al. 2007; Nettleton 2006: 42]. In neo-liberal discourse, individuals are conceptualised as 'active citizens' with the right to self-determination and with obligations towards their community or state. These rights and obligations are, however, asserted in a free-market environment [Bryant et al. 2007: 1195]. The notion of citizenship, in terms of citizens' rights,<sup>9</sup> becomes a personal matter in a society that is increasingly commodified [Susen 2010: 261–262] and individualised. New notions of citizenship mingling private and public spheres in new ways imply particular identities [Plummer 2003: 59]. In postmodern societies the concept of individual choice becomes crucial to those who can afford to exercise it [Rose 2001: 16]; but this is once again predominantly understood in terms of the market [see Plummer 2003: 23–25]. Thus, there is a clear connection to the increasing influence of consumerism. Consumerism in birth care builds on the idea that a birthing woman is an active actor, who deliberately chooses which services to accept, considers the pros and cons, and thinks about advantages and disadvantages. Her active approach ultimately leads to a general improvement of care in the system, as health-care facilities compete for as many 'clients' as possible. Consumerism then requires an environment to imitate a market, and turns birth care into a product [cf. Hrešanová and Hasmanová Marhánková 2008; Hrešanová 2008]. Bryant et al. [2007: 1195] point out that the neo-liberal concepts of self-discipline, self-control, and personal responsibility have transformed various spheres of the individuals' intimate worlds in late modernity, whether we are dealing with the field of sexuality, parenting, or health. Many of my informants employed a similar understanding of responsibility when they made decisions about which maternity hospital to give birth in. Běta, Alena, Františka, and Eva mentioned that they used various sources, such as birth-related websites, books, or information from their friends or relatives, to make a responsible decision about which maternity hospital to give birth in. However, within the hospital setting their chances of exercising informed choice were severely limited.

Františka and Běta tried their best to get information they considered crucial for making an informed decision about birth care. However, both of them observed that they waited too long to get answers from health-care providers and these sometimes did not reach them at all; women were frequently referred to other health-care providers who never got back to them. What Dana, Františka, and Běta considered the most problematic about the care they were given was the very fact that they did not receive enough information about medical interventions or medication administered to them or their babies. Overall, women evaluated the health-care providers' way of communicating as unsatisfactory precisely because they did not get enough information about their state of health or health

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<sup>9</sup> In conformity with Marshall's classic essay, Rose [2007: 131] understands citizenship as related to 'citizenship projects', by which he means 'the ways that authorities thought about (some) individuals as potential citizens, and the way they tried to act upon them in that context'.

care. In this regard, other birthing women often substituted missing information and care.

Běta was among those who did not receive even basic information about her baby's health and his transfer to an incubator right after he was born. Běta learned this fact eight hours later after she made several attempts to get him back. After being transferred to a postpartum ward without her child, a resolute midwife informed her that she would get her baby once she was able to get out of bed on her own, go to the bathroom, and have a shower. Běta wanted to have her baby with her as soon as possible. Therefore, she tried to get out of bed several times and was scolded for causing a 'false alert' each time she failed.

Most women considered the separation from their child as the worst part. Only one of my informants did not mind being separated from her baby for several hours after the delivery, but the other women suffered greatly from being separated from their babies. Three out of these seven women describe this separation as a traumatic experience. They asked the midwives to bring their babies back to them several times. Thus, it is not surprising that a feeling of despair dominated some of these narratives. This was evoked by a response to a lack of midwife care in the cases of at least four women but also by general physical exhaustion and the demanding character of care for a new-born. Alena's comment reveals how much she felt the absence of care in a maternity hospital which happened to be enrolled in the Baby-Friendly Hospital Initiative.

A: I don't know, in the end I really was in such a state that I was willing to sign out against medical advice to get home.

E: Why?

A: Because I was telling myself that it's gonna be the same at home, just I would be on my own and my partner would be there all the time, so at least somebody would help you ...

My informants often got a minimum or even no information about how to care for their babies; for example, how to bathe them or change their diapers. But what they lacked the most was advice on how to breastfeed. Problems with breastfeeding constituted another dominant theme in their birth narratives, which I have explored elsewhere [Hřešánová 2011].

