South African media and childbirth: an analysis of *Living and Loving*

By

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Declaration

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December 2021

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Abstract

The South African private healthcare sector has the highest Caesarean section rate in the world. According to the latest study completed by the Council for Medical Schemes (CMS), approximately 77% of babies are delivered by Caesarean section in the private sector costing around R42,400 per operation compared to between R16,900 – R25,400 per vaginal birth (CMS, 2020:12). There has been an urgent calling for the reduction of what is likely to be extreme levels of medically unnecessary Caesarean section delivery rates. In the same breath, there has been a higher demand for a move away from medicalised births to a return to more natural ones involving less unnecessary intervention in low-risk pregnancies and labours. While the issue of medicalised birth is a multifaceted one, there is speculation as to whether the media has a role to play in painting birth and labour as an event filled with fear and risk that requires urgent, expert medical intervention. This study seeks to understand whether the popular *Living and Loving* magazine, that focuses on pregnancy, birth, and labour, amongst various other topics, portrays a dominant message concerning childbirth in its publication, and whether this message has changed over the years since its origination in the 1970s. Such a study will inform journalistic practices and demonstrate evidence as to whether journalists are sufficiently enabling readers to make informed decisions about childbirth by trusting the information from such a media product. A content analysis was completed of all articles relating specifically to birth published in *Living and Loving* between 1970 and 2019. Academic research in this area is limited in South Africa. A study such as this one is necessary in order to decipher as to whether the media are to blame for the number of discourses presently going on concerning Caesarean section rates, midwife-led births, and vaginal births. A major finding was that *Living and Loving* magazine seeks to actively educate women so that they can make empowered decisions regarding their birth plan. While the magazine was thorough in providing the pros and cons of all birth options, it was clear it leaned more towards vaginal birth without unnecessary intervention. However, this message changed slightly as the years went on, and it is assumed this is due to societal and journalistic pressures to remain objective and balanced as a publication.

Opsomming

Die Suid-Afrikaanse private gesondheidsorg sektor het die hoogste voorkoms van keisersnee-operasies ter wêreld. Volgens die jongste studie van die Raad op Mediese Skemas (RMS) word ongeveer 77% van babas deur middel van ’n keisersnee in die privaatsektor gebore, teen ’n koste van ongeveer R42,400 per operasie, vergeleke met tussen R16,900 – R25,400 per vaginale geboorte (CMS, 2020:12). Daar word ’n ernstige beroep gedoen vir die vermindering van uitermatige hoë vlakke van medies-onnodige keisersnee-bevallings. In dieselfde asem is daar ’n groeiende aanvraag vir ’n wegbeweeg vanaf gemedikaliseerde geboortes na ‘n meer natuurlike geboorte wat minder onnodige intervensies behels in die geval van lae risiko swangerskappe en bevallings. Terwyl die kwessie van gemedikaliseerde geboorte vele fasette behels, word daar gespekuleer tot watter mate die media daartoe bydra om ’n beeld te skep van geboorte en bevalling as ’n gebeurtenis wat met vrees en risiko geassosieer word en wat altyd dringende, spesialis mediese intervensie vereis. Hierdie studie poog om te verstaan of die gewilde *Living and Loving* tydskrif, wat op swangerskap, geboorte en die bevalling fokus, tesame met verskeie ander onderwerpe,’n dominante boodskap betreffende kindergeboorte weergee, en of hierdie boodskap oor die jare verander het sedert die tydskrif in 1970 gestig is. Sodanige studie sal joernalistiekpraktyk belig en bewys lewer dat joernaliste lesers genoegsaam in staat stel om ingeligte besluite rakende hul kind se geboorte te neem deur die inligting van daardie spesifieke media produk te vertrou. Daar is beperkte navorsing in dié veld in Suid-Afrika. ’n Studie soos hierdie is dus nodig om te bepaal of die media die skuld moet dra vir die vele diskoerse wat tans gevoer word oor keisersnitte, die rol van voedvroue en vaginale geboortes. Die bevindings van hierdie studie is gebaseer op ’n inhoudsanalise van alle artikels oor geboorte wat tussen 1970 en 2019 in *Living and Loving* gepubliseer is. ’n Belangrike bevinding is dat die tydskrif *Living and Loving* aktief daarna gestreef het om vroue sodanig in te lig dat hulle bemagtig is om goeie besluite oor hul geboorteplan te neem. Terwyl die tydskrif baie deeglik was in die oorweging van die voor- en nadele van alle geboorte opsies, was dit duidelik dat dit meer ten gunste was van vaginale geboortes sonder onnodige intervensie. Met die jare het hierdie boodskap egter ’n verandering begin ondergaan, waarskynlik as gevolg van samelewingsdruk op joernalistiekpraktyk om aan die vereistes van objektiwiteit en balans te voldoen.

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Chapter 1: Background

1.1. Scope of study and research problem

Mass media have an impact on our decision-making regarding health and wellbeing. The mass media encompass television programs, films, magazines, advertisements, and more (Theroux, 2011:62). According to the hypodermic needle theory, emerging from Harold Lasswell in the 1920s, the mass media were seen as all-powerful, its content directly affecting audience decision-making (Babbie & Mouton, 2001:34). While a number of theories, such as Stuart Hall's socio-cultural approach (1980:129) and McCombs and Shaw's gatekeeper theory (1972:177), have attempted to offer more nuanced explanations of the mass media's power, most theorists agree that the mass media have an important role to play in shaping people's perceptions, even though this still cannot necessarily be proven as a direct link (see for example: Wakefield, Loken & Hornik, 2010; Gottfredsdottir, Magnúsdóttir & Hálfdánsdóttir, 2015 & Pentescua, Cetinb & Orzanb, 2015).

Against this background, an important question is to what extent the mass media have an impact on a mother's childbirth plan, the way in which she desires for her foetus to be born, if any. Research completed by Holdsworth-Taylor in 2010 showed that expecting mothers increasingly base their childbirth decisions and birth plans on what they see on the internet, television, and on what they hear or read in the media. It has also been noted in research completed by Luce, Cash, Hundley, Cheyne, Van Teijlingen, and Angell (2016:1) that the portrayal of birth in the media is often dramatic, sensationalised, and comical, rather than realistic. Simultaneously, adolescents will often be exposed to childbirth and develop both an understanding and assumption of it, based on its representation in the mass media (Kitzinger & Kitzinger, 2001:60).

Few studies exist that explore the impact mass media have on the public's perceptions of childbirth (Seale, 2002:198). However, the little research that has been done, reveals the effects that the portrayal of childbirth by different types of media have on women's perceptions; this includes reality television shows, movies, magazines, newspapers, and social media. In their study, Luce *et al* (2016) explored the influence of the mass media on first-time pregnant women. A scoping review of 56 publications that investigated the effects of the media on perceptions of childbirth, revealed three themes: the medicalisation of childbirth, women using media to learn about birth, and the idea of childbirth missing from life as an everyday event (Luce *et al*., 2016). The first two of these themes are explored in this study, as they reoccurred in other research when completing the literature review, such as; Gottfredsdottir, Magnúsdóttir and Hálfdánsdóttir (2015), Panazzolo and Mohammed (2011), Lyerly (2009), and Oosthuizen, Bergh, Grimbeek and Pattinson (2017). The results of Luce *et al* (2016:7) showed that the mass media predominantly promote a medicalised birth whereby the mother

is passive in the birthing process, and that there is an absence of "normal" birth in the media. The study's authors (Luce *et al*., 2016:6) suggested the following reason for this:

> Redefining childbirth as pathological helped justify doctors' authority over the birthing process, legitimised by their specialised knowledge. By medicalising childbirth, the medical establishment rendered both women and midwives as passive agents in the birthing process. The female body, thus, was reduced to an inferior status, and childbirth was now something that was 'performed' on a woman, rather than something women performed (Luce *et al*., 2016:6).

A secondary reasoning for the medicalisation of birth, is the prevailing worldview enforced by the media that childbirth is a dangerous, risky and extremely painful experience; so much so, that medical intervention is needed in order for the process to be as safe as possible (Bryant, Porter, Tracy & Sullivan, 2007:1192.) According to Luce *et al* (2016:2), the media may seek to maintain the dominant ideology that childbirth needs medical intervention, because intervention leads to drama and drama attracts an audience. For example, in television, entertainment value is of the utmost importance (Luce *et al*., 2016:4). Kitzinger and Kitzinger (2001:61) provided an example of this in action:

> TV has produced a powerful mythology of birth. The drama of this myth is in the medical emergency, the speeding ambulance, the urgent bleep, and the struggles of a team of doctors and nurses to combat death. There are heart monitors on which the trace flattens out, Caesarean deliveries, massive haemorrhages, resuscitation of the baby. It is a drama that feeds the fears inherent in the dominant medical model of birth and, in this way, it conditions pregnant women to submit to its rituals (Kitzinger & Kitzinger, 2001:61).

The above quote describes how natural birth or home birth will not produce the same effect in the media, and by dramatising hospitalised births, women are conditioned to expect the same from their birth experience (Squire, 2003:183). However, do we find a similar trend towards entertainment in the print media and specifically specialist pregnancy magazines?

1.1.1. Pregnancy Magazines

According to Consalvo (1997:52) "women's magazines can be criticised for many things, but they are important sources of information about women's health". Previously, women's magazines published articles concerning topics such as child rearing, pregnancy and birth, but it was only around the 1920s when the first women's magazines focusing primarily on these topics, began to emerge (Freidenfelds, 2019:130). Freire (1970) describes how it was also around this time that medical knowledge, aimed towards the rearing of children and navigating pregnancy, developed and became more scientific. In the United States, *Parents* magazine was first published in 1926. *Parents* saw itself

as a "service magazine" that included advice articles on topics ranging from early pregnancy to late adolescence (Schlossman, 1985:65-77). The magazine's goal was to disseminate scientific knowledge of all kinds, covering subjects like children's development and family life at home (Schlossman, 1985:65-77). According to the Alliance for Audited Media, as of 2020, the magazine's circulation was 2,210,329.

Around the same time *Parents* magazine entered the world of print media, *Life* magazine, which had been in circulation since 1883, was bought by *Time* magazine in 1936 (Tucker, Unwin & Unwin, 2019). Its first publication since the acquisition featured what would come to be known as an iconic and brilliant opening picture: that of a doctor in a crowded delivery room, holding a newborn baby and captioned with the words "Life begins". *Life* went on to follow the life of that baby, George Story, through his marriage, having children of his own, and the pursuit of his career as a journalist (Sumner, 2010:89). A few days after *Life* announced it would be closing its doors, Story died of heart failure, which *Life* went on to write about in its very last publication, captioned with the words "A Life Ends" (Sumner, 2010:89).

Mother and Baby, known as "UK's No.1 Pregnancy, Baby and Toddler Magazine"(About us, 2020), started in 1956 to fill the gap in the market, where birth-focused publications within print media in the United Kingdom were missing (McIntosh, 2017:2). However, it was only by the 1970s that the first picture of childbirth was printed, and personal birth stories became more entrenched in the messaging of the magazine (McIntosh, 2017:2). In a study completed by McIntosh (2017), the changing messages about women's preferred place of birth was explored in relation to *Mother and Baby*. The findings suggested the content of the magazine mirrored changes to national policy between 1956 and 1992, as it moved from home birth to predominantly hospital birth. This was evident in both the language and the structure of the magazine content (McIntosh, 2017:5). In South Africa, four magazines focussing primarily on birth and pregnancy are *Living and Loving*, *Your Pregnancy*, *Mamas & Papas*, and *Baba & Kleuter*. The table below shows the latest circulation numbers collected by the Audit Bureau of Circulation (ABC) which was the fourth quarter (Q4) of 2020.

Table 1: Magazine circulation for quarter four 2020

Publication	Period	Frequency	Paid circulation	Free circulation	Total circulation
Living and Loving	Magazine moved online exclusively on August 2019				
Your Pregnancy	July – December	Alternate Months	6,221	134	6,355
Mamas & Papas	October -December	Monthly	0	0	Discontinued
Baba & Kleuter	July - December	Alternate Months	7,568	0	7,568

Starting out in September 1970, *Living and Loving* was the first pregnancy magazine to emerge in the South African print media environment and while the magazine still exists today, it moved online exclusively in August 2019 (Bizcommunity, 2019). At the time of writing, there was limited evidence of research exploring the relationship between pregnancy magazines and childbirth in South African.

1.1.2. The history of birth in South Africa

The first state registered nurse-midwife in the world was Sister Louisa Jane Barrett who trained in Kimberley, South Africa in the 1890s (Abrahams, Jewkes, Mvo, 2001:240). Today, the South African midwifery profession is regulated by the Nursing Act, Act No 3 of 2005 and the regulatory body of midwifery is the South African Nursing Council (SANC) (South African Nursing Council, 2019). In order to practise as a nurse in South Africa, one has to undergo training involving general nursing, community nursing, psychiatry and midwifery; while full-time midwives are expected to undergo the usual nursing training and follow that with an advanced diploma in midwifery (Maidment, 2018). Birth in South Africa is said to have been shaped by colonisation and the history of the apartheid system (Abrahams, Jewkes & Mvo, 2001:240). In 1994, Shula Marks published a book telling of her experience of the nursing system in South Africa, describing how pre-1994, nursing was a profession for white English-speaking women, and racial tensions developed as the profession became more democratic, post-apartheid (Marks, 1994). As a response to disparity, the National Health System implemented a new approach to primary healthcare in 1994 in order to ensure disadvantaged communities received access to basic healthcare services (Abrahams, Jewkes & Mvo, 2001:240). As a part of the South African National Health System, the majority of all primary maternity services in the public sector are provided for by midwives/nurses (Abrahams, Jewkes & Mvo, 2001:240). Midwives also work independently in South Africa. Some open their own private practices or birthing centres where they can sometimes be supported by private obstetricians who they will call on for emergencies or refer to when approached by women who have high-risk pregnancies (Abrahams, Jewkes & Mvo, 2001:241). However, obstetricians supporting midwives is a declining phenomenon in some parts of the world. According to a World Health Organization study (2016) exploring the voices of midwives, the following findings were found from various countries:

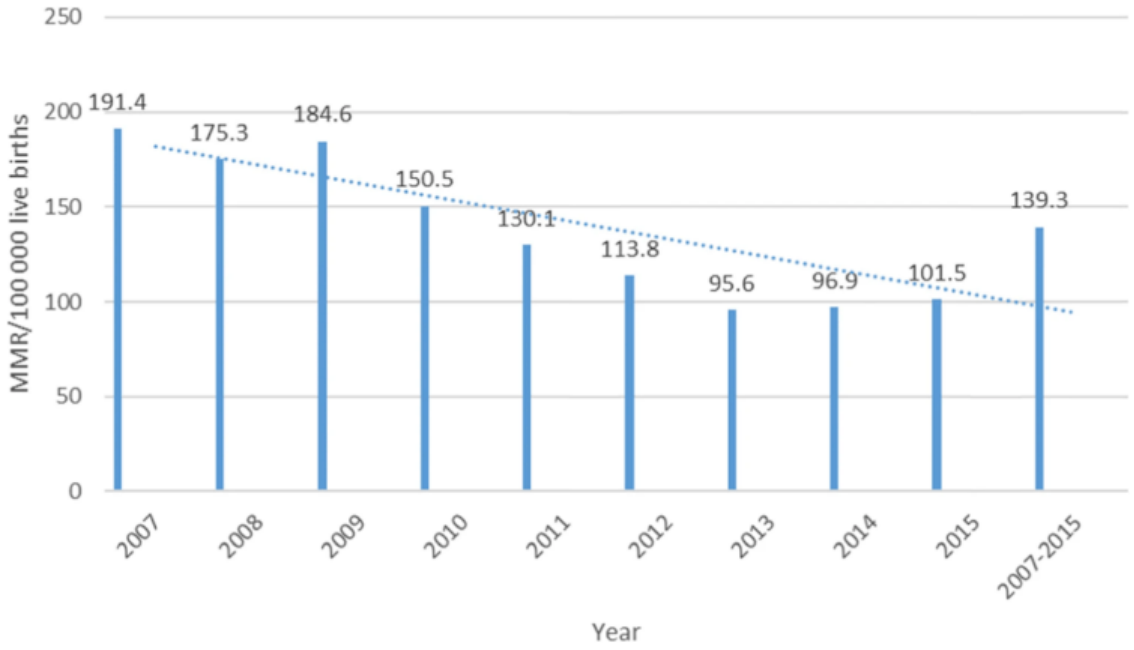
- European country: Obstetricians are sometimes disrespectful and don’t value our work.
- Greece: Obstetricians have taken over childbirth and midwifery personnel work mostly as their obstetric nurses, following orders and discouraged to voice their opinion.
- Malta: Midwifery personnel are not independent practitioners in Malta but are subservient to the medical profession.

- Turkey: The public see midwifery personnel as caregivers or nurses' aides and midwifery laws are incomplete and inconsistent. There is a medical domination of the maternity care system.

In South Africa, the same sentiments are echoed, as fewer obstetricians are willing to support private-led midwives (Fokazi, 2019). As a response, the Right to Birth SA movement was launched in October 2019 by Glynnys Garrod, a midwife and the founder of Birth Options, in collaboration with first-time moms Courtney Atkinson and Nikki Banner. This movement is a response to the possibility of "midwifery-supported birth" disappearing in South Africa as more obstetricians and gynaecologists are moving away from this kind of birth due to the higher risk for litigation (Fokazi, 2019). During the launch, various registered midwives and doulas (a person who provides emotional and physical support during labour and childbirth) shared their stories and responses towards the rising number of private sector hospitals terminating their relationships with midwifery teams (Mamacos, 2019). In 2020, Birth Options announced the closing of their doors as of July that year, as the midwives had been "unable to secure reliable private Obstetric back-up and Private Hospital support" to continue with their services (Birth Options Midwifery Team, 2020). The team showed considerable concern over the ever-increasing medicalisation of childbirth and the rising number of Caesareans in South Africa (Fokazi, 2019).

The first recorded C-section in Africa was in the early 1800s, performed by James Miranda Stuart Barry, who was later discovered to be a woman by the name of Margaret Ann Bulky (Holland, 2019). Barry disguised herself as a man for the majority of her adult life in order to receive a formal education and practise as a doctor (Holland, 2019). From 1910 to 1994 the maternal mortality rate (MMR) in South Africa was high, although there is not a lot of research to provide the exact numbers (Coovadia, Jewkes, Barron, Sanders & McIntyre, 2009). However, it was found that the MMR for South Africa in 1980 was 208 per 100,000 live births (Hogan, Foreman, Naghavi, Ahn, Wang, Makela, Lopez, Lozano, Murray, 2010). In 1998, this number dropped to 150 maternal deaths per 100,000 live births, increasing to 311 in 2009 (Statistics South Africa, 2015). According to the 2016 South African Demographic and Health Survey, the MMR during the seven-year period before the release of the survey, was 536 deaths per 100,000 live births. As of 2017, South Africa's MMR has decreased to 134 deaths per 100,000 live births (Saving Mothers 2017 Annual Report, 2017).

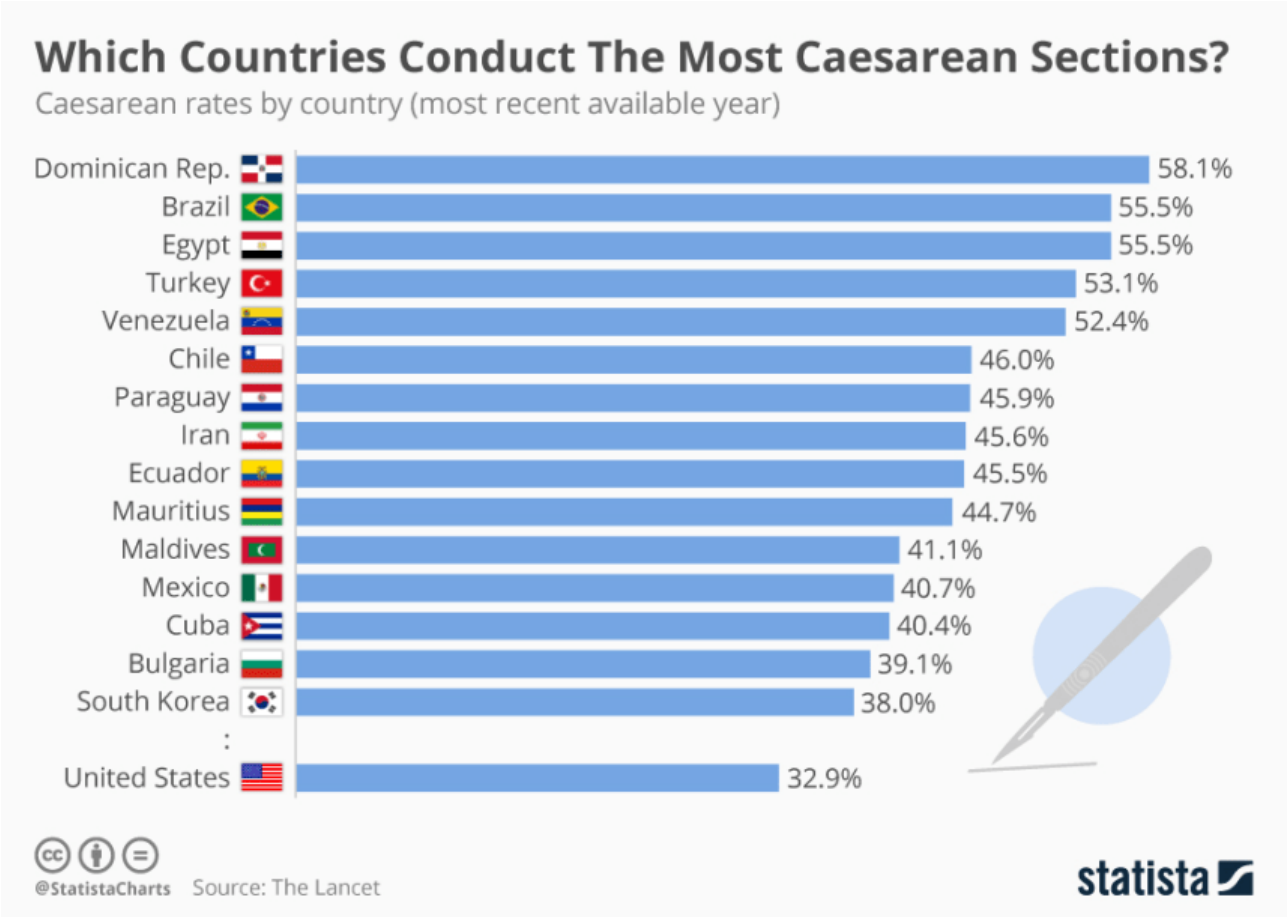
The graph below retrieved from Statistics South Africa (2015) demonstrates the maternal mortality ratio per 100,000 live births by year for South Africa from 2007 to 2015.



The country has made significant progress in decreasing MMRs over the years, specifically due to the availability of antiretroviral programmes for HIV-positive pregnant women (Moodley, Fawcus & Pattinson, 2018:4). However, according to a study published by *The Lancet Global Health* in 2019 which involved over 3,500 mothers from 22 African countries, the MMR rate following a C-section is 50 times higher in Africa compared to high-income countries (Bishop *et al*., 2019). The results suggested peripartum haemorrhage and anaesthesia complications were the primary causes of death (Bishop *et al*., 2019).

According to the latest study (2020) completed by the Council for Medical Schemes (CMS), the 2018 rate of Caesarean deliveries in the South African population covered by medical aid was 76.9%, among the highest rates in the world. This is considering that in 2018, the country with the highest C-section rates across public and private healthcare was the Dominican Republic at 58.1%. (*Boerma et al, 2018*).

The graph below (created by Statista based on the findings of Boerma *et al*, 2018) represents Caesarean section rates per country for the most recent available year.



Whereas the table below represents the comparison between Caesarean section rates in the public versus private medical sector between 2006 and 2015 (Solanki, Cornell, Daviaud & Fawcus, 2020).

Province	Public sector 2006	Public sector 2015	Private sector, 2015	Public sector movement, 2015 v. 2006	Private v. public difference, 2015
North West	12.6	27.6	86.5	15.0	59.0
Northern Cape	11.0	16.3	74.7	5.3	58.4
Free State	11.6	16.0	72.9	4.4	56.9
Limpopo	15.1	22.3	73.4	7.2	51.1
Gauteng	13.7	25.6	75.0	11.9	49.5
Mpumalanga	13.1	19.3	68.2	6.2	48.8
KwaZulu-Natal	21.1	28.8	76.8	7.6	48.0
Eastern Cape	9.5	22.7	66.1	13.2	43.4
Western Cape	19.9	28.1	68.2	8.2	40.1
SA	15.1	24.1	73.6	9.0	49.5

CS = caesarean section; SA = South Africa/n.

The CMS advised urgent steps to be taken to reduce the "high levels of medically unnecessary Caesarean delivery rates in the medical schemes population" and suggested the following reasoning behind these high rates:

> The high frequency of Caesarean deliveries in the private sector may be indicative of inefficient use of healthcare resources, supplier induced demand, lack of coordinated maternal care and poor choices by members of medical schemes. Caesarean deliveries attract higher

> healthcare costs for hospital, specialists, pharmaceuticals and other healthcare services compared to normal vaginal deliveries (CMS, 2020).

In the public sector, the Caesarean rate was reported as 27.4% (Saving Mothers 2017 Annual Report, 2017). In the fifth Saving Mothers Annual Report, it was declared the maternal mortality rate between 2011 and 2013 was three times higher for pregnant women having Caesarean delivery versus vaginal delivery (Saving Mothers Annual Report, 2017:47). The same finding was discovered in the sixth Saving Mothers report for 2014-2016 (Saving Mothers Annual Report, 2017:47). In response, the *South African Medical Journal* released an advocacy publication for their 106th volume entitled 'Maternal deaths from bleeding associated with Caesarean section: A national emergency' (Fawcus *et al*., 2016).

However, according to Schlosberg and Templer (2010:37) giving birth surgically in South Africa is often perceived as safer and less likely to involve complications than vaginal delivery, despite a woman experiencing a low or high-risk pregnancy. However, Professor Rob Pattinson, director of the Medical Research Council's maternal and infant health care strategies research unit, has completed research on Caesareans in the public medical sector, and his results have shown the risk of maternal death was higher for Caesareans, compared to vaginal birth (Koen, Snyman, Pattinson & Makin, 2016). Pattinson is quoted describing how a "major concern is the complications that are associated with them…haemorrhaging is much more common for C-sections…subsequent pregnancies also have a higher complication rate" (Fokazi, 2011).

Professor Lynette Denny, who is the head of obstetrics and gynaecology at the University of Cape Town (UCT) and Groote Schuur, rejects the notion that a Caesarean is a safer form of childbirth, calling it a false perception:

> Women are being duped into believing that a C-section is easier, quicker and that it will prevent injury to the bladder and rectum. That is not true. Unnecessary interventions in childbirth, such as C-sections without medical indication are, in my opinion, not only bad practice but an assault on women and their babies, and should be discouraged at all costs (Fokazi, 2011).

In response to these notions, specifically the Right to Birth Movement, South African obstetrician and gynaecologist Peter de Jong said lawyers target vaginal births when suing doctors because it is regarded as high-risk, and obstetricians in South Africa pay approximately R1.3 million annually in risk-cover premiums (Fokazi, 2019), he continued:

> Unfortunately, obstetrics is fraught with medico-legal complications. In a case where delivery goes wrong, an obstetrician, who has an unlimited risk insurance cover, is more likely to be

> sued than a midwife. While obstetricians don't necessarily have any issues with midwives, it's just not worth the risk in the end (Fokazi, 2019).

In 2017, the South African Association of Obstetricians and Gynaecologists president, Dr Johannes van Waart said the insurance cover annual cost was R250,000 in 2013, R850,000 in 2017, and was expected to become R1 million in 2018 (Emmett, 2017). Research has been completed in South Africa to explore this perceived notion amongst both the public and obstetricians/gynaecologists. Keeton (2010:21) suggested the reasons for high rates of Caesarean section deliveries in South Africa are related to medical aid scheme membership and wealth, rather than curtailing childbirth risks. A research study (James, Wibbelink &Muthige, 2012:408) suggested the issue lies in midwives not being given full access to the care of pregnant women but are expected to take a step down to the obstetricians/gynaecologists. An international study, described by *Health24* (2018) as a "first-ever study" to reveal the real reasons for why doctors choose C-section over natural birth, involved 7,785 obstetricians and 1197 midwives from 20 different countries. The authors, Panda, Begley and Daly (2018) said the reasoning behind the study was to gain an understanding for Caesarean section rates increasing worldwide, from the point of views of obstetricians and midwives. Three main themes emerged from the results (Panda, Begley & Daly, 2018):

- Theme 1: clinicians' personal beliefs (professional philosophies; beliefs in relation to women's request for CS; ambiguous versus clear clinical reasons)
- Theme 2: health care systems (litigation; resources; private versus public/insurance/payments; guidelines and management policy)
- Theme 3: clinicians' characteristics (personal convenience; clinicians' demographics; confidence and skills).

Peter de Jong echoed these themes in an interview that *Cape Argus* published under the title "Why being a gynae 'is not worth it'":

> Doctors go to private practice because they want to earn a decent living, but this is no longer rewarding. My first 90 deliveries in a year cover my insurance premiums only before any overheads. I've never heard of any doctors who were sued for doing a C-section, but many of the doctors I know have been sued for doing a normal delivery. Whenever something goes wrong with normal delivery, lawyers always ask 'why didn't you do a Caesarean… didn't you see the potential of things going wrong?' (Fokazi, 2013).

South African physicians are not the only ones facing this dilemma – it is a problem in many countries (Betrán, Temmerman, Kingdon, Mohiddin, Opiyo, Torloni, Zhang, Musana, Wanyonyi, Gülmezoglu, & Downe, 2018). A Caesarean is commonly believed to be a safer procedure, even though this

argument lacks scientific evidence (Jena, Schoemaker, Bhattacharya & Seabury, 2015). As a result, Kravitz, Rolph and McGuigan (1991) argue physicians are more likely to be sued for vaginal delivery complications compared to unnecessary Caesarean complications, even without evidence of error. According to Betrán *et al* (2018), this situation may then lead to physicians encouraging Caesarean deliveries for their own protection instead of focusing on the needs of the mother and unborn child.

1.1.3. Research problem

The aim of this study is to explore whether there is a dominant message concerning childbirth in the South African pregnancy and baby magazine, *Living and Loving*, and whether this message has changed over the years. This will be done by completing a content analysis of articles focusing predominantly on childbirth from *Living and Loving* magazine and noting the mention of certain words relating to childbirth and birth methods, throughout the years.

The content analysis will cover the entire duration of the publication's existence as a print magazine; from September 1970 to September 2019. While research has been completed in South Africa on the statistics surrounding childbirth and how these have changed dramatically over the decades, little research has been completed on the media's involvement in this messaging. At the time of writing, preliminary research on several databases indicated that no research has been conducted primarily on whether the mass media select and reinforce a dominant ideology regarding childbirth methods. According to Claassen (2011:351), it is important to raise the standards of science and health reporting in South Africa. This research is therefore important as it is imperative that people are made aware of the true realities of childbirth, and of the possible external influences impacting decisions regarding childbirth and birth plans. This research is also important as it aims to bring to light how the media may be responsible for creating "hegemonic and anti-hegemonic effects to enforce or challenge mainstream ideologies" related to childbirth, which may not be the safest or best option for the mother and child (Walker, 2012:20).

1.1.4. Research questions

The proposed study will ask the following research questions in order to address the problem statement:

1) What is the dominant message concerning childbirth in the South African pregnancy and baby magazine, *Living and Loving*?

2) How has this message changed throughout the duration of the publication as a physical magazine (1970 to 2019)?

1.2. Brief chapter overview

This study is organised into six chapters. An introduction to the study forms a part of Chapter one. This chapter includes the rationale behind the study and an overall background. The history of pregnancy magazines, as well as birth as a whole in South Africa, is discussed. These two sections are included in the background section in order to show the relation between birth and the media. The introduction also includes the research problem and questions.

In Chapter two, the literature review explores various focus areas related to the research problem and questions. These focus areas include childbirth in the media, birth as a form of business, health care in the media, the physiology of birth, and different approaches to birth. A summary of what has been covered is provided at the end of this chapter.

In Chapter three, the study's theoretical points of departure are discussed. The theory used is Niklas Luhmann's social systems theory. History of this theory as well as the justification for use of this theory is provided in this chapter.

In Chapter four, the study's research design and method are explained. The study follows a qualitative approach to content analysis. The process of coding and strategy behind the data analysis are also discussed.

In Chapter five, the findings of the data analysis are discussed and visualised in graphs. This chapter seeks to answer the research questions based on the content analysis of the data.

In Chapter six, the research is concluded, and a summary of the important findings are given. Research problems or shortfalls are addressed, as well as opportunities for further research. The limitations of the research related to place, conditions and/or time are discussed, and further recommendations are made.

Chapter 2: The multifaceted approach to childbirth

2.1. Introduction

Chapter one provided background information regarding the research problem as well as placed the study into context historically within the medical and childbirth environment, as well as the media environment.

The aim of the literature review is to develop an understanding of the existing research and debates relevant to the chosen area of study. This chapter discusses the key themes to emerge most frequently during the literature review process, and of which this particular study is located. These key aspects are childbirth in the media, birth as business, health care coverage, physiological birth, and birth not as a one-size-fits-all procedure.

2.2. Childbirth in the media

In a study limited to 170 female college students, Walker (2012) found that these women learned about childbirth when watching fictional movies and reality television shows. The results showed, 43% of the respondents stated they had gathered some information regarding childbirth from reality television shows and films, and 40% said the same for fictional shows and films (Walker, 2012:56). In interviews with a collection of these survey participants, Walker (2012:76) came to realise despite the participants being "aware of editing techniques of visual media", many admitted "most of what they know about childbirth is based on what they have seen from popular visual media, specifically fictional depictions". The study completed by Walker (2012) focussed primarily on the impact of reality television and fictional film on perceptions of childbirth but did not include print media.

A content analysis involving the country's main newspapers published from 1990 to 2011, was the method used for the first study on media presentation of planned home birth in Iceland (Gottfredsdottir, Magnúsdóttir & Hálfdánsdóttir, 2015). While this particular study explored only one type of childbirth (planned home birth), it focused on the representation of this birthing method, solely, in print media. After analysing 127 newspaper articles, five themes emerged: "approach to safety, having a choice, the medicalization of childbirth, the relationship between women and midwives, and the reaction of the pregnant woman's local community" (Gottfredsdottir *et al*, 2015:138). The overarching theme that emerged from their analysis was that women should be given the freedom to give birth where they feel safe, and that planned home birth is one of these options (Gottfredsdottire *et al*, 2015:143). However, the results also showed there was a distinction in the public media discourse; while midwives shared the views of pregnant women who found the home

to be a safe place for giving birth, physicians or obstetricians spoke with caution (Gottfredsdottir *et al*, 2015:143).

Luce *et al.* (2016) explored this distinction in their research, stating, as science and medicine have improved, there has been a growing mistrust of midwives and of the capability of women to give birth in an active way. Their study suggested mass media play a dominant role in confirming this narrative: that childbirth is dangerous, leaving "women with no alternative than to 'choose' heroic health professionals (mainly doctors) to save them and their babies, and hence accept medical control and interventions" (Luce *et al*., 2016:6).