## **Strategies and requirements**

Women employed various strategies to be able to exercise their right to an informed choice in the context of birth care. 'Asking a lot of questions' constituted their main strategy. Běta explained that all the questions she raised were not because she wanted to be nosy but because she needed to know 'for her peace of mind'. However, her impressions were:

... health-care providers often think, 'oh, she won't understand this', 'I won't tell her anything', so they'd rather tell you nothing 'cos they don't want to deal with it. (Běta, 25, one child)

All the communication partners, except Cecilie, sought information they considered crucial for their baby's health. Gabriela and Hana especially emphasised that in the university clinic where they gave birth it was necessary to 'let the midwives know what you need'. These participants believed that women should realise that 'they are not alone in the maternity hospital' and approach the hospital staff accordingly. Therefore, they fully respected and accepted the bureaucratic nature of maternity care in that hospital.

But some women may have difficulty making repeated requests and generally raising their voice. When recalling her experience, Běta regretted that she was not 'tougher' about insisting on her needs and wondered whether she would have really received all the information and care she required. It seems that the other women felt similarly. Several of my participants felt retrospectively regretted not being able to do certain things in a different manner during labour or after the delivery and for not insisting on their demands. Women shared a feeling of failure that they had not opposed the system for the 'good of their children', and I believe that this needs to be seen in relation to two things: first, to the dominant social norms in a maternity hospital, which operates as a modern organisation with bureaucratic rules [Hrešanová 2008]; second, to the internalised technologies of gender [Martin 2003: 58] that women adopt during the socialisation process. Through these technologies they constitute and discipline their self as a feminine subject. Martin [2003: 57–58] has highlighted that, once internalised, the technologies of gender are permanently employed, including, of course, the time of labour and delivery, too. She shows how women tend to behave submissively during labour because of social expectations related to their gender even though they feel that their needs are not met and they feel dissatisfied with their own behaviour. Or they articulate their particular wishes but feel uneasy and 'selfish' about it afterwards. My informants reflected such contradictions and stated that one should not have to be 'tough' in order to attain key information about their baby's health, to become acquainted with the basic principles of breastfeeding, to get answers to their questions, or to have the child by their side when they asked for it. They believe that these things should be 'common practice'.

Faced with a situation where it is too difficult to get answers from health-care providers and one has to be 'touch', Alena chose to employ yet another strategy to get the care she wanted for her child. In order to avoid being scolded by the health-care workers she simply gave them the answers they wanted to hear, but otherwise ignored them and did things her own way. She refused to perform procedures that she found pointless, superfluous or unhealthy. For instance, when her baby was sleeping she skipped the hourly measuring of the infant's temperature. She tried to avoid bathing her baby, as there were only a limited number of

washbasins and 'they were used by everybody in the maternity hospital', which she felt was not good for her child. Her approach resembles the sceptical attitude adopted by many women under socialism that I described above [Heitlinger 1987].

One of the few specific demands that most of the interviewees shared was to have their partner with them during childbirth, and approximately half of the interviewees had their partner by them throughout the birthing process. The vast majority of women considered the presence of their partner at the birth to be a positive experience. The partners had tried to help the women in various ways, i.e. by massaging their backs or, as one woman told me, informing them about 'what was going on down there'. Hana noted that her partner had been an important intermediary in communicating with the midwives, as during her contractions she was unable to register what they were telling her. Cecilie, whose most important requirement was that her partner be constantly present, was extremely grateful to have this possibility, as her partner was a key psychological support to her. Alena, however, was not lucky enough to enjoy her partner's presence during her labour. After the initial check-ups, the midwives told her that there was no room for her partner to be with her in the birthing room, and she felt very negatively about this. Cecilie, along with several other women, viewed her partner as a 'guardian, who kept his eye on the personnel so that his partner's needs were met. Šmídová [2008: 20] interviewed a number of new mothers and fathers and found they understood the presence of the father at childbirth in a similar way.

Several of my communication partners had special requirements related to 'prep'; they refused to have an enema, and some of them also declined the epidural. The most important thing for Františka was that there be good communication with the hospital staff and that the use of tranquillizers be under her control. For the other women, breast-feeding or being with the child all the time was crucial. None of the women had any specific requirements for their birthing position or what hospital equipment should be used during the first or second stage of labour. Only two of my participants considered it important that the hospital facilities be tidy. Faced with the reality of what was happening at the hospital, many women reduced their requirements on birth care to the mere wish to receive basic information about those aspects of care they considered crucial. Dana explained how 'easily' she lowered her original demands on care. She said that if she had wished for:

... the child to be by my side after the delivery and they had told me it was impossible then I wouldn't have argued with them. I was emotionally exhausted, you don't know anything, right, [I was] sewed up, exhausted, so in that situation you easily lower your expectations. I felt the atmosphere was like you're the patient and you know nothing, and we're the doctors and we know what's best for this child. So I think that if I'd started to talk about any alternative things there, they would have looked at me like 'you're a moron' and said 'well, interesting, but we don't do things like that here, adieu!' (Dana, 28, two children)

Thinking about the paternalistic behaviour of her doctors, she added that she was afraid to ask for everything she wanted during her first childbirth because she realised that being a vegetarian was already unusual enough in the context of the maternity hospital. According to Běta, the period right after the delivery was very difficult and demanding because 'a woman is very fragile in a way'.