In research completed by Holdsworth-Taylor (2010), exploring how childbirth is portrayed in internet-based media, a distinction was discovered between what the researcher described as "natural content" versus "mainstream content" (Holdsworth-Taylor, 2010:34). The distinction is further explained in the research findings:

> Natural sources focused on eliminating fear, discrediting hospital births, and promoting 'alternative' options such as homebirth and midwifery. Mainstream sources reinforced fears, discredited home births, reported statistics from studies, and employed misinformation. Popular internet sources tended to have the goal of educating whereas media uncovered in the purposive searches tended towards entertainment goals…women may become confused and develop a heavily biased representation of birth (Holdsworth-Taylor, 2010:34).

The idea of the media representing birth in an entertaining way to draw in audience members is not a new one. It has been suggested that mass media will often focus on storytelling, sensationalism, drama, danger and unpredictabilities to attract an audience (Luce *et al.*, 2016). A slow and lengthy labour without medical intervention or midwives will often not be shown, as there is not enough drama (Clement, 1998:284) Because women experience how birth plays out through magazines, television and internet-based media, it is important to decipher the dominant ideology regarding childbirth that is being portrayed through mass media (Kitzinger & Kitzinger, 2001:61). Research completed by Luce *et al*. (2016:6) suggested these portrayals influence the decisions women and their families make regarding delivery method, their expectations of the birth experience, and the safest place to give birth, which has ultimately led to more childbirth interventions. Dahlen (2010:147) compared the way in which birth is misrepresented in the media, to how the MMR (Measles, Mumps, Rubella) vaccine controversy was misrepresented in the media:

> It would have been very difficult for parents to ignore the headlines, leading to understandable parental anxiety about the MMR vaccine. The media fanned the flames of the controversy,

> providing equal coverage to opposing views and promoting bad publicity about the safety of the vaccine (Dahlen, 2010:147).

According to Bedford and Elliman (2010) there exist a link between the media representation of the controversy and the consequential decline in vaccine uptake, resulting in measles cases increasing. If a story is reported in the media in such a way to produce an emotive response through sensationalist headlines or use of drama, Bick (2010:148) argues that it is imperative for the actual event of the story to be communicated accurately to women and their families in order for them to respond to the information in an active way; otherwise, women's fear of childbirth may increase. According to Seale (2002) there is possibly even a risk between the media and tokophobia (a pathological fear of giving birth), yet few studies explore the true impact of the media's representation of childbirth on women's childbirth decision-making. In an article written by Johnson (2016), mother and founder of Empowered Birth Project, Katie Vigos had the following to say regarding her experience of the media's portrayal of childbirth, which ultimately led to an intense fear of giving birth:

> The only reference I had was what I'd been exposed to in the media, and they're alike — a woman on her back, screaming. These unrealistic portrayals create expectations around birth: Birth is something women hate to do, it's terrifying, it makes the woman horrible to be around. With these depictions, we're risking a continuation of unrealistic expectations among birthing women and families (Johnson, 2016).

According to Evolutionary Parenting blogger Tracy Cassels "the more we view something, the more we normalize it and the media inundate us with images that tell us the same thing: Birth is fearful…when we go into (childbirth) with fear, it changes the whole physiological process, it makes the negative outcomes we fear much more likely to happen" (Johnson, 2016).

But why the drama? Tulloch and Lupton (2003:45) describe how mass media, such as newspapers, need to make money, and that's not always good for our health.

2.3. Birth means business

The documentary, *The Business of Being Born* (2008), examines how the American health care system approaches childbirth, emphasising the idea that it has become a business of its own as more medical practitioners convince women to have costly interventions (especially when labour is taking too long) by reinforcing the idea that they are not capable of birthing on their own. Medicalised birth has emerged as a dominant ideology, and *The Business of Being Born* (2008) suggests this is because health practitioners and hospitals can benefit financially from this. *The Business of Being Born* (2008) includes a scene where a group of obstetricians were asked if they had ever experienced a fully natural childbirth involving no interventions, and all said no. While the reasoning behind the increasing

medicalisation of childbirth is not straightforward, some hypothesise the answers have to do with money. In an interview with Patricia Burkhardt, Clinical Associate Professor of NYU Midwifery Program, she said, “Hospitals are businesses. They want those beds filled and emptied, they don’t want women hanging around in the labour room” (*The Business of Being Born*, 2008).

Two of the many medical interventions involving labour are induction and Caesarean section. According to Brown University Economist Emily Oster and NY Midtown OB/GYN Physician W. Spencer McClelland (2019), physicians are routinely paid around 15% more for a C-section than they are for a vaginal delivery. The reason for this may be that a Caesarean is considered to be major and complex surgery so the physician’s payment should reflect this. However, according to Brown and McClelland (2019) this logic is flawed: while vaginal birth is often uncomplicated, it can be extremely time-consuming, but despite this “payments are fixed—they reflect the mode of delivery, not the difficulty”. One might suggest, medical staff then be paid for the time it takes for a baby to be born and take into consideration the amount of time they are spending in the hospital instead of resting, being with family etc., but this could lead to other issues, such as a system where labours are extended unnecessarily, and C-sections avoided when they are needed in an emergency or high-risk pregnancies (Oster & McClelland, 2019). In research completed by Betrán, Temmerman, Kingdon, Mohiddin, Opiyo, Torloni, Zhang, Musana, Wanyonyi, Gülmezoglu, and Downe (2018:61-62), the researchers described how it was possible in some situations for private maternity care to sustain an entire hospital financially, and if a Caesarean generates more revenue, a woman may be persuaded that that is the best delivery option for both themselves and their baby. In South Africa, Professor Lynette Denny, who is head of obstetrics and gynaecology at the University of Cape Town and Groote Schuur Hospital, agreed with this suggestion, stating that while public hospitals perform Caesareans for evidence-based and safety reasons, the motives are different in the private sector, including financial gain and convenience for physicians (Fokazi, 2011).

Similarly, to elective Caesareans, induction allows for the medical doctor to know exactly when a woman will begin labour and, depending on the type of induction, may accelerate the delivery process (Pregnancy, Birth and Baby, 2019). It has also been suggested that financial incentives for inducing labour are at play. Holden (2008) says the film *The Business of Being Born* suggests “because hospitals are businesses that thrive on a high turnover, drugs to induce and speed labour (and that often make it more intense and painful) serve the system by filling and emptying beds at a faster rate”. Moore and Low (2012) explored the factors influencing elective induction of labour, and the research results show provider practice preference or convenience as one of the influences. This was related to the medical provider’s planned absence, desire to have more control over or expedite the birth, as well as “convenience, creation of a production system to ensure that women deliver like clockwork

during daylight hours, freedom of doctors to practice as they see best, doctors not trusting the natural and normal birth process, and limited attention placed on the risks of elective induction of labour" (Moore & Low, 2012:247). While some hypothesise that there is a clear "association of the induction of labour with Caesarean delivery" (OB/GYN Dr Michael Silverstein in *The Business of Being Born*, 2008), Moore and Low's (2012:248) study suggested partial reasoning for elective labour was medical providers' lack of knowledge and/or comfort with natural childbirth as well as a lack of understanding with regards to elective induction risks and consequences. This idea is echoed in another study, namely that inexperience in performing vaginal delivery, specifically in settings without supervision or support from senior staff, is feared and therefore associated with higher Caesarean deliveries (Litorp, Mgaya, Mbekenga, Kidanto, Johnsdotter & Essen, 2015:235). In some situations, this had led to younger obstetricians becoming skilled in Caesarean delivery but losing confidence in their ability to undertake vaginal assisted deliveries and breech deliveries (Bailey, 2005).

However, in South Africa, midwives, obstetricians, gynaecologists, and others involved in the birthing process, suggest financial gain is only one of the determining factors influencing the medicalisation of birth in the private sector. According to Panda, Begley and Daly (2018) health care coverage plays a significant role.

2.4. Health care coverage

"South Africa at risk of having no private practice obstetricians in four years" was the headline of an article published by *Times Live* in November 2016 (Dlamini & Child). In 2017, *Cape Argus* published "Obstetricians: 'Litigated out of practice'" (Isaacs, 2017). *CapeTalk* radio station then interviewed South African Society of Obstetricians and Gynaecologists council member Dr Johannes van Waart in April 2020 to discuss "Obstetricians leaving SA as 'insurance premiums rise to a R1 million a year'" (Friedman, 2020). Many of the articles came as a response to the medical costs obstetricians and gynaecologists are having to pay to avoid litigation. In 2015, South African Health Minister, Aaron Motsoaledi, said within eight years, between 2005 and 2013, the cost of indemnity insurance for private specialists in obstetrics had increased by 382%. His assumption for this increase was that because the "Road Accident Fund tap has run dry", lawyers are targeting medical professionals (Erasmus, 2017). According to Dr Peter Koll, obstetrician and gynaecologist, the costs do not stop at insurance, describing how the statute of limitation to file a lawsuit is calculated from when the child turns 21. In other words, if an obstetrician retires at age 60, he could potentially be sued until he is over 80 (Erasmus, 2017). *Go Legal* defines birth injury as "any type of injury to a baby that results from trauma during the birth process" and states birth injury claims can involve compensation not only for past medical expenses, but as well as for future ones (DSC Attorneys, 2020).

In further research, Howarth and Carstens (2014) explored whether private obstetric care in South Africa is at risk of extinction due to the "escalation in medical and legal costs brought about by a dramatic increase in medical negligence litigation". The results showed private obstetric indemnity cover will likely become unaffordable by the end of 2020, leading to obstetricians leaving the practice. This in itself would force many private healthcare users to move over to public facilities, which are already significantly overloaded, and as a result, increase the state's litigation burden (Howarth & Carstens, 2014). South African gynaecologist and obstetrician, Dr Chris Archer, made the decision to stop delivering babies after 25 years of practice:

> I did it for several reasons, but the high insurance premiums and the litigation [in general] was a major part of the decision. There's a big gap in the 35- to 45-year-old age group. Soon we'll retire and there will be a critical shortage because the younger doctors don't want to do obstetrics because it's not worth it (Laganparsad, 2015).

The only way to respond to these raising litigation costs has been for obstetricians to raise their fees or to do "more Caesarean deliveries to avoid the unpredictable pitfalls of vaginal deliveries" (De Jong, 2016). Howarth and Carstens (2014) agreed with this sentiment, stating the increasing Caesarean section rate is justified through the response to litigation, and in itself, demonstrates the frailties existing within the medical system. According to Dr van Waart, because a vaginal birth includes complication costs, an elective Caesarean delivery completed during the day is the cheapest form of delivery, especially since private hospitals are not assisting in covering cost of litigation insurance, even though they are making a profit (De Jong, 2016). The South African Society of Obstetricians and Gynaecologists (SASOG) showed concern if the situation continues to worsen (De Jong, 2016):

> SASOG has determined that the doctor's cost price of a delivery is in the region of R13,000 and medical aid re-imbursement is typically around R4,600. This shows that obstetrical care for private obstetricians is not worth the salt, thus many have already stopped practicing obstetrics, retired, or are emigrating to greener pastures. There is nothing inherently wrong with delivery in the public sector – but a flood of previously "private" patients to public facilities will result in chaos (De Jong, 2016).

However, according to Howarth and Carstens (2014) it is not so simple: "private patients, private providers, public patients, public providers, policymakers and politicians" all carry this responsibility. According to Betrán *et al* (2018:1360), while fear of litigation is a factor associated with an increased likelihood of an obstetrician agreeing to a woman's request for elective Caesarean, another factor is being a male obstetrician. This observation is affirmed by a literature study completed by Loke, Davies and Mak (2019) on whether health professionals were in support of women choosing elective

Caesareans in low-risk pregnancies, the results showed male obstetricians were more likely to agree to perform Caesarean sections in these instances, compared to female obstetricians. Another study confirming this found male obstetricians were more likely to execute a requested Caesarean section compared to female obstetricians in district hospitals (odds ratio of 1.53) and clinics (odds ratio of 2.26) (Liu, Lin, Chen & Lee, 2008). In the research mentioned previously (Panda, Begley & Daly, 2017), litigation costs were only one of the three primary reasons for why obstetricians and/or gynaecologists encourage elective Caesarean deliveries. Of the 34 studies included in this research, clinicians' personal beliefs and their influence on the decision to perform Caesarean sections, were mentioned in every single one (Panda, Begley & Daly, 2018:5). A sub-theme of this reasoning was clinicians' belief that Caesarean is the safer option of delivery (Panda *et al*, 2018:13). A midwife who was interviewed for a study by Bryant *et al* (2007:1197) said the following about this sub-theme:

> You know all that kind of talk around, "it's the most dangerous journey the baby will ever make, down the women's vagina." And, so they've lost faith, some of them . . .I actually think that the belief system amongst obstetricians is now that it's [CS] so safe that why would you risk that whole painful, messy, vaginal, risky business? (Bryant *et al*., 2007:1197).

A second sub-theme within this category was lack of cooperation between midwife and obstetrician due to the varying levels of expertise. An obstetrician interviewed for the research study by Bagheri, Alavi and Abbaszadeh (2013:47) said the following about this relationship:

> The midwives are a great help, and they are better in vaginal deliveries, but they should take responsibility. If they start the delivery, and then call us in for a very serious condition and put the responsibilities to us, I prefer to have a delivery from the very beginning myself (Bagheri, Alavi & Abbaszadeh, 2013:47).

Linked to taking on responsibility, it was found in the study completed by Panda *et al* (2018) that confidence in skills was a sub-theme in their research. They discovered some clinicians feared performing vaginal births due to lack of skills or fear of complications. An obstetrician interviewed in research performed by Cox (2011:6) said "it is certainly easier to do a repeat C-section, so why not just say, 'Shoot, I don't have to deal with VBACs, great…and I get to have a little bit of an easier life.' I think when you get to the heart of it, that's what's going on".

This reasoning is related to the sub-theme of convenience for clinicians in encouraging elective Caesareans. It has been said, in South Africa, elective Caesareans are preferred by obstetricians because it is dangerous for them to go out alone at night to the hospital (De Jong, 2016). However, most Caesareans occur during working hours particularly on weekdays (Betrán *et al*, 2018:1360). It has been suggested that this finding demonstrates physicians are encouraging Caesareans for

convenience (See for example: Murray, 2000; Litorp, Mgaya, Mbekenga, Kidanto, Johnsdotter & Essen, 2015 & Schantz, Sim, Petit, Rany & Goyet, 2016). In an article published on Cape Talk AM radio station's website, it is argued that doctors are able to schedule C-sections well in advance, giving them the means to perform over 25 procedures in one day, overall bringing in more money (Hong & Ramphele, 2015). This type of motivation is underscored by comments from obstetricians from a number of international studies:

> We should manage our work. The Caesarean section gives us the opportunity to manage our schedules, finding someone to work instead of us, tell the hospital when we are leaving. Of course, physicians welcome this (Bagheri *et al*, 2013:47).
>
> With CS I minimize my time and I earn more! (Litorp *et al*, 2015b).

In another study (Cox 2011), a midwife commented on the topic of convenience:

> I have been appalled at how many OBS [Obstetricians] will let them pick the date on their first OB visit for their repeat Caesarean. Repeat Caesareans are not only OK here, they are promoted! They can pick the date, which is very convenient…and they're selling, they're selling Caesareans (Cox 2011:6).

According to South African Doctor Vernon Wessels, while childbirth is daunting for every woman, especially if it is her first birth, "childbirth is a normal occurrence and in the majority of cases will progress uncomplicated" (Wessels & Pedro, 2020). Professor Lynette Denny agrees, stating "the vast majority of women are more than capable of delivering vaginally and if all is well it is without doubt the safest option for mothers and their babies" (Fokazi, 2011). However, the medicalisation of the birthing process has removed the physiological and natural experience of birth and replaced it with one where the woman is passive in her own labour experience and/or under the impression that her body is not capable of birthing a child (Luce *et al*., 2016:3).

2.5. Physiological birth

While there is no debate over the fact that every woman should have access to a safe Caesarean section if a birth emergency requires it; what is debated is the reasoning behind providing women with a Caesarean delivery in cases where surgery is not needed (Betrán *et al*, 2018:1358). The question has been raised as to whether more Caesarean deliveries are the result of moving away from a physiological birth to a medicalised one (Fokazi, 2011). A significant moment in history shifting physiological birth to medicalised birth was the campaign and work of Doctor Joseph Bolivar DeLee, a physician from Chicago who was said to have "dominated the field of obstetrics in the early twentieth century" (Leavitt, 1988:1353). Dr DeLee was subsequently blamed for unnecessarily medicalising childbirth through his overemphasis of drugs and instruments use during labour and

delivery, many of which put women at a higher risk compared to if they have been allowed to give birth without surgical interference (See for example: Rothman,1982 and Wertz & Wertz, 1979). However, it has been said Dr DeLee's contribution to the world of obstetrics cannot be discounted; placing him in the "pantheon of contributors to medical progress" (Leavitt, 1988:1353). He believed unassisted labour was a pathogenic and terrifying experience, likening natural birth to "falling on a pitchfork, driving the handle through her perineum" and likening women to salmon which die shortly after spawning:

> Perhaps laceration, prolapse and all the evils [women in labor are subject to] are, in fact, natural to labor and therefore normal, in the same way as the death of the mother salmon and the death of the male bee in copulation, are natural and normal. If you adopt this view, I have no ground to stand on, but, if you believe that a woman after delivery should be as healthy, as well, as anatomically perfect as she was before, and that the child should be undamaged, then you will have to agree with me that labor is pathogenic, because experience has proved such ideal results exceedingly rare (DeLee, 1920:39-41).

As the medicalisation of birth continued, research studies on birth increased; focusing very little on the physiological experience, and rather on how interventions could save women from natural labour through "oxytocin to stimulate and accelerate labour, forceps to expedite vaginal birth and drugs to protect women from childbirth pain" (Leavitt, 1988:1353). On the other side of the spectrum, in the 1930s, British obstetrician, Grantly Dick-Read published his first book entitled *Natural Childbirth*, thus beginning his lifelong quest to change and challenge medicalised obstetric practise and eliminate the association of birth with fear, tension and pain (Caton, 1996). Dick-Read published further books on the subject, namely: *Childbirth without Fear* (1942) and *The Practice of Natural Childbirth* (1944). His beliefs were said to have made "natural childbirth" a household term and began the movement of women demanding a return to a more physiological and unmedicalised birth (Al-Gailani, 2017:474). In response to the movement, many natural birthing processes emerged. The Lamaze Method, also known as the "psychoprophylactic technique" gained traction in the 1950s (Zwelling, 2001). The French obstetrician, Fernand Lamaze, published the book *Painless Childbirth* after visiting the Soviet Union and observing birth using psychoprophylaxis, which is a method that includes patterned breathing techniques and relaxation to decrease pain throughout labour, under the supervision of a *monitrice* (midwife) (Bergström, Kieler & Waldenström, 2010). However, the original creator of this method is said to be Ukrainian psychotherapist I.Z. Velvovskii who developed the method after studying Ivan Pavlov's conditioned response study on dogs:

> Through regular practice during pregnancy and by responding to simulated contractions, the woman is expected to react in the same way when experiencing real contractions during labor, according to Pavlov's theory of conditioned response (Bergström *et al*, 2010:794).

The Lamaze Method gained popularity in the United States of America after Marjorie Karmel published *Thank You, Dr. Lamaze* (1959), a first-hand account of her experience giving birth to her child using the Lamaze Method in Paris. Soon after, Karmel and German physical therapist Elisabeth Bing founded the American Society for Psychoprophylaxis in Obstetrics, today known as Lamaze International (Lothian, 2011:118).

Three other childbirth preparation methods are the Bradley Method, the Leboyer Method, and the Mongan Method. The Bradley Method was created by obstetrician Dr Robert Bradley in 1947 and focused on a woman giving birth with her partner by her side. The concept was revolutionary for its time since men were prohibited from entering the birth room at all (Gurevich, 2019). The partner acted as the coach during labour and was the woman's primary supporter in achieving a physiological and unmedicated birth (Varner, 2015:128). The Leboyer Method was introduced by French obstetrician Frederick Leboyer and brought to the public in his book *Birth Without Violence* (1974). Leboyer described how unborn babies experience fear and anxiety, and that a person's birth experience will shape their life and influence them in the long-term (Hasan, 2017). While Leboyer was not against the use of birth interventions when needed, he encouraged the idea of a "gentle birth" which could be achieved by using only dim lighting in the birth room, playing soft music during labour, and not forcing the baby to cry as soon as it is delivered (Hasan, 2017). The baby is rather placed on the mother's stomach to encourage immediate newborn-maternal contact, the umbilical cord is cut only after it has stopped pulsating, and the father is encouraged to participate in the birth and often the one to give the newborn child a water bath to relax the craniosacral axis and raise the new-born's lowered temperature (Gimbel & Nocon, 1977:12). The Mongan Method, also known as hypnobirthing, was created by Marie Mongan and popularised with herbook titled *Hypnobirthing: The Breakthrough to Safer, Easier, More Comfortable Childbirth* in 1992. The belief behind the method is that pain during labour can be reduced if a woman releases herself to the natural rhythm of her labouring body to function as nature intended (Phillips-Moore, 2005). In hypnobirthing classes, pregnant women are told to think of contractions as uterine waves; pushing as birth breathing; and to reframe their thinking by imagining scenarios of relaxation (Moyer, 2019).

In a study completed by Lothian (2000), the researcher explored the question "Why natural childbirth?" An answer suggested was that while physiological birth can occur in a home or a hospital, with an obstetrician or with a midwife, the focus is that the woman is allowed to respond to how she feels:

> Whether she gives birth in a hospital, birthing center, or at home, she is able to use a wide variety of comfort measures; for example, moving freely, listening to music, taking a shower or bath, and having her feet and hands massaged. She is able to create an environment that is just what she needs as she does the hard work of labor and birth (Lothian, 2000:45).

However, while the natural childbirth movement has gained momentum, it has also been criticised for bringing shame and guilt on those who choose a more medicalised birth, or are unable to go ahead with their natural birth plan due to emergency complications (Tuteur, 2016a).

2.6. Birth is not a one-size-fits-all procedure

According to the World Health Organization (n.d.) low-resource settings experience the largest incidence of deaths of both mothers and new-borns, and most of them could have been prevented:

> Of the more than 130 million births occurring each year, an estimated 303,000 result in the mother's death, 2.6 million in stillbirth, and another 2.7 million in a new-born death within the first 28 days of birth (World Health Organization, n.d.)

As a response to these statistics, the World Health Organization introduced the WHO Safe Childbirth Checklist to be used as a guide for birth attendants to ensure women receive an improved quality of care when giving birth. This "organized list of evidence-based essential birth practices" was developed after receiving "input from nurses, midwives, obstetricians, paediatricians, general practitioners, patient safety experts and patients from around the world" and acknowledges that birth is not a one-size-fits-all procedure (World Health Organization, 2015:7-9). The checklist covers four main events or what they call "pause points": upon admission, just before pushing or Caesarean, soon after the birth, and before discharge. Three years later, in 2018, the World Health Organization published a *New WHO guideline on intrapartum care*, a 200-page document that focuses on how to make childbirth a positive experience. In the document, the organisation acknowledges:

> Whilst much is known about the clinical management of labour and childbirth less attention is paid to what, beyond clinical interventions, needs to be done to make women feel safe, comfortable and positive about the experience. The growing knowledge on how to initiate, accelerate, terminate, regulate, or monitor the physiological process of labour and childbirth has led to an increasing medicalization of the process. It is now being understood that this approach may undermine a woman's own capability in giving birth and could negatively impact her experience of what should normally be a positive, life-changing experience (World Health Organization, 2018).

The WHO made 56 evidence-based recommendations in order to adopt a human-rights and women-centred approach to birth. These recommendations focused on the following themes:

- Respectful labour and childbirth care;
- Emotional support from a companion of choice;
- Effective communication of staff;
- Pain relief strategies;
- Regular labour monitoring, documentation, audit, and feedback;
- Oral fluid and food intake;
- Mobility in labour and birth position of choice;
- Pre-established referral plan; and
- Continuity of care (WHO, 2018).

The overarching reasoning behind these new recommendations was to "substantially reduce the growing rate of unnecessary Caesarean sections that has currently reached an epidemic proportion" (WHO, 2018). The first recommendation emphasises women's rights concerning choice: "respectful maternity care…enables informed choice and continuous support during labour and childbirth" (WHO, 2018:19). However, there has been speculation as to whether women should be allowed to have full ownership over their birthing method of choice (Loke, Davies & Mak, 2019).

The argument that it is a women's right to choose her own birth method has been brought up in opinion pieces concerning women who have felt shame and guilt when choosing not to have a "natural birth". See for example, Tuteur's opinion piece published in the *Washington Post* in 2016:

> But like the perfect wedding, the perfect birth is often a fiction; women who buy into the idealized experience can face enormous disappointment, distress and feelings of failure if they have a Caesarean section, choose an epidural or are unable to breast-feed immediately after delivery, all of which result, at times, from factors outside mothers' control. Yet for mothers in search of the perfect experience, any medical intervention, even a lifesaving one, can become a source of bitter shame (Tuteur, 2016a).

Tuteur, who is an obstetrician/gynaecologist published a book entitled *Push Back: Guilt in the Age of Natural Parenting* in response to the natural birth movement that she believed was causing women with other birth plan choices to experience guilt and shame (Tuteur, 2016b). Linked to this is the argument that women are now practising their right to choose an elective Caesarean. Obstetrician and gynaecologist Dr Peter De Jong says birth has become a medical procedure where women are able to exercise their right in choosing the birth option that they desire (Fokazi, 2011). In the United Kingdom, some women are complaining of being denied the right to an elective Caesarean. Birthrights, a UK-based organisation that aims to protect women's human rights related to childbirth,

has said it "handled more requests for support from women unable to access a Caesarean section than any other issue" (Malik, 2018).

Loke, Davies and Mak (2019) explored the question of whether it is up to the mother to "choose" a Caesarean section as the mode of birth. Their research included a literature search of studies that explored women's rights to elective Caesareans in uncomplicated and low-risk pregnancies. Their results showed obstetricians were particularly supportive of this right, and in countries that had well-developed private healthcare, many health professionals argued in support of this decision by stating it was a women's right to "have the freedom to choose the mode of birth" (Loke *et al*, 2019:1). The topic of litigation featured strongly:

> Obstetricians considered the CS to be a convenient scheduled procedure, one that was less likely to attract litigation, while also generating more income. As a result, when women requested a CS, the obstetricians would provide the woman with a description of the benefits and potential complications of undergoing a CS, and allow them to make the decision (Loke *et al*, 2019:2).

Obed, Bako, Agida and Nwobodo (2013) explored this same topic in a sub region of West Africa. Their study involved assessing the attitudes toward Caesarean Delivery on Maternal Request (CDMR) of all Senior Consultant Obstetricians (at least 10 years' experience) that attended an examiners' meeting of the Faculty of Obstetrics and Gynaecology at the West African College of Surgeons in Ibadan, Nigeria. Of the 112 questionnaires, 97.8% of the obstetricians said they were aware of the International Federation of Gynecology and Obstetrics's (FIGO) stand on Caesarean section (Obed, Bako, Agida & Nwobodo, 2013:74). FIGO released the following statement concerning Caesarean sections in 2007:

> FIGO supports the view that childbearing, for the great majority of women throughout the world, is a normal, physiological process influenced by culture, traditions, religion and psychosocial factors. FIGO further asserts that childbearing is a family event that requires as a starting point a health-oriented rather than a disease-oriented model of care from providers (FIGO, 2007).

However, while 97.8% of the obstetricians said they were aware of this statement, 88.9% said it is important to "accommodate the feelings of the women and have respect for the patient's autonomy" in relation to women requesting CDMR. 81.2% of the obstetricians said they had experience in permitting CDMRs (Obed *et al*, 2013:76-77).

The research exploring the opinions of midwives revealed that while many of the midwives argued women should be allowed to choose elective Caesareans in uncomplicated pregnancies, it is also the

responsibility and duty of midwives to provide information on what they deem as the safest birth option, and that there is little scientific evidence demonstrating elective Caesarean is the safest birth option (Loke *et al*, 2019:4-5). In the same statement from FIGO in 2007, it is said that women are required to be counselled and informed of the most "up-to-date, complete and understandable information on the risks and benefits of proposed interventions" and that it is an obstetricians responsibility to "offer women evidence based delivery care within a framework of professional practice" (FIGO, 2007).

The debate over whether women should have full control over their birthing plan is a controversial topic (Hundley, Phipps, Treadwell, Baker, Horn & van Teijlingen, 2013). In an article published by Independent Online, The Board of Healthcare Funders (BHF) spokeswoman Heidi Kruger said she regretted the decision made by the Health Professions Council of South Africa that a woman's delivery method is her choice, irrespective of whether the choice is medical indicated or not (Fokazi, 2011). However, in research completed by Coxon, Sandall and Fulop (2013:66) it was argued that this choice can often be influenced rather than informed. By referring to a study completed by Douglas and Wildavsky in 1982, they argued certain risks can be "selected" while others are "overlooked" in order to support an argument (Coxon, Sandall & Fulop, 2013:66). According to the researchers, the media is an example of one of the vehicles that drives this "risk selection" in relation to giving birth, and is responsible for spreading the notion that parents-to-be are responsible for effectively managing the risk that comes with giving birth as much as possible (Coxon *et al*, 2013:54). According to Betrán *et al* (2018:1359), birth by elective Caesarean is represented as convenient, controllable and even fashionable. This has led to midwives often blaming the media for representing childbirth inaccurately and consequently leading to unnecessary medical interventions (Hundley, Luce, van Teijlingen & Edlund, 2019:57).

2.7. Summary

In conclusion, it is evident that expecting mothers learn about childbirth in several ways such as through communication with various medical professionals, antenatal classes, literature, stories passed on from others, and largely, through media sources. These messages impact decision-making and feelings towards birth. Birth has developed over the years to become a business through its transformation into a highly-medicalised event. Potential reasons behind the medicalisation of birth include high obstetric risk insurance cover, the ability to plan and hasten birth, and the act of defensive medical decision-making. What is not under debate is the reasoning behind medicalised births that have saved both mother and child, nor is the praise that should be given to medical practitioners and childbirth attendants who have had to make life-altering and drastic decisions in high-risk births. However, it is clear there has been a call from the public for a more natural and less-medicalised

childbirth experience, specifically for those considered low-risk who desire to be active participants in the delivery of their child. In the next chapter, the study's theoretical points of departure are discussed.

Chapter 3: The construction of childbirth as a media topic

3.1. Introduction

A primary reason for why mass communication should be researched is to recognise and explore the fundamentally significant role of the mass media in the process of establishing a democratic society (Fourie, 2007: xxii). In this chapter, Niklas Luhmann's theory of mass media will be discussed, with specific reference to the representation of childbirth in mass media. Two theories linked to Luhmann's concept of information versus non-information is that of media selectivity and framing theory. Lastly, the media bias known as false balance is discussed. These theories are all explored in relation specifically to mass media communication.

3.2. Niklas Luhmann's social systems theory

Niklas Luhmann's theory of social systems has been described as "the best description and analysis of contemporary society presently available" (Moeller 2012:3). Luhmann is well-known for declaring:

> Whatever we know about our society, or indeed about the world in which we live, we know through the mass media. This is true not only of our knowledge of society and history but also of our knowledge of nature. What we know about the stratosphere is the same as what Plato knows about Atlantis: we've heard tell of it. On the other hand, we know so much about the mass media that we are not able to trust these sources (Luhmann, 2000:9).

Luhmann, born in Germany in 1927, studied sociology at Harvard University in 1960, where Talcott Parsons introduced him to systems theory (Meyer, Gibson & Ward, 2015:340). In 1984, Luhmann published *Soziale Systems*, which is regarded as his primary piece of work (Childs, 1998). Luhmann's systems theory hypothesised that society is composed solely of communication and that society has gradually separated into individualised spheres of communication, such as education, politics and art (Görke & Scholl, 2006:646).

In 1995, Luhmann published his book *The Reality of the Mass Media (Die Realität der Massenmedien)* in which he argued that the mass media is a "set of recursive, self-referential programs of communication, whose functions are not determined by the external values of truthfulness, objectivity, or knowledge, nor by specific social interests or political directives" (Luhmann, 1995). It is from this standpoint that Luhmann views the mass media as a system that does not present reality, but rather manufactures reality through the production of advertising, reports, news etc. (Bechmann & Stehr, 2011:142). This in part has to do with the appearance of novelty: the mass media experience a pressure to report on something new every day, making yesterday's news

"old" (Bechmann & Stehr, 2011:144). Similarly, to how Luhmann declares that what we know of the stratosphere is what we have heard tell of it, childbirth stories and experiences of labour have been passed on from generations through its infiltration within the mass media (Holdsworth-Taylor, 2010).

As a social system, Luhmann hypothesised, the mass media system is based on what is known as functional differentiation (Artieri & Gemini, 2019: 567). Functional differentiation can be explained as the way in which "modern society organizes itself by delegating different functions to specialized societal systems in order to cope with societal problems which could not be solved from other systems, or before the system has emerged" (Görke & Scholl, 2006:647). This phenomenon relies on distinct binary codes (Gren & Zierhofer, 2003:619). For example, the legal system operates using the binary codes legal versus illegal, while the system of science uses the binary codes true versus false. The mass media system operates on the code of information versus non-information, whereby information in this instance is the positive value (Artieri & Gemini, 2019:567). The left side of these binary codes always pertains to a positive value, while the right side pertains to a negative value. An example is given of the way in which these binary codes, within their individual systems, impact society:

> The code of money is paying/not paying. The code of power is being in position/being in opposition. And the code of law is right/not right...No one wants to end up in a marginalised (op)position without power, without the possibility of paying for anything and without any legal rights. The negative value of the codes makes you think – that is reflect – how you can change your position, make money and achieve rights. The upshot is that societal communications that function and disseminate through such codes motivate participants to connect to the left sides of the codes and thereby accept the communication and thereby reproduce the society (Tække & Paulsen, 2010:49).

While the communication does not always succeed in further entrenching the formed social systems, the codes increase the probability of success, and the media make it probable that communication will be successful (Luhmann, 1986:18). If something is to be viewed as informative, there is a requirement for the possibility of viewing something else as non-informative (Luhmann, 2000:17). Informative events are selected to be published, while events that are coded as non-informative are not (Luhmann, 1995:32).

3.3. Media selectivity and framing theory

Whether a published event is incorrect or not, what is viewed in the mass media affects public opinion and communication indirectly through framing (Bechmann & Stehr, 2011:146). Therefore, the selection of "information" is subjective, further demonstrating how the media do not reflect society

like a mirror, but rather construct reality (Artieri & Gemini, 2019:567). This "unavoidable, yet intended and regulated" distinction is known as media selectivity (Bechmann & Stehr, 2011:144). Media selectivity is steered by the preference for "unusual events and moral judgments...which then affects our view of social reality" (Bechmann & Stehr, 2011:143).

Simultaneously, media houses select what to produce based on specific ideas they have about their audience; ideas that are based on statistics and assumptions, making production generalised rather than individualised (Bechmann & Stehr, 2011:143). Published information is often represented as neutral and objective, but conflict, scandal, and abnormal behaviour is preferred over providing the truth, specifically scientifically-generated truths (Bechmann & Stehr, 2011:145). Even media prominence does not represent truth or scientific reputation, and credibility itself does not ensure media prominence (Weingart & Pansegrau, 1999:14-16). Therefore, individuals may only construct their identities within the constraints set out by the media, as they determine what is information and what is not (Artieri & Gemini, 2019:566). It is argued that scientific reputation and media prominence compete with one another with regards to the media reporting on scientific topics:

> This implies that in cases where scientific and media evaluations diverge, the media's control over public attention opens the possibility that priority-setting and evaluation within science are no longer the exclusive orientation criteria for the public's willingness to grant financial support (Weingart & Pansegrau, 1999:1).