The kind of requirements that my participants had and the nature of their demands reflect a wider tendency among Czech women to view birth care as a kind of 'menu' of particular services offered by different maternity hospitals [see Hrešanová 2011: 71]. There are similar trends in other countries of the region. For instance, in post-socialist Russia, Rivkin-Fish [2005: 207] observed how Russian health-care facilities had developed and offered a complex set of options to meet the 'needs and wishes' of their 'clients'. A decade or two earlier similar trends had emerged in many Western countries. In North America Lippman [1999] showed that the concept of 'choice', whereby women assumed more control over childbirth, was replaced by 'multiple menus' of birth-care services instead. The nature of my participants' requirements reflects their wider understandings of birth care, and the women I talked to substantially differed in this regard.

### **Women's notions of birth care**

Amongst the eight participants of this study I identified several approaches to and conceptualisations of birth care, which were also shared by the 32 women I interviewed during my previous ethnographic study [cf. Hrešanová 2011]. Here I approach these eight cases as a baseline to illustrate the diversity of understandings of birth care among women, while I acknowledge that the categorisation outlined below is not and cannot be fully exhaustive. There are three distinct features that distinguish the different ways in which women understand birth care. The most striking feature is the woman's attitude towards medical interventions (1); therefore, I use it here as the criterion according to which I list the identified notions. The second feature (2) is the woman's knowledge about birth care. The final feature is the woman's view of her own position and subjectivity in relation to the birth-care providers and the level to which this perception is influenced by consumerism (3). On a scale of possible conceptualisations of birth care, I identified five different categories of birth-care notions that could be observed among my interviewees. The first two categories of women unconditionally accept the medicalised model of birth care, but differed from each other by the degree to which they were informed about medical interventions and actual birth-care practices.

The first notion of birth care conforms to the care currently provided. It accepts the current state of care no matter what kind of care it is or how embedded it is in the medical model of birth care. Women who adhere to this notion accept care 'as it is', and regard it as something 'that has to happen'. They consider it a

norm and call it 'normal', thus positioning themselves into the role of 'patient', though they did not explicitly express things that way themselves. This notion is associated with a low level of awareness of what options exist for women in the birth-care system. This may be the result of a conscious decision 'not to be informed'. Gabriela as well as some other women whom I interviewed during my previous ethnographic study [Hrešanová 2011: 71] were convinced that 'too much information is harmful' and that it is, therefore, better 'not to bother oneself with it' (Gabriela). A low level of birth-care awareness may also be the result of other circumstances, such as being busy or pressed for time.

The second notion conforms to the classic medical model of childbirth and birth care. It differs from the previous conceptualisation in that it includes the desire to know more about the medical interventions and technology involved in childbirth. For example, Hana was generally very well informed about why certain medical procedures were performed and she generally accepted explanations from health-care workers as to why particular medical interventions were necessary. She regarded the doctors as authorised to check the woman's condition themselves using the appropriate technology and not just take her word for it. For example, she told me that: '... they saw on my monitor that I was having contractions and they check to see if you're pretending to have them or not ...' She considered paternalism in the medical profession to be legitimate, as did Cécilie, Gabriela and Hana, who had internalised biomedical arguments and accepted the related treatment to prevent any possible medical problems. These women seemed to be convinced that the birthing process is inherently risky and viewed doctors as the authority entitled to make all the decisions. This is best illustrated by the case of Hana. She describes how the midwife brought her breakfast in the morning. She refused the breakfast on the grounds that she was told to come to the clinic on an empty stomach. The midwife had to persuade Hana to eat by quoting a doctor.