Using Luhmann's functional differentiation theory, media selectivity and framing theory as starting points, the argument is that mass media have taken the lead in deciding what is worthy of reporting or not, regardless of the weight of evidence in scientific research, as the mass media have different criteria than the sciences in selecting which topics are worthy of reporting (Weingart & Pansegrau, 1999:1). Similarly to scientific reputation, prominence in the media increases the value and attractiveness of a news item, and media attention in itself can directly translate to political legitimation and the allocation of resources (Weingart & Pansegrau, 1999:2). Dissimilarly to scientific reputation, credibility does not translate to prominence, but rather media prominence is reliant on criteria such as a scientist having an enigmatic personality or their work relates to leading problems and fears within society (Goodell, 1977). In fact, the media may focus on scientists who do not have valid scientific reputations but who possess qualities that meet the needs of media criteria, and this may directly impact political decisions and funding (Weingart & Pansegrau, 1999:4). Unlike science, where the binary code is truth versus false, in the media opinions can be reported in such a way that they are informational and come across as fact, resulting in the creation of a reality that is not consensual (Bechmann & Stehr, 2011:144). This leads to what Luhmann describes as the function

of the mass media to "irritate" societal communication through the creation of "permanent restlessness" (Luhmann, 1995:174).

Previously, the mass media have been perceived as the most ideal transmitters of scientific information, capable of disseminating facts and theories to an audience without changing the meaning (Macdonald, 1996). However, the selection of what to include, as well as the wording of the chosen information is unavoidably biased (Schäfer, 2011:403). Only a small fraction of issues and opinions of a scientific topic are published in the media due to a journalist applying their own personal criteria "to select some bits of information and discard others" (Schäfer, 2011:403). To add to this, science journalism is more "entertainment-oriented" translating to sensationalised wording (Schäfer, 2011:403). The issue with this is that there is evidence of media consumers intrinsically trusting what is said in the media regarding scientific research and scientists due to an assumed authority and expertise (Nisbet & Scheufele, 2009:1769). It is implied that "relative to authority, deference, and respect, scientists have earned a rich bounty of perceptual capital" (Nisbet & Scheufele, 2009:1769). While framing and selectivity are both an "unavoidable reality of the science communication process", making it impossible to have the existence of "'unframed' information", journalists are able reduce the influence of framing and media selectivity by exploring all perspectives of the topic (Nisbet & Scheufele, 2009:1770). However, this needs to be done wisely, otherwise it can lead to a secondary mass communication downfall; false balance, or what is commonly known as bothsidesism.

3.4. False balance

False balance can be described as a journalistic attempt to present both or all sides of a debate or issue "as more equal than is justified by the evidence", in order to appear objective (Rietdijk & Archer, 2019:2). While impartiality is something that a respectable journalist prides themselves in, "when the weight of scientific evidence points incontrovertibly one direction, doggedly reporting both 'sides' equally can result in misleading coverage" (Grimes, 2016). An example of this is on the reporting of climate change. It has been said that a large number of people do not obtain their knowledge on climate change directly from scientific literature, but rather from the internet and the media (Anderson, 2019). While there is no issue with interviewing a climate change scientist as well as a climate change denier and including their quotes in a single article, if the effort is to provide a "360-degree view", a false balance of the facts is created (Anderson, 2019). Critics of mass communication have described how this false balance has the possibility of further confusing rather than empowering media consumers to make educated decisions regarding scientific and health-related topics (Koehler, 2016:24). Linked to this theory, this study investigates how a specialist magazine such as *Living and Loving* portrays and frames the issue of childbirth for its South African readers.

3.5. Summary

In summary, according to Luhmann's theory, there are two features at play here based on media selectivity: the constant search for novelty and the relationship between information and non-information. Luhmann's theory was chosen as the theoretical point of departure for this research as it aptly addresses the concern that the mass media do in fact not represent reality. Luhmann's theory addresses how the mass media create frames of reference that consumers utilise in order to create discourses concerning events and subject matter (Tuchman, 1978), such as childbirth. Luhman's theory can be linked to both media selectivity and framing theory, which both can result in false balance when journalists attempt to appear as objective in their media selection and word choice. As the media frame and selectively publish information versus non-information, such as fear concerning childbirth or the prominence of one birth plan over another, it can be difficult to then challenge that presentation and suggest an alternative perspective (Geller, Bernhardt, Gardner & Rodgers, 2005:204). In the next chapter, the research method and design are discussed.

Chapter 4: Method

4.1. Introduction

The research design and research methodology will be discussed in this chapter. This chapter is divided into qualitative research, research design, gathering of data, data analysis method, and summary. The reasoning behind the chosen research design and method are discussed, as well as the advantages and disadvantages of the chosen data-gathering method.

4.2. Qualitative research

A primary difference between qualitative versus quantitative research is made apparent in the quest and depth of understanding (Henning, van Rensburg & Smit, 2004:3). While quantitative research includes focus on variable control and quantity of understanding, qualitative research aims for depth where the variables are not controlled so that there is freedom for natural development and exploration of the phenomenon (Henning, van Rensburg & Smit, 2004:3). While quantitative research has been considered to be a more reliable research approach as it is based on numerical method and data, qualitative research is able to reveal beliefs, attitudes and behaviours (Pathak, Jena & Kalra, 2013:192). Qualitative research first emerged in psychological studies as researchers began to realise it was difficult to study human behaviour in numerical form (Gibson, Rodriguez, Curran & Wattis, 2004:422). However, qualitative research has since been used in various fields, specifically clinical research (Pathak, Jena & Kalra, 2013:192). There are four primary qualitative research designs, namely phenomenology, grounded theory, ethnography and the case study (Astalin, 2013:119). Some researchers say the fifth major qualitative research design is narrative (Creswell, 2006 & Plano Clark, 2016). For the purposes of this this study, a qualitative approach has been taken, but the research method of content analysis is used both qualitatively and quantitatively. In simple terms, qualitative research focuses on wording rather than numbers which is more suitable for this research topic in order to gain an understanding of how childbirth is framed and expressed in *Living and Loving* magazine (Creswell & Poth, 2007:42-43). The quantitative data presented first in the data analysis chapter provides a foundation for the qualitative data by representing the frequency of use for specific, childbirth-related words. Qualitative and quantitative methods can be used sequentially in research "where the first approach is used to facilitate the design of the second" and to be used in "parallel as different approaches to the same question" (Hammarberg, Kirkman & de Lacey, 2016:498).

4.3. Content Analysis

Content analysis is a research method and process of data analysis that successfully reduces the volume of data collected, by selecting and identifying categories from the text and grouping them

together in order to gain an understanding of it (Bengtsson, 2016:8). This is achieved by "making replicable and valid references from texts (or other meaningful matter) to the contexts of their use" (Krippendorff, 2004:24). However, content analysis is not merely a counting process while sifting through data but involves making valid inferences from the data and linking the results to the environment in which they are found (Downe-Wambolt, 1992:313). Content analysis is understood to be a reliable research method that successfully precludes the personal influence of the researcher (Bengtsson, 2016:9). However, this is only achieved if the important step of the content analysis research method is taken which is for the researcher to consider his/her pre-existing biases. This requires self-reflection and an honest acknowledgment of the researcher's "pre-understanding" of the topic at hand, while planning and analysing the data in order to minimise bias and prejudice in the results (Burnard, 1995:236). This step is taken to avoid losing objectivity in the research, which is a possibility when choosing to research from a qualitative approach (Wimmer & Dominick, 2011:48). Content analysis is suited to this research study as this type of research method can be used to produce qualitative and quantitative data results, which this study aimed to do (Bengtsson, 2016:10). However, it is important for every researcher to acknowledge their own personal ideas and assumptions of reality before beginning the analysis (Fourie, 2007:147). As a young woman who has never been pregnant or given birth, I, as the researcher do not have any direct experience with childbirth or being in labour. However, the various methods and approaches towards childbirth, particularly the growing medicalisation of childbirth, has become an invested interest of mine for many years. The rapidly increasing caesarean section rates within South Africa has also become a growing concern of mine, especially if the procedure is performed without any necessary medical reasoning.

4.4. Data gathering

Quantitative content analysis involves sifting through data and presenting the frequency of facts, words, categories or themes and presenting them in percentages or numbers (Berelson, 1952). The quantitative content analysis of this research data will be conducted by analysing every article relating specifically to childbirth in *Living and Loving* magazines published from September 1970 to September 2019, the period of which this magazine was published as a physical magazine. All *Living and Loving* articles that were analysed are referenced at the end of this study, and the physical articles can be made available upon request. The entirety of the physical magazine was chosen to be analysed in order to gather a great understanding of how the journalists of this magazine wrote about childbirth and to answer the two research questions: "what is the dominant message concerning childbirth in the South African pregnancy and baby magazine, *Living and Loving"* and "how has this message changed over the years?". In order to accurately and fairly answer these questions, every article

published by *Living and Loving* was read, all articles relating specifically to childbirth were set aside, and each of these articles became the basis of the content analysis.

The magazines were made available for analysis at the National Library of South Africa at the Cape Town campus. For the purpose of the quantitative content analysis, the tables below show the following words and concepts relating to childbirth which were counted in order to identify the frequency of their use in the magazine over the 49 years:

Table 2: Exact word found in text			
Midwife	Doctor Gynaecologist Obstetrician	Induction	Nitrous oxide Gas Laughing gas
C-section Caesarean Caesarean section	Epidural	Hypnosis Hypnotherapy	Forceps
Episiotomy	Deep breathing Breathing techniques	Ventouse delivery Vacuum extractor	

Table 3: Concept found in text
Midwife-led birth
Vaginal birth
Home birth
Hospital birth
Elective Caesarean

The frequency of these words/concepts were noted in order to note whether the use of such words increased or decreased over the years, and to identify whether the journalists of *Living and Loving* magazine were sharing a specific dominant message through their word choice and word choice combinations. For example, publishing articles relating more to C-sections over vaginal births, or for example, continually using the words “episiotomy” or “forceps" when writing about childbirth, as a whole. This part of the content analysis addresses Luhmann’s theory and media selectivity, and how word choice in news articles is a reflection of reality rather than reality itself (Artieri & Gemini,

2019:567). An example of the impact of media selectivity is if the *Living and Loving* magazine journalists write the word "doctor" or "obstetrician" every time they refer to childbirth. This would be constructing the reality that childbirth always goes hand-in-hand with a medical doctor (rather than, for example, a midwife). This first part of the content analysis is important as it identifies possible media bias which can "strongly impact the individual and public perception of news events" and a "difficult-to-detect, yet powerful form of slanted news coverage is bias by word choice" (Hamborg, Zhukova & Gipp, 2019:1).

This type of coding in content analysis is known as manifest analysis (Bengtsson, 2016:10). In contrast to manifest analysis, is latent analysis, which was completed in the secondary part of this content analysis. Latent analysis extends to the interpretive level to discover underlying meanings of the text (i.e. what is this text talking about?) (Downe-Wambolt, 1992:314). Therefore, the quantitative content analysis essentially answers the question "how many?" while the qualitative content analysis seeks to interpret the results and to discover the deeper meaning (Bengtsson, 2016:10). The researcher will ask specific and unrestricted questions throughout the analysis such as "what strikes you?" and "what is happening here?" (Creswell & Poth, 2007:153). In this part of the analysis, the overarching theme of each individual text was determined. This was achieved through immersion in the data "in order to identify hidden meanings in the text" and "for each category or theme, the researcher chooses appropriate meaning units presented in the running text as quotations" (Bengtsson, 2016:12). On a practical level, the entire content analysis was created in Microsoft Excel for ease of manipulation of the data, specifically for the quantitative content analysis results.

4.5. Summary

Chapter four explored different research designs and methods and provided reasoning for this research study's chosen method and design. Qualitative versus quantitative content analysis was discussed, as well as two different content analysis coding approaches: manifest analysis and latent analysis. Furthermore, the chapter identified how each of these coding approaches were used in this research study and identified which words or phrases formed a part of the manifest analysis. In the next chapter, the findings of the content analysis are described and elaborated on.

Chapter 5: Data analysis

5.1. Introduction

This chapter covers in detail the results of the content analysis from both the latent and manifest coding approaches. This can also be understood as the results of the quantitative and qualitative content analysis. The quantitative analysis results provide an introduction to the qualitative analysis results, in a sense, as they provide the groundwork in deciphering the dominant message concerning childbirth in the South African pregnancy and baby magazine, *Living and Loving*, and whether this message changed throughout the duration of the published magazine. The quantitative findings are also displayed in graphs. The qualitative analysis is separated into categories according to the most prominent frames discovered during the coding process. Analysis of these findings is provided.

5.2. Quantitative analysis

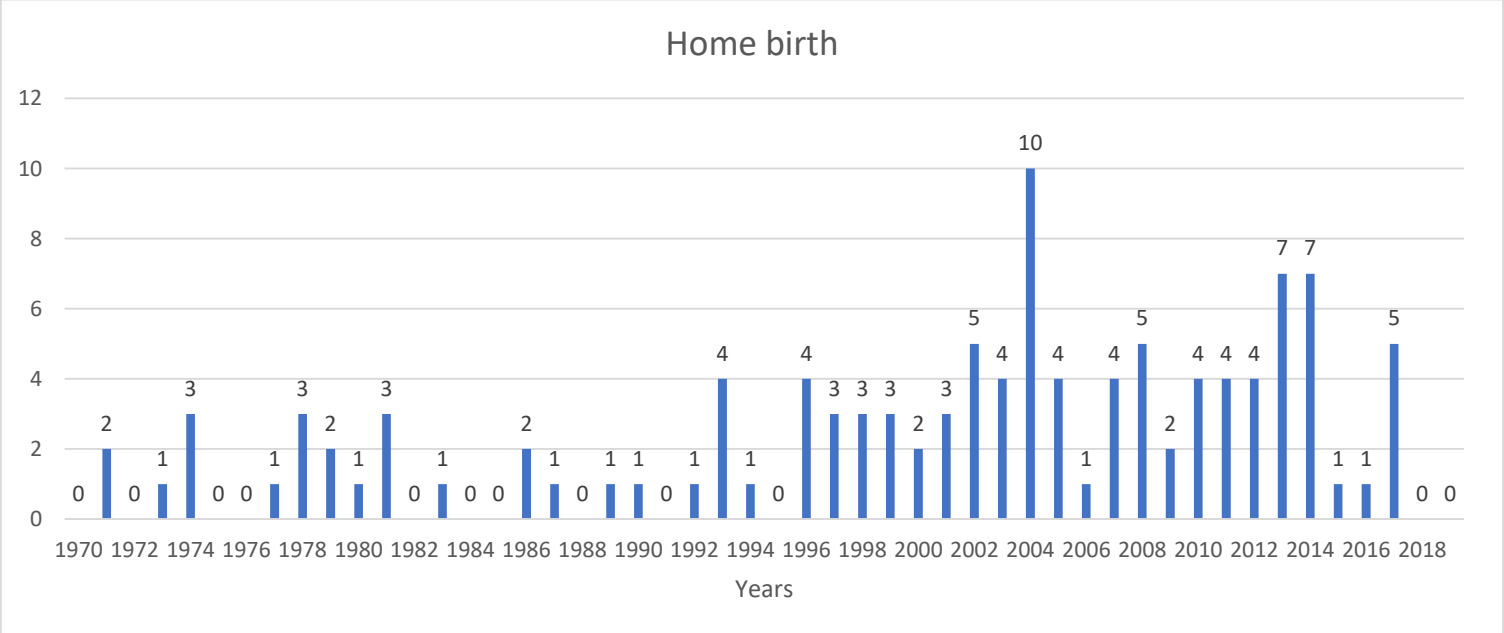
The quantitative analysis involved sifting through every *Living and Loving* magazine printed from September 1970 to September 2019. All articles relating specifically to childbirth were photocopied for the analysis. This resulted in 618 articles. In order for an article to be included in the analysis, it had to be about childbirth. Articles that mentioned childbirth or labour briefly, but that didn't focus primarily on the topic, were not included in the analysis. Frequency of the following words were noted using tables in Microsoft Excel: midwife, gynaecologist and/or obstetrician (synonymous with the word "doctor"), forceps, epidural, nitrous oxide/gas/laughing gas, induction, C-section/Caesarean/Caesarean section, whether an elective Caesarean was chosen, deep breathing, episiotomy, hypnosis/hypnotherapy, ventouse delivery/vacuum extractor, as well as mentions of whether the birth was a home birth, a hospital birth, a vaginal birth, and/or a midwife-led birth. It was noted every time any of these words were used, and the article did not necessarily have to focus specifically on the said word.

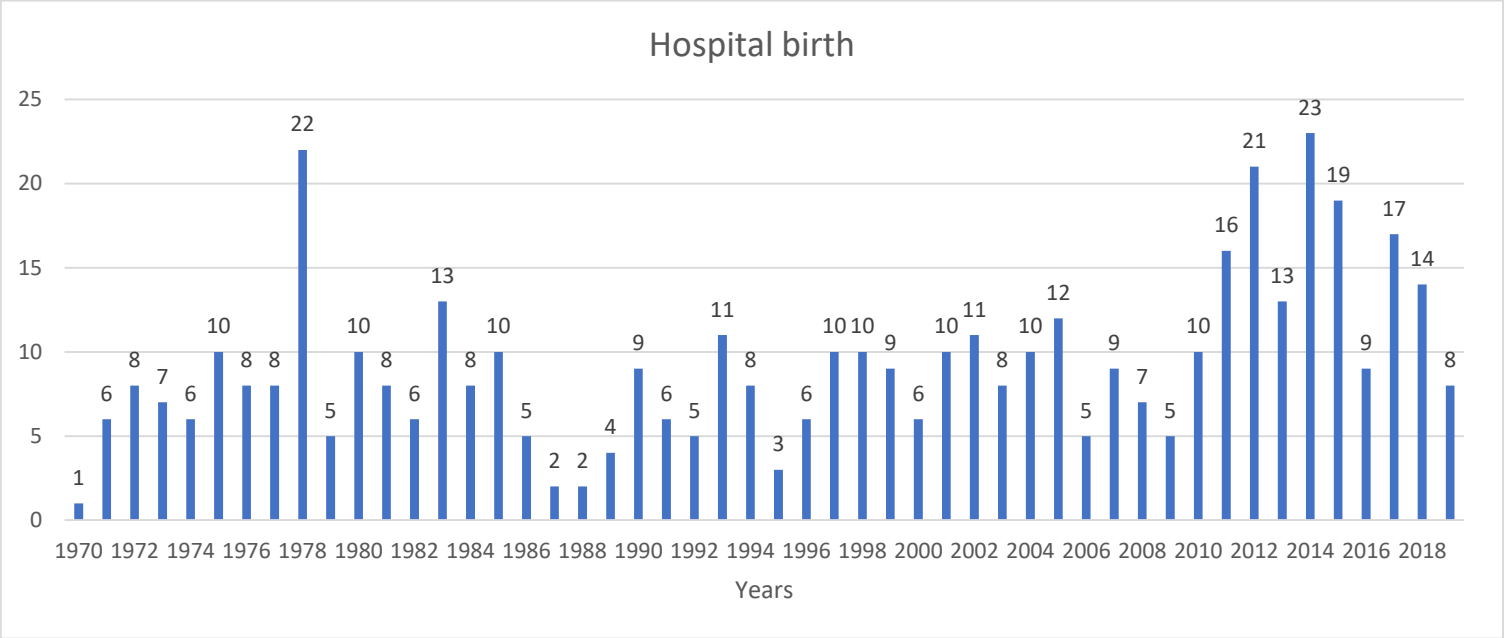
Table 4: Frequency of word usage

Exact word	Frequency of mention
Midwife	338
Doctor/gynaecologist/obstetrician	437
Forceps	90
Induction	99

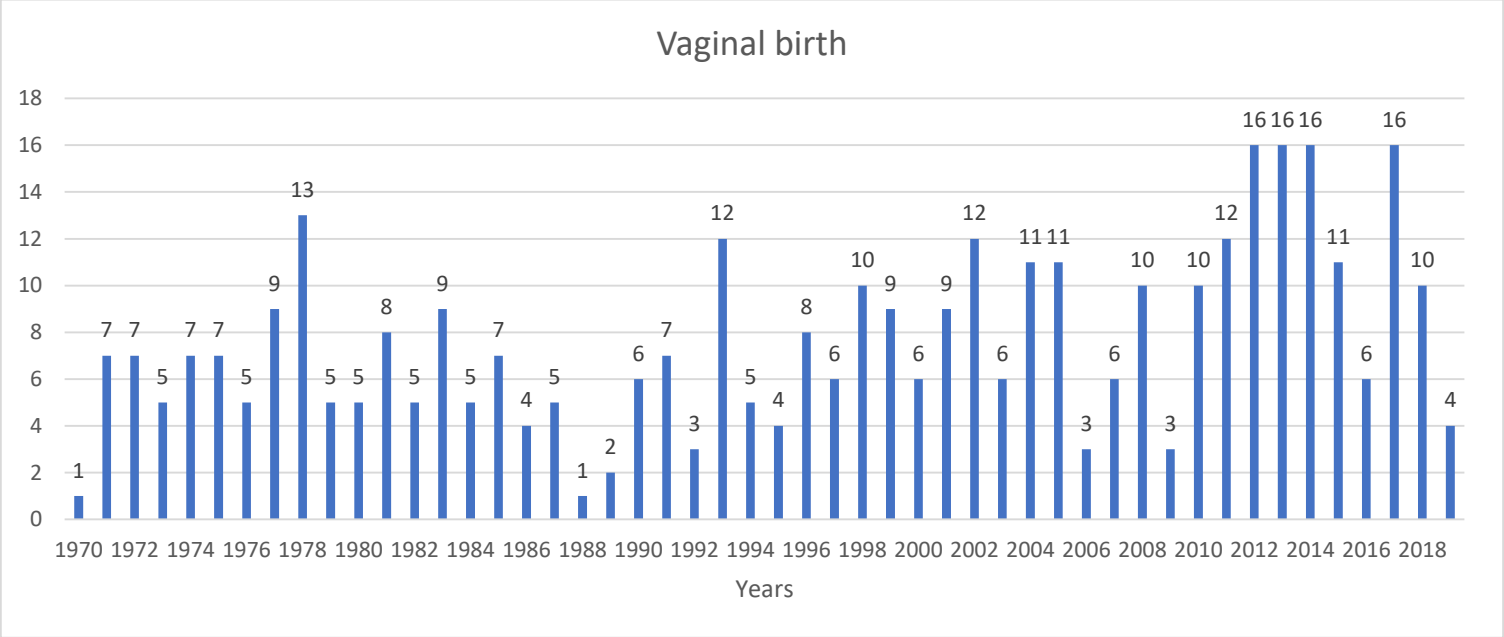
Epidural	120
Nitrous oxide/gas/laughing gas	41
C-section/Caesarean/Caesarean section	256
Episiotomy	76
Deep breathing/breathing techniques	73
Hypnosis/hypnotherapy	21
Ventouse delivery/vacuum extractor	58
Concept	**Frequency of mention**
Midwife-led birth	153
Vaginal birth	381
Home birth	114
Hospital birth	459
Elective Caesarean	51

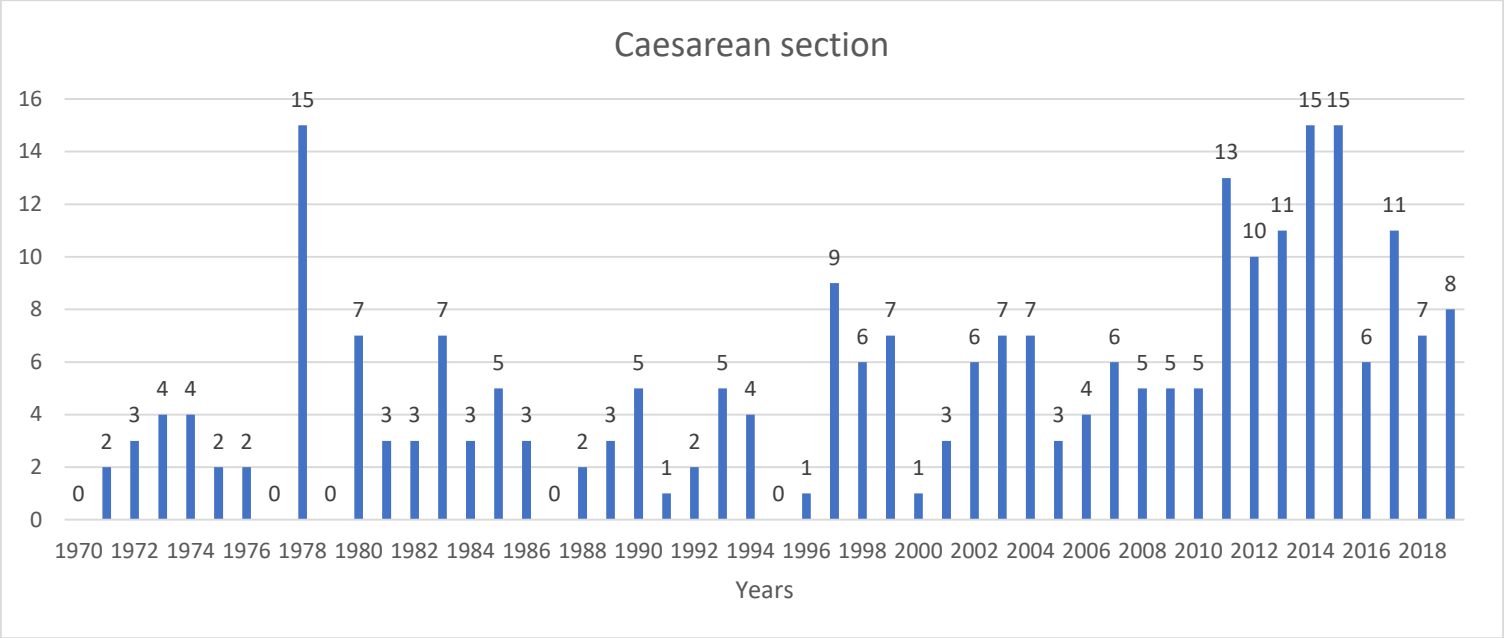
The two graphs below show the comparison between home versus hospital births from 1970 to 2019. It is clear that hospital births were more frequent.

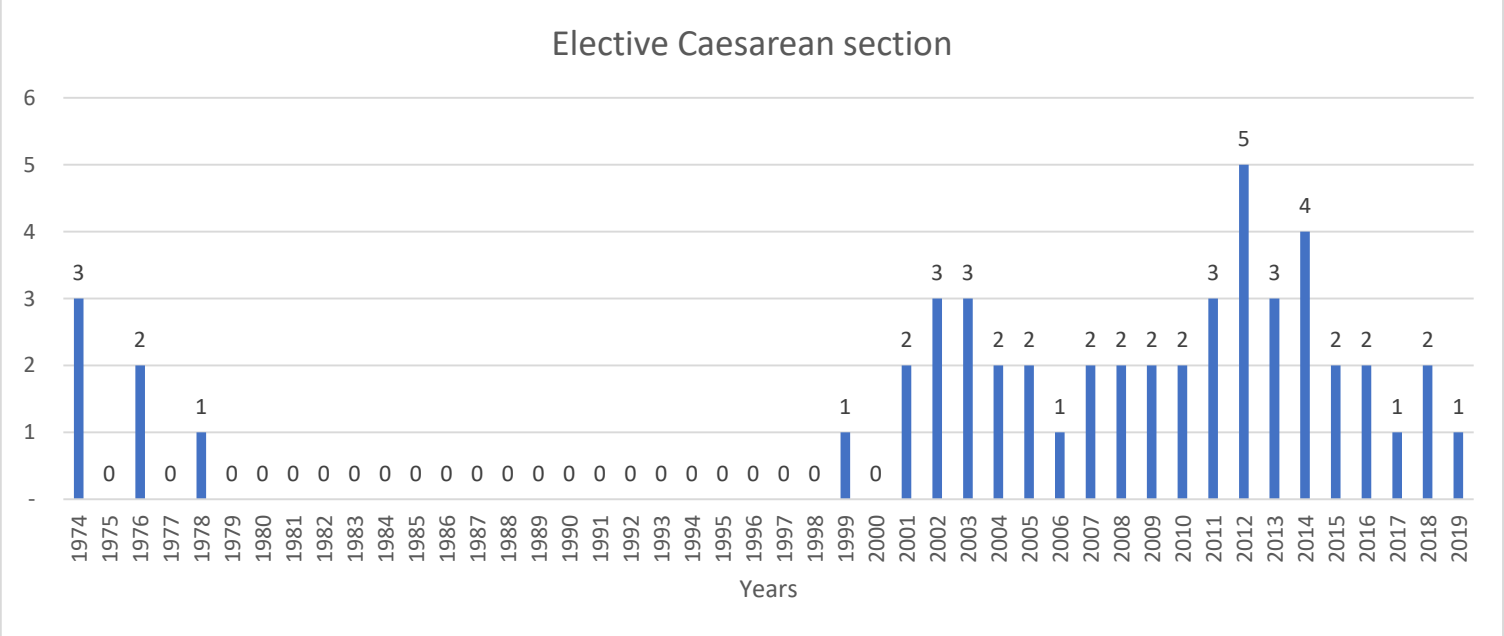




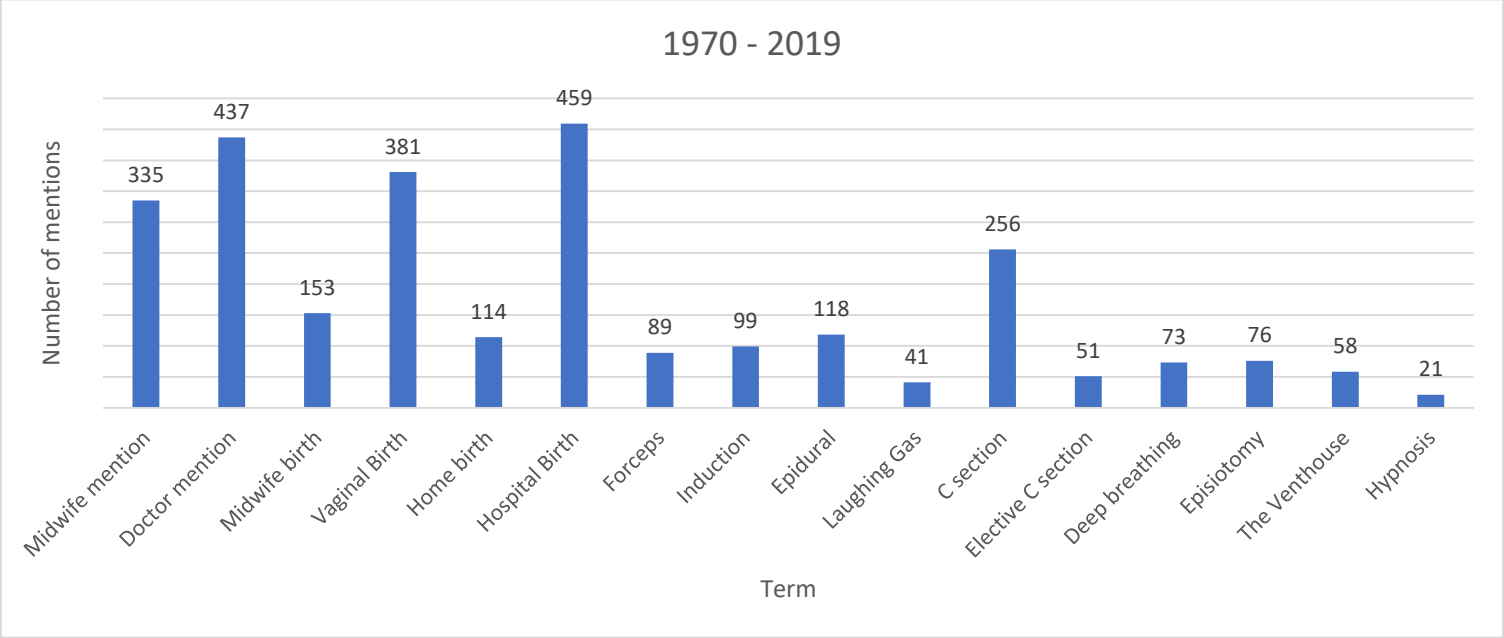
The three graphs below show the frequency of articles pertaining to vaginal births, Caesarean sections, and elective Caesarean sections. It is clear that the frequency of article mentioning elective Caesarean sections only appeared a few times in the late 1970s and increased dramatically from 1999 onwards. Vaginal birth remained constant throughout the years, increasing slightly, which seemed to also be the case for Caesarean sections.







The final graph shows the frequency of the mention of each word or concept over the 49 years of the magazine's existence. It is clear that the most frequently mentioned terms were hospital birth and doctor/gynaecologist/obstetrician, with the terms vaginal birth and midwife coming in at third and fourth place.



There is a clear indication that hospital births overseen by doctors is the norm within the data results. While midwife-led birth and home birth feature throughout the results, hospital births are approximately four times more common. Vaginal birth is evidently more common than caesarean section, but these vaginal births were not necessarily without medical intervention such as pain relief, episiotomy, induction etc. The reason for why caesarean sections become more common as the years go on is because this procedure was not taken lightly in earlier years and was considered to be a serious, last-resort option. Proof of this can be viewed in the qualitative analysis. A secondary obvious reasoning behind the frequency of elective caesarean sections only beginning mostly from the 2000s onwards is because medical professionals did not allow for the requesting of caesarean sections during the late 1900s in South Africa. The reason behind the high mentions of caesarean section rates in the magazine in 1978 is that many of these articles featured high-risk pregnancies such as one woman suffering from toxaemia, one woman having had previous medical issues with her kidneys, and another woman expecting breech twins.

5.3. Qualitative analysis

Once the quantitative analysis had been completed, the 618 articles were analysed and coded for recurring frames. Quotes and pieces of text were pulled from relevant articles that demonstrated allegiance with the relevant frame. A spreadsheet containing all data collected from the content analysis can be requested from the researcher for review. Direct quotes from specific medical

professionals such as midwives and obstetricians/gynaecologists have been noted, as this knowledge may be necessary in order to understand the context. These frames, together with examples as evidence, are organised in tables and discussed below. These frames are having a positive birth experience, fear and pain relating to childbirth and pain relief, the medicalisation of birth versus medical necessity, Caesarean section, elective Caesarean section and natural birth, and the birth environment and medical practitioner.

5.3.1. Frame one: Positive birth experience

The most prominent frame to come up throughout the content analysis was the concept of having a positive physiological birth experience. This can be detected in many of the articles for the entirety of the duration of the magazine as a publication. This is evident mainly in the word choice, inclusion of specific quotations, and underlying emotions behind a piece. During the coding process, this frame came up 127 times. This frame can be understood in two ways: the journalist describing how birth should be a positive experience, as well as the trauma that comes from not having a positive birth experience. A few examples of where this frame is especially evident in the text, can be viewed below.