Běta's perspective represents well the third possible notion of birth care. Běta agreed, in many respects, with the medical model of birth care, yet differed from women who adopted the second conceptualisation of birth care in that she significantly criticised the actual care. Having a professional background in nursing and addiction studies, she herself was experienced in providing health care as a special kind of 'service'. Unfortunately she was not treated like a 'client' at the maternity hospital when she gave birth. Her critical view of birth care was significantly based on how she viewed her position in the whole birth-care system. Běta considered the right to an informed choice and the concept of personal responsibility as crucial needs in childbirth; in her view the relationship between health-care provider and user should be a relation of equal partners. Běta was also very well informed about the possibilities of birth care during pregnancy and educated herself further in this field. We may conclude that what is distinct about this birth-care conceptualisation, like in the fifth notion of birth care, is a particular kind of subjectivity that is highly influenced by the idea of consumerism.

The fourth notion of birth care favours non-medicalised birth care, minimal medical interventions in the birthing process and alternative birth practices in general. Most Czech maternity hospitals, however, view these practices as *non lege artis* and tend to insist on performing at least some medical interventions (especially the administration of oxytocin after the delivery). Dana told me that her preference was to have an 'alternative' form of childbirth, but after she had assessed her options and the sources and care offered in the maternity hospitals available to her, she reconciled herself with the idea of not being able to have the birth care she wanted. Dana was well informed about different birth-care practices and had learned about them from books, internet sources, and a magazine called *Aperio*, which promotes alternative parenting practices. However, while she was generally aware of birth-care alternatives, she had rather poor *particular* knowledge, as she did not know where (in which maternity hospitals) these birth-care practices were offered, probably because at a certain point she decided not to pursue her wishes further. In this regard her approach was the closest to the views of the women who participated in Hašková's study a decade earlier. Hašková [2001a] observed that women from various educational backgrounds were generally very knowledgeable about childbirth and birth care and often read expert literature on the topic; but they were paradoxically largely uninformed about particular birth-care options (such as the option to refuse shaving, an enema or episiotomy, or to have or refuse various kinds of anaesthetics or analgesics) in maternity hospitals in which they received care [ibid.: 31].

The fourth notion of birth care is that of the women who shared a preference for non-medicalised birth care and were able to articulate their (alternative) birth-care wishes, but who in the end largely conformed to the mainstream medicalised standard of care and gave up their demands. Dana, and some of the women I talked to in my previous ethnographic study of maternity hospitals [Hrešanová 2011: 72], seemed to some extent to adopt the subjectivity of a birth-care 'consumer'. But in the end they resigned from exercising the power that is attributed to such a position in the system. Instead, the birth-care providers continued to have the main decision-making power over birth care, and these women were left in a position that I would call 'disciplined consumers'.

The fifth notion of birth care is represented by the opinions of Alena, Eva and Františka. Although they differ in some aspects, they all criticised the medical model and adopted the idea of consumerism. Their notion of birth care revolves around informed choice and free decision-making, and involves specific requirements for birth care. However, these requirements were shown to be in conflict with the practices of the hospital. Alena demonstrated the strongest consumerist approach. She understood birth care as a service that is offered, and regretted that the Czech system does not enable women to give birth at home. She added that she was willing to 'pay extra' because the opportunity to apply one's own ideas about birth care 'is worth it'. In her view, key decisions about birth care should not be made by health-care providers, the choices should remain with the women (or parents) themselves. She told me:

I actually believe that the mother should be the one who drives the decisions about what goes on! Of course, I don't mean that the mother can throw the baby out the window if she wants, but ... The mother or the parents are one hundred per cent responsible for the child and if the mother says she wants this and that, then they [medical workers] should oblige. I really believe this. (Alena, 31, one child)

For these women it was imperative to have certain things under their own control, whether it was the matter of using tranquillizers or the possibility of having the baby by their side. On the whole, this birth-care notion is most closely linked to the specific subjectivity of an autonomous individual who strives to make decisions about her health care on her own, i.e. relatively independently of medical authorities. At the same time she is willing to take responsibility for her decisions, which she bases on her generally high level of knowledge about birth care and childbirth issues. The following table summarises key features of these birth-care notions.