Table 5: Positive birth experience
“Giving birth is your greatest adventure - enjoy it” (Wylie, 1973:52).
“This is the most satisfactory and exciting part of labour. Now you can help to push your baby along the birth canal” (Neilson, 1975:46).
Quote from an obstetrician/gynaecologist: “Come on, sit up and take your baby out. Come on, you can deliver this baby - I'll watch” (de Wet, 1977:96-97).
“The incomparable natural euphoria of childbirth…” (Salt, 1980:48).
“Every couple has the right to a satisfying birth experience” (Torngren, 1983:40).
“More and more women - and their doctors - are deciding that a mother should be an active participant in childbirth, rather than a passive patient...a sense of being in control of her body so that birth can be a natural, joyous process” (Oxford, 1985:22-27).
“As active birth methods and the movement away from hi-tech obstetric practices are gaining ground, methods which the medical world once scorned are earning new respect and recognition” (Oxford, 1986:40).
“Giving birth is a deeply emotional experience and the most amazing of all of life's miracles!” (Ryley, 1993:28-31).
“The mother had instinctively opted for the water bath, rather than go through the conventional methods of delivering...exchanging one watery environment for another makes birth a gentler experience for a baby” (Wayman, 1995:22). (On water birth)
“I’d have 40 children just to experience a pregnancy and birth like that again” (Anthony, 2003a:12). (On a midwife-led birth)
“A mom-to-be reminds us that having a baby is as much about the soul as it is about the body” (Cloete-Ehret, 2004:136).

Quote from a hypnobirthing practitioner: "HypnoBirthing is not a rigid set of beliefs that is trying to make couples birth a certain way. Rather, it is about bringing nature back into the picture through relaxation and a positive, confident mindset. When couples are relaxed and confident, they make better decisions and can actually enjoy the journey of birth" (Porter in Alexander, 2010c:62).
Quote from a GP in obstetrics: "With the right preparation, support and environment, the birthing process can be a blissful experience for a woman - more so than is widely known or acknowledged. Science is increasingly discovering that how a mother gives birth has lifelong effects on both her and her baby, and an ecstatic birth - one that takes us 'beyond' ourselves - is a gift of a lifetime" (Buckley in Torngren, 2010:39-44).
Quote from a midwife: "Research done in the 1990s in South Africa showed that women who had good, natural deliveries, supported and encouraged by a birth companion, went on to breastfeed with more success, experienced increased self-esteem and reported better relationships with the father of their children. A positive birth experience can be so empowering that its good effects are felt long after the birth. A good birth means so much more than a healthy baby and mom" (Sister Lilian, 2011:68-70).
"Mom's who've used this technique have, without exception, referred to their birth experience as 'beautiful'" (Markman, 2012:55). (On Hypnobirthing)

Table 6: Lack of positive birth experience
"The experience of giving birth is unique. No matter what the delivery is like, uncomplicated or difficult, the mother will never forget it and will remember the smallest details even after several years have passed" (Living and Loving, 1981:81).
"It was because of her own difficult and disappointing experiences in the delivery room that Femmy de Lyser....decided to dedicate herself to making childbirth happier and healthier for women all over the world" (Norbom, 1983:96).
"The hospital treated it (birth) as a totally mechanised process, almost as if I didn't have anything to do with the birth" (de Lyser in Norbom, 1983:97).
"Of course, it's fairly obvious that the more difficult and lengthy a birth is, the more effect it will have on the baby. Many doctors now believe that the problem goes further back, and they think that mothers who don't feel good about birth before the event are more likely to have a more difficult time" (Richards, 1985:48).
"For a long time, Anne couldn't think about the birth of her first child without feeling angry or tearful. It took three and a half years before she was able to face giving birth again" (Lismore, 1996:2).
"There are many reasons women give for wanting to have their babies at home; among them, like Tana, an unpleasant hospital birth experience" (Living and Loving, 1998:96).
Quote from a midwife: "More women are realising that they have the right to a happy, safe and empowering pregnancy and birth experience characterised by compassionate care and honesty about all the options available" (Sister Lilian, 2004:38).
"You always have a choice; if the first birth experience did not work for you, then consider other options and allow yourself to make the change" (Veitch, 2006:55).
"Birth trauma is linked to the following, as listed by the International Birth Trauma Association: induction, poor pain relief options, feelings of loss of control, high levels of medical intervention, traumatic or emergency deliveries, impersonal treatment or problems with hospital staff, not being listened to, lack of information or explanation, lack of privacy or dignity" (Jacks, 2018:26-29).

Relating primarily to the lack of positive birth experience was the frame of fear and pain, often referring to a traumatic birth experience.

5.3.2. Frame two: Fear and pain relating to childbirth and pain relief

The concept of fear, specifically of experiencing pain during childbirth, was detected during the content analysis. The journalists often acknowledged this fear, stating every woman experiences it when thinking about labour and birth. This would then lead to suggestions on how to manage both the fear and the pain, either through natural or chemical means. The term "fear-tension-pain syndrome" emerged when discussing the British obstetrician and natural birth advocate, Grantly Dick-Read. An overarching message related to this frame was the idea that fear of pain leads to tension and the body goes into fight-or-flight mode which consequently increases pain and leads to women needing more interventions during birth. It was frequently suggested that if this fear can be managed in low-risk pregnancies, it is possible to have a natural birth without a need for medical pain relief, and that this "purposeful pain" can be used for good during labour. While this was not always the norm, there was often a sense that going without medical pain relief was praised or celebrated. There were also instances of the negative side effects given in relation to medical pain relief.

Having an irrational fear of pain during childbirth was sometimes connected to the media and how they are often responsible for sharing over-dramatised and incorrect ideas concerning pain and childbirth.

A few examples of where these sub-frames are especially evident in the text, can be viewed below.

Table 7: Fear and pain during labour/childbirth
"How I overcame my fear of having a baby" (Zahavi, 1973:52).
"Unfortunately the word ' labour' has become synonymous with pain over the years, although recently with the enlightened teaching of obstetricians and midwives this need no longer be true" (Gilbert, 1974:58).
"Modern medicine for all its successes, has never been able to fully remove the age-old fear of pregnant women that something might go wrong" (Tangvald, 1978:8-12).
"Fear is actually a medical problem as well as a very personal one, for it affects most people in a way that puts them at a disadvantage. It sends their blood pressure up, keeps them awake, makes the muscles tense and prevents the natural relaxation that ought to be part of the ideal labour" (Gunn, 1984:74-75).
"What becomes clear is that suppression, relief or absence of pain is not merely a matter of administering the right drugs but a more subtle combination of medication, understanding, knowledge and confidence" (Carter, 1990:75-76).
"Hunger, tiredness and being in a strange environment such as a hospital labour ward, can make contractions more painful" (Kott, 2002:28-30).
"If the fight or flight hormones are activated by feelings of fear or danger, contractions will slow" (Meyer, 2012:44-45)

"The pain of labour is directly related to the level of fear women feel. Fear triggers the release of adrenaline; and breeds tension; tension causes the cervix to contract, and so the sensation of pain is amplified (Gallet, 2015:58-59).
"A 2012 study found a fear of childbirth can prolong labour" (Dimbylow, 2016:18-20).
"Try to remain positive and calm during labour as fear can cause your body to tense up, slowing down the process" (Lewis, 2016:23-25).
Quote from a midwife: "It's a scientific fact that stress causes a release of adrenaline, and that adrenaline suppresses oxytocin, the hormone that helps open your cervix. If more stress equals a slower birth, it makes perfect sense that a calm birth speeds things up (Pritchard, 2017:20-21).
"It's time to relax into labour and give yourself and your baby the birth you envision. A study published in BJOG, an International Journal of Obstetrics and Gynaecology, in 2012 confirmed that women who have a fear of childbirth spend longer in labour than those who have no such fear. In fact, labour was prolonged on average by an hour and a half. The rate of emergency C-section as well as assisted labour was also higher. Researchers have found that when women feel capable, confident and cared for, they feel less pain during labour. They perceive their pain as more manageable and they're better able to cope (Mcdonald, 2019:16-18).

Table 8: Childbirth over-dramatised in the media
"You see it time and time again in the movies - women screaming, swearing at their partners, begging for medication. But over-the-top Hollywood renditions of birth aren't necessarily true" (Meyer, 2012:44-45).
"Dump the Hollywood version: Labour isn't pretty or subtle. Whether by watching birthing videos or attending antenatal classes, your partner will be better prepared if he isn't expecting a Hollywood delivery (McCormack, 2013:52).
"Whether it's movies or a general misconception that has led us to believe that lying down during natural birth is the only or best way, there are many more options available" (Malone, 2013:54-56).
"The classic Hollywood image of a woman lying in a hospital bed, sweating and screaming her head off is one of the most enduring notions we have of childbirth, but just about everything that those women are doing is setting them up for a difficult labour. While the Hollywood-hospital-bed position might be what we've come to expect from pregnancy, it's in actual fact the least efficient position in which to labour" (Guedes, 2014:40-41).
"In most movies, there's generally a very dramatic scene in which the woman's waters break and she's rushed off to hospital. In reality, not all women experience this. According to the American Pregnancy Association, only one in 10 women experience this" (Selepe, 2015:18-19).
"Childbirth on TV or in movies is often very dramatic, suggesting birth is risky and very painful. Childbirth is far less dramatic than what you see in the movies, and generally a whole lot slower" (Gidish, 2019:22-23).

Table 9: Pro natural pain relief/pain being celebrated
"The birth of a baby is the most natural thing in the world and the most wonderful experience for any couple. Should doctors try to ease the pain of childbirth or not? Some doctors say no, they think that this pain is quite natural and shouldn't be interfered with. Other doctors, however, put forward a strong case as to why they try to ease the pain as much as possible" (Schwabenthan, 1972:41-45).

“The important thing is not that the pain disappears, but that the fright of the pain is done away with. Pain is not an evil thing, it tells doctors and nurses that something is happening” (Living and Loving, 1972:76-77).
Quote from gynaecologist: “‘But,’ warned the gynaecologist, ‘You get nothing for nothing; where there's great maternal pain relief there's also a price to pay’” (Seaman, 1982:86-90).
“Pain is part of the ecstasy of birth” (Swan, 1990:20-23)
Quote from a midwife: “There's no pain like labour pain - purposeful, positive pain. Aptly named, labour is hard and it works!” (Ryley, 1993:28-31).
“The majority of drugs administered during labour tend to slow the progress of labour. They also cross the placenta and therefore enter the baby's circulation, where they'll have an effect similar to the effect they have on the mother” (American Baby Editors, 1993a:32-36).
“It’s possible that the pain plays some role in helping a mother to start caring for her baby. When experimental animals received anaesthesia for birth, they showed altered behaviour toward their young, even rejecting them. Women's enjoyment of birth has never been related to effective pain relief” (Lieberman, 1996:24-28)
“Much of the secret of effective pain relief lies with you” (Living and Loving, 1999:80-82).
Quote from a midwife: “It is a good idea to start with natural pain relief if possible, and try the following options...chemical pain relief increases chances of intervention” (Sister Lilian, 2002:43-45).
Quote from a midwife: “During labour and birth, breathing plays a vital role in improving your ability to cope with pain and allows the birth to proceed more easily, often eliminating the need for technical or medicinal intervention” (Sister Lilian, 2003:23-25).
“You may prefer not to have any pain relief or only have it when you really need it” (Khumalo, 2005:47-48).
Quote from a midwife: “It is possible to give birth naturally without fear and pain, but first you'll need to learn how to breathe properly and prepare your body, mind and birthing environment. Forget the epidural, pethidine injections or 'happy' gas - there are ways in which you can naturally ensure that your experience of labour will be a beautiful memory” (Alexander, 2007b:51-53).
Quote from a midwife: “The first step in overcoming labour pain is understanding where it originates from” (Sister Lilian, 2008:50-51).
“The concept of giving birth 'as nature intended' is growing in popularity worldwide, with experts claiming that using certain techniques can decrease the pain and duration of labour, limit the need for medication or intervention and help mothers to enjoy, rather than dread, the birthing experience” (Cooper Howell, 2015:18-19).
“One of the most important things to work on when opting for non-medical pain relief is your mental state” (Klinkenberg, 2015:34-35).
“Hypnobirthing: this birthing method is currently drawing a lot of interest. It helps moms to overcome their fears and relax by using their natural instinct to give birth. By learning exactly how the body's perfectly designed for birth, using deep relaxation (self-hypnosis), breathing and releasing fear, a mother's able to work with her body through the process, instead of holding back (Barnardo, 2013b:56-57).
“There are times when a combination of non-pharmacological methods (hypnosis, reflexology, massage and water therapy) is more effective than pain medication. Remember that pain medication has side effects that subsequently need to be managed with other medication. While the term 'mind over matter' may sound like hocus-pocus when it comes to the pain of birth, it really has proven to be helpful” (Stevenson, 2011:52-53).

"Medicated pain relief during labour can result in drowsiness in the newborn. an epidural can result in full loss of sensation and this can affect the mother's ability to push (Hime, 2013:46-48)
Quote from an obstetrician/gynaecologist: "Many women who choose a drug-free labour say that it's empowering. Labour and epidural are almost synonymous in most pregnant social circles. But they needn't be, says Obstetrician and Gynaecologist, Dr Natalya Dinat, 'When given the chance to have a supported and active labour, many women don't ask for drugs because of the potential side-effects'. Pain relief also has its benefits. Epidurals help moms-to-be who are scared and battling to cope (Gallet, 2013:50-52).
"During labour, your body does however produce a mix of hormones that are designed to help you cope with the pain, and many midwives incorporate natural methods of pain relief - from movement, massage, breathing techniques and warm water, to lots of encouragement. There are also various methods of medicated pain relief available in hospitals (Gallet, 2014:22-24).
"Controlling your breathing during labour is the best natural pain control mechanism at your disposal" (Living and Loving, 2018:10-13).

While various pain relief options were mentioned throughout the magazine, it was noted that when epidural and induction were spoken about, this was often led with a warning of the side effects relating to these procedures. The pros and cons relating to other interventions such as forceps, ventouse delivery, episiotomy, and laughing gas were often made clear, but the overarching message regarding epidural and induction was that both should only be used when absolutely necessary. It should be noted that this was not always the case though, and in some instances, favour was shown towards these interventions. However, this was not the norm. Instances where no cons were mentioned of epidurals or induction would be considered pro epidural or induction, and vice versa.

Examples of quotes relating to epidural and induction are below.

Table 10: Epidurals and induction
"One mustn't lose sight of the fact that any medical procedure can have side effects, and epidural anaesthesia is no exception. Some doctors are not in favour of giving an epidural" (Delvin, 1975:114).
"What are the subtle, but far-reaching effects of induction? Today, labour is induced for convenience. Oxytocin-induced labours are usually shorter, but they can also be more painful. And so, in order to relieve the mother of this, either more drugs have to be given to her (perhaps having a bad effect on the unborn baby) or a greater number of epidurals have to be done. In many cases, this increases the necessity for forceps deliveries" (Gilbert, Eldridge & Eldridge, 1975:66).
"It's known that having an epidural can increase the need for forceps by two or three times, because it keeps the baby's head from turning properly and the mother can't push as effectively" (Stewart, 1990:56-60).
"Drugs given during labour have been tried and tested to ensure their safety. However, some of them slow down labour and many cross the placenta, entering the foetal circulation and effecting the baby. However there are a few cons and before making your decision, You'll need to weigh them up against total pain relief: Epidural anaesthetics tend to be associated with a higher rate of assisted births such as forceps and vacuum deliveries...you can't move around during labour" (Perchman, 1991:39-43).
"Before accepting painkillers, there are two important considerations you should think about. With most drugs, you'll lose some awareness of what's happening around you and, as many women want to experience every second of giving birth, they may find this unacceptable. Secondly, and more importantly, most drugs

cross the placenta to the baby and many moms don't want their baby to be drugged in any way. A useful tip is to wait a little while before accepting drugs...likely to lead to episiotomy and can't push properly" (Wayman, 1992:51-53).
"You can rest assured that for whatever reason you need to be induced, inductions have been a great boon to modern obstetrics. Doctors are cautious in their use of this intravenous drip and usually won't set it up until at least six hours after trying prostaglandin pessaries" (Perchman, 1993:40-43).
"The sort of pain relief you choose can also make a big difference. Having an epidural anaesthetic increases the need for forceps by two or three times because it may delay the baby's descent through the birth canal, or affect the baby's position in the canal and it stops you from being able to push as effectively" (Perchman, 1993:42-45).
"While the epidural can be a lifesaver for a difficult or extremely painful labour, it may interfere with the progress of a normal labour" (Lieberman, 1996:24-28).
"If your doctor suggests an induction soon after your due date and you've experienced no problems, you could ask to wait a few days to see if labour starts naturally" (Peirson, 1998:92-93).
"There has to be a good medical reason or exceptional personal circumstances to trigger labour artificially, and the decision must be taken by your gynae or an obstetrician. False started labour is more painful...may need a Caesar if it doesn't work...may lead to higher risk of an assisted delivery...natural alternatives" (Kruger, 1999:28-32).
"Up to one woman in three may need medical help to start labour...because medical action is being taken from the start, there's a greater likelihood of a more medically managed or high-tech birth...inductions shouldn't be done purely for convenience...powerful ways to take control" (Chilton, 2000:47-51).
"The great thing about an epidural is that it can provide total pain relief by numbing the nerves that carry pain signals from the uterus to the brain. Epidurals are not linked to an increase in Caesareans. A forceps or ventouse delivery may be more likely if you're numb and can't feel to push. Now that weaker concentrations of anaesthetic are used, this is less common" (Living and Loving, 2001:44-54).
"Epidurals - an epidemic? If birth is a normal, natural process why are so many women choosing epidurals during labour? And in making this decision are women doing themselves and their babies more harm than good without knowing it? - The counter argument of epidural devotees is that there are no medals for bravery doing drug-free labour so why be a martyr? Forceps may be needed , but it's also worth knowing that an epidural or other drug used for pain relief can also turn a normal birth into a medically managed affair which can be disappointing if you're not prepared" (Living and Loving, 2002: 30-32).
Quote from a midwife: "This can slow labour and research has shown this can lead to unnecessary intervention...if all is in order and there are no risk factors in allowing the pregnancy to continue, nature should be allowed to take its course" (Sister Lilian, 2004:40-44).
"The main reason for taking a DIY approach is to avoid medical induction" (Morley, 2004:50-53).
"It's a situation over which women have very little control, notwithstanding the intervention of prebooked Caesareans and planned inductions. It could be that an overdue baby isn't really overdue at all" (Suckerman, 2005:46-48).
"A lot of moms-to-be seem to think that an epidural equals pain-free labour, and that's why they opt for it. But while an epidural is undoubtedly very beneficial, it's important you know about the possible side effects before making your decision. Epidurals are undoubtedly associated with an increase in intervention, such as forceps or ventouse delivery and episiotomies" (Richley, 2006:78-79).
"An epidural is a common method of pain relief during labour, and, in my opinion, a must if you're considering a vaginal delivery" (Van der Westhuizen in Jorgensen, 2017:40).