**Table 1. An overview of birth-care notions**

| Birth-care notion | KEY ASPECTS OF THE FIVE BIRTH-CARE NOTIONS  |  |  |
|-------------------|---|--|--|
|                   | Medicalisation of birth care  | Birth-care awareness/knowledge   | The position and subjectivity of women in relation to birth-care providers                     |
| 1                 | Unconditional acceptance of the current form of birth care  | Low birth-care awareness and knowledge of birth-care practices           | 'A woman is a patient' (an inexplicitly expressed view)  |
| 2                 | Unconditional acceptance of the medical form of birth care  | High birth-care awareness and knowledge                                  | 'A woman is a patient' (an explicitly articulated view)  |
| 3                 | Critical acceptance of the medical form of birth care   | High birth-care awareness and knowledge                                  | 'A woman is an autonomous consumer and a responsible patient equal to the birth-care provider' |
| 4                 | 'Surrender' to the mainstream medicalised birth-care model despite a personal preference for non-medical birth care | Good general awareness, low knowledge of particular birth-care practices | 'A woman is a disciplined consumer'  |
| 5                 | Hypercritical – denial  | High awareness and knowledge   | 'A woman is an autonomous consumer exercising informed choice, free decision-making'           |

## Conclusion

This text discussed the birth-care experiences of eight women. The birth narratives revealed the women's different understandings of birth care, and while these eight cases cannot and are not intended to make a statement about the Czech birth-care system generally, I believe that they still provide valuable insights into the Czech birth-care system and the factors shaping a woman's childbirth experience.

First, they demonstrate that women have different expectations and understandings of birth care. Altogether, I identified five different birth-care notions. These ranged from the view where birth care was not considered anything special to think about to an outlook based on detailed knowledge of birth-care practices. Women also differed in the extent to which they accepted medical authority over managing the process of childbirth; some of them accepted this, while others claimed their own authority to make decisions about birth care. Three of the five birth-care notions in varying degree adopt the rhetoric of consumerism and neo-liberal subjectivities, both of which are accompanying features of the post-socialist reforms of the health-care system. Of course these are not exclusive to the Czech context and are observed in other post-socialist countries, too. Based on qualitative research in Russia, Temkina and Zdravomyslova [2008] showed that some women had become demanding and knowledgeable' [ibid.: 277] about birth care and approached paid services as 'more reliable and better organized' [ibid.: 285]. Similarly, some of my participants advocated that 'it's worth it to pay extra' because it meant they got the conditions under their control and believed that this would translate into better health services and health. These women are like Temkina and Zdravomyslova's respondents, who considered themselves to be 'responsible consumers' [ibid.: 287], and therefore 'obtain[ed] specialised medical knowledge and became experts in reproductive health' [Temkina and Zdravomyslova 2008: 289]. These similar birth-care views, however, relate to birth/health-care systems with strikingly different degrees of 'marketisation' in their birth care.

Second, these eight birth narratives also point to tensions in provider-receiver relationships, which constituted one of the most prominent themes. I have argued that the frustration women feel about birth care reflects a clash between different understandings of birth care: an understanding descended from the socialist era and understandings that have arisen with the post-socialist reforms. Women, whose understandings of birth care were influenced by the neo-liberal discourses around health and the idea of consumerism, strove to exercise an informed choice in birth care and often made informed decisions about where to give birth. They also expected to be equal partners with their health-care providers and were ready to accept responsibility for their choices and health. These participants also understood health care generally as a service. Hasmanová Marhánková [2014] described similar forms of subjectivity in relation to medical authorities among parents rejecting compulsory vaccination of their babies. In maternity hospitals many of my informants faced a different reality. Midwives and doctors did not provide them with enough information and treated them in a paternalistic way. Most of my in-

formants whose main priority was *to be informed* considered poor communication and a lack of information about health and health care as the key deficiencies of care. Similarly, women who participated in Hašková's study [2001a] a decade earlier expressed the same disillusionment about not being informed. This may be something characteristic of the health-care system as a whole, as Křížová [2006: 122] has observed a general lack of respect for the idea of patients making informed choices among Czech physicians working in different medical fields. According to her, doctors say that they don't have time to communicate more with patients.

My participants viewed the paternalistic style of communication and unfriendly treatment as a socialist legacy. In the first part of the paper I showed that this style of interaction between birth-care providers and birthing women was common in socialist hospitals. Impersonal birth care and rude behaviour were actually long-term issues that people complained about and had been regularly discussed in medical journals since the 1950s. The current birth-care system offers women more alternatives, but the very same shortcomings in care continue to exist. The birth narratives revealed that the agency of women to exercise informed choice was frequently restricted in hospital settings in a manner similar to the way it used to be during the socialist period, despite the consumerist and neo-liberal discourses that stress the opposite. But a lack of communication and authoritarian behaviour cannot be simply understood as the malpractice of individual midwives and physicians. The interactional level of birth care provision is shaped by and embedded in a wider organisational, structural and political context. Thus, women's birth-care experiences always reflect wider structural arrangements.

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