"In medicalised birth, artificial oxytocin (syntocinon) is often given to mothers, but getting the dose exactly right is difficult. Too much syntocinon can create very strong contractions that are painful for the mother and stressful for the baby, necessitating further obstetric interventions. Helping mothers to make their own, natural, oxytocin is much safer" (Torngren, 2008:69-72).

While foregoing pain relief was often celebrated, medical advancement was frequently celebrated, specifically relating to lifesaving procedures and operations where, in the past, without them would have led to disastrous results.

5.3.3. Frame three: The medicalisation of birth versus medical necessity

The frame of the medicalisation of birth and labour was detected. This can be understood in two ways: childbirth and labour becoming a medicalised event, whether this is necessary or not, versus medical necessity, where medical intervention was celebrated for high-risk pregnancies and births which required lifesaving medical intervention. An example of the medicalisation of birth found early on in the magazine was the routine procedure of shaving a woman's pubic region, giving her an enema and a routine episiotomy during every labour. In the magazine, these procedures were then questioned and foregone later on as they were deemed medically unnecessary, and intervention was questioned. A few examples of where these two sub-frames are especially evident in the text, can be viewed below.

Table 11: Medicalisation of birth and intervention
"I had the best doctors and gynaecologists, and all the staff were marvelous. I just did exactly what the doctor told me" (Bennett, 1973:30).
"Episiotomy is best for baby" (Rayner, 1978:130-132).
"The miracle of modern monitoring can give early warning that something is done...it really is the baby's best friend" (Bowring, 1980:18-23).
"The ideal is a quick, easy vaginal delivery, but because we walk upright, the human pelvis is not fully adapted for either locomotion or child bearing so complications during birth may arise and delivery is very much an individual matter in a rapidly changing situation...you may be induced...dad may take leave or for when it's convenient" (Seaman, 1982:86-90).
"Is our assumption that birth in the past was easy and natural unfounded? Or has it been complicated by doctors who want to be seen to work for their fees? (McCracken, 1988:62-65).
"Many first time mothers have episiotomies but is this procedure always justified? That's the question only your doctor or midwife can answer...midwives are taught how to support the perineum while moving the baby's head so that the mother doesn't tear, but they're often not given the opportunity to put this procedure into practice before the doctor decides to cut" (Perchman, 1992:86-87).
"Episiotomy is almost routine in many hospitals, and is performed in about 50 to 70 percent of deliveries (especially first-time births), but unless it's a medical necessity you do have a choice" (Peirson, 1998:94-95).

"Gynae or midwife? Home birth or hospital? Many women feel more confident about giving birth in a place where specialised medical assistance is close at hand if there's a problem. However, some childbirth campaigners argue that unnecessary intervention is more likely in a hospital - and if you and your partner feel intimidated by the environment, you could feel forced into making decisions you may regret later (Moorhead & Kruger, 2000:38-41).
"When it comes to looking at birthing trends, there is no doubt that historical circumstances and medical advances have played a vital role in shaping and changing our attitude towards labour. While medical trends such as elective Caesarean sections, epidurals and routine episiotomy procedures are still popular and often encouraged by practitioners, more and more women are now going back to their roots and exploring the approaches commonly used by their ancestors" (Alexander, 2007b:51-53).
Quote from a midwife: "Natural birth is an intrinsic biological process that, if given time, occurs spontaneously. Any intervention, such as a vaginal examination or even a routine observation can sometimes disturb the mother's feelings during labour and set her off course emotionally. Interventions during labour and birth are physically intrusive...they scare the mother and increase their hormonal output of adrenalin, which inhibits labour" (Litteljohn in Wessels, 2009:64-66).
Quote from a GP in obstetrics: "Hospital environments and routines are not generally conducive to the shift in consciousness that giving birth naturally requires. A woman's hormonal physiology is further disturbed by practices such as induction, the use of painkillers and epidurals, Caesarean surgery, and separation of a mother and her baby after birth. If the mother is in hospital, she may be put onto an artificial oxytocin drip (syntocinon) to 'speed things up'. This can cause longer, stronger and more frequent contractions that cause stress to the baby. They are also more painful for the mother, so she will probably require pain relief (morphine derivatives like pethidine or an epidural). The baby is affected by the drugs, which cross the placenta, and the mother is immobilised in bed. The mother's progress may slow down and more syntocinon may be given. The baby is likely to go into foetal distress because of the lengthened and intensified contractions, which cut down the oxygen she is getting. Thus, a Caesarean may have to be performed to get the baby out fast. Even if a C-section isn't done, a mother who has had an epidural will find it harder to push the baby out; the foetal ejection reflex will probably not happen and frequently the baby needs to be pulled out (by forceps or a vacuum extraction). Both a mother and her baby are likely to be 'woozy' and 'out of it'. Therefore, bonding and early breastfeeding are compromised because the baby is disoriented and her 'breastfeeding reflexes' may be weak" (Buckley in Torngren, 2010:39-44).
Quote from a midwife: "CTG (cardiotocography) is invaluable in high-risk pregnancies and deliveries or when complications develop during labour. However, continuous monitoring in low-risk labours is associated with higher rates of medical intervention" (Sister Lilian, 2002:38-42).
"Childbirth is a natural, normal and life-changing process. While sometimes intervention may be required in order for a safe outcome for you and your baby, birth is not automatically a medical event the moment you fall pregnant" (Alexander, 2007c:63-66).

Table 12: Medical necessity
"Of course in a few cases, there are complications. This isn't half as horrifying as it sounds. It simply means that you will need more medical help than you would for an ordinary birth" (Living and Loving, 1972:18-22).
"Obstetricians prefer that a woman have her baby by normal delivery through the birth canal. Childbirth, doctors stress, is a natural process and any surgical assistance given to the birth is for the benefit of the mother and child" (Medical experts, 1973:12).
"Back in the old days, our mothers and grandmothers put in a lot of hard work having a baby. We are more fortunate. Dr Patricia Gilbert lists some of the labour-saving devices available to modern moms (Living and Loving, 1974:58).

“Doctors are well-prepared to help him...the quickness of saving a baby's life” (Evelyn, 1978:17-19).
“Before the 1930s doctors usually had to concentrate so much on the mothers survival that the safe delivery of the baby was often of secondary importance” (McCracken, 1988:62-65).
“With today's medical technology, tiny babies born too soon have a much better chance in their fight for life” (Fuller, 1989:16-17).
“Incredible advances in the treatment of sick and small babies, both in and out of the womb, have dramatically improved their chances of survival” (Du Plessis, 1992:30-32).
While a positive approach towards labour is undoubtedly best, it's only realistic to bear in mind the possibility of complications so that you're prepared if you need extra attention” (Marshall, 1997:28-33).
“Labour and birth nearly always go as expected, but hitches do sometimes necessitate an emergency induction or Caesarean section. Back in the old days it wasn’t uncommon for babies (and mothers) to die during labour or from complications after the birth. But thanks to today’s regular antenatal care, modern technology and better training, most complications can now be dealt with quickly and effectively to ensure a safe delivery and healthy baby” (Swan-Inggs, 1998:57-59).
“The miracle of modern monitoring can give doctors an early warning so that something can be done to save the baby before it is too late. The modern equipment we have today makes giving birth much easier and relatively safer than 40 years ago. The survival rate of mothers and babies increased dramatically after the invention of forceps. Death during childbirth was 'an expected' tragedy before this device was discovered. The Caesarean section was another great 'invention' to treat obstructed and difficult labour” (Van Vuuren, 2010:54-58).
“Extra medical intervention can ease the process and speed delivery” (Sidley, 2014:38-39).

On the note of medical necessity versus the medicalisation of birth, the frame of Caesarean section emerged.

5.3.4 Frame four: Caesarean section, elective Caesarean section and natural birth

A Caesarean section was framed in a positive light throughout the magazine when in relation to high-risk pregnancies. This operation was celebrated when saving the lives of both mother and baby in drastic situations. It was often acknowledged that the woman may feel let down or disappointed when her labour led to this outcome, sometimes even stating that she may feel like her body failed her. The text often included a large amount of consoling of the woman and reassurance that this operation may have been unwanted but that at least the baby is safe. This was especially evident in the early years of the magazine specifically throughout the 1970s and 1980s. Overall, the concept of elective Caesarean sections were framed negatively throughout the magazine, with a few, minor exceptions. While the magazine sought to come off as balanced, specifically relating to a woman having the right to choose her own birth method, the overarching message was that Caesarean sections should be reserved for high-risk pregnancies and labours. This led to the frame of power dynamics in birth and labour emerging throughout the 1990s and 2000s of the magazine. Women were often encouraged to challenge their medical practitioners when they encouraged unnecessary intervention or Caesarean

sections for convenience. Other ideas relating to the frame of power dynamics in birth that were frequently discussed, included being an active participant in birth, choosing your own birth position, and creating a birth plan and giving it to your medical practitioner.

Finally, a celebration of natural birth and "returning to your roots" was a frame that was evident throughout the magazine, but became especially evident at the same time that medical intervention and elective Caesarean sections became more frequent (approximately around the 2000s). The magazine stayed true to its stance on the necessity of medical intervention in high-risk instances, but frequently wrote about natural birth for low-risk pregnancies and labours in a romantic manner, stating many pros such as shorter labours, less postnatal depression, less downtime, more birth satisfaction, ease in breastfeeding etc. However, the magazine acknowledged the concept of guilt related to choosing intervention during labour and positioned themselves as being against the idea of shaming a woman for choosing for relief such as pain medication during labour.

Examples of these four sub-frames can be seen below.

Table 13: Caesarean section commentary
"Confinement without a doctor's help can be disastrous...nowadays, if there is any doubt in the case of a first baby, doctors usually perform this operation, which is considered much more lightly than it used to be (Living and Loving, 1971:30-35) (On Caesarean section).
"Many women say they would like to have all their babies by Caesarean section because the birth is easier. However, if there's no medical reason why a woman should have her baby Caesarean section then there's no chance of a doctor agreeing to it (Living and Loving, 1972:18-23).
"This is only done, however, if the mother's life is in danger or the baby cannot be born the natural way" (Schwabenthan, 1972:41-45).
"For me a Caesar was normal as it was the only way I could give birth" (Orme, 1986:70-73).
"Researchers have found higher levels of postnatal depression among women who've had Caesarean sections, with fewer mothers continuing to breastfeed and many being distressed because they didn't see their babies immediately after delivery" (Living and Loving, 1990:56-57).
"A prem baby born by Caesarean section is at greater risk of having breathing difficulties as the lungs are unprepared" (Fuller, 1989:16-17).
"Most, but not all, breech babies are delivered by Caesarean section" (Perchman, 1993:34-36).
"The increased rate of Caesars in most countries is not only due to increasing medical know-how and monitoring, but also a tool in a more defensive type of medicine in which doctors may be sued rather than risking labour-related complications. The decision for a Caesarean delivery should, however, never be made lightly as the operation involves greater health risks than a vaginal birth" (Ryley, 1994:28-30).
Quote from midwife: "Let me make my philosophy on birthing quite clear, as it's not always acceptable to the medical and midwifery fraternity. I believe that in the vast majority of cases, birth should unfold naturally and without medical intervention. Probably only about 10 percent of women or their babies need medical intervention, and I applaud medical science for the great strides it has made in saving womens and babies' lives. However, I'm distressed by unnecessary interference in so many of the remaining 90 percent of births. Insist on being remonitored before an induction or Caesarean is done (Sister Lilian, 1995:32-36).

“Caesareans are on the increase, the bad news, say advocates of natural childbirth in South Africa and elsewhere, is that the Caesarean rate is on the increase in most developed countries. Even though you may be allowed to go into labour and attempt a normal delivery, you'll probably still stand a relatively high chance of having a Caesarean. Statistics reveal that women are three times more likely to have a Caesarean now than they were 20 years ago. This despite the World Health Organization that there's no medical justification for a national rate of more than 15 percent...swing towards the first world...high-tech birthing option” (Udal, 1997:30-34).
“Once a rare operation, the Caesarean section or 'Caesar' is becoming increasingly common. This is partly because doctors fear being sued if a difficult birth causes complications that could have been avoided by a Caesar, and partly because the operation is now so safe it has fewer risks than other forms of birth, such as a high forceps delivery” (McDonald, 1997:57-60).
“A Caesarean section is the safest birth option if you and your baby are at risk. Compared with 20 years ago, more women today have Caesarean births, an issue which is hotly contested by those who believe that many Caesars could be avoided if it were not for technological intervention and medical procedures which, it is argued, impede the natural birthing process” (Cameron, 1997:34-37).
“The Caesarean section is cast time and again as the hero or villain in the birth scenario - can you avoid a Caesar? Could it be then that the hospital environment which tends to be clinical with routines and procedures that are unfamiliar to labouring mothers, is stressful, possibly resulting in more Caesars? Perhaps - but with added safety precautions comes the price of less freedom.
Because of high-tech monitoring devices used during labour, some believe the conditions being overdiagnosed - a degree of dropped heartbeat recorded on monitors during contractions is normal and it's quite tricky to distinguish to what degree the baby is in distress, or if he really is. For the baby's safety, doctors usually err on the side of caution and perform a Caesar” (Khumalo, 1999:32-34).
“If for any reason your cervix can’t dilate sufficiently you'll need a Caesar, which is much faster but not easier on a baby than ordinary labour” (Living and Loving, 1999:22-26).
“Labour is hard work, but despite a rising incidence in C-sections, remember your body is actually designed to give birth” (Kruger, 2003:30-32).
Quote from a midwife: “A Caesar should not be undertaken lightly although it does provide a safe birth option for both mother and child. Continuous monitoring is common in most private hospitals, but does restrict movement. This can slow labour and research has shown this can lead to unnecessary intervention. If all is in order and there are no risk factors in allowing the pregnancy to continue, nature should be allowed to take its course” (Sister Lilian, 2004:40-44).
“A Caesarean can cost up to R20,000, almost twice the amount of a natural, vaginal birth, if you are not on a medical aid” (Suckerman, 2005:46-48).
“The number of Caesarean sections has soared in the last years, while only 50 years ago it would have been quite unusual. Caesareans are supposed to be performed as a matter of medical emergency, when obstetric complications arise with a mom and/or her baby. Nowadays, however, moms-to-be can elect to have a Caesar in some countries - including us. Whatever your feelings on the subject, it is important to know about the risk factors of both a vaginal as well as a Caesar birth. What's more, there are even a few things you can do to decrease your chances of needing a C-section” (Van Vuuren, 2007:65-70).
“Having a Caesarean: unfortunately this is a very real ' fear' as South Africa has one of the highest Caesarean rates in the world. Being well-informed and having an open line of communication with your doctor or midwife can reduce the need for a surgical birth. Always remember that it is never too late to get a second opinion” (Alexander, 2007c:63-66).
Quote from a midwife: “A Caesarean section may be necessary (in no more than 15% of all births) and is a life-preserving intervention, yet is often extremely invasive and traumatic for both mother and her baby” (Littlejohn in Wessels, 2009:64-66).

"According to statistics, women suffer a lesser degree of emotional distress and depression from having a C-section, if they are prepared for the process. 'The necessity of Caesareans is often dictated and driven by society and now, more than ever, by fear of litigation', explains Wypkema. According to statistics there is an average of 35% Caesarean incidence in first-world countries, but a much higher incidence of 75% in the private sector. There are, however, medical reasons why a mother cannot always have a vaginal delivery" (Van Vuuren, 2009:51-53).
Quote from a midwife: "A Caesarean section may be necessary (in no more than 15% of all births) and is a life-preserving intervention, yet is often extremely invasive and traumatic for both mother and her baby" (Littlejohn,Wessels, 2009:64-66).
Quote from a midwife: "A natural birth in which all goes well will have the best outcome, but if either Mom or Baby really needs intervention, such as delivery by Caesarean section, then that's the best birth for them" (Sister Lilian, 2011:68-70).
"Certain clinical indications point to the fact that it's safer for both mom and baby to have a C-section" (Gallet, 2014:32-34).

Table 14: Elective Caesarean section commentary
"Many moms are opting for elective Caesars in the belief that it's a less traumatic way of bringing baby into the world. Instead of being pushed and squeezed through his mother's pelvis, the baby is simply lifted out. The bonus is that she knows what date and time baby will arrive, and her pelvic floor muscles are left intact. Despite this growing trend, research shows that, provided there are no complications, giving birth as nature intended is better for baby's physical and emotional wellbeing. And mom reaps benefits, too. While there's a growing trend towards Caesareans, research shows that a natural birth is still better for baby's health and wellbeing" (Moore, 2002:36-37).
Quote from an obstetrician/gynaecologist: "While the operation is obviously performed for a range of maternal and foetal reasons, mothers-to-be are also choosing it as their preferred birth option. Often we obstetricians are asked the question whether it is appropriate for us to perform Caesareans on request. Maternal choice was given as the reason for Caesareans being performed in 38% of all Caesarean deliveries in one particular hospital, raising the question of whether this is a reasonable birthing option in the absence of any particular obstetric reason. As we obstetricians routinely involve women in decisions pertaining to their pregnancies, such as testing to determine any foetal anomalies, it seemed logical to extend this to the discussions on delivery options. Women who think that a Caesarean will spare them the pain and tedium of normal labour, need to be counselled and the real risks must be explained to them. One can't deny that it is more convenient for an obstetrician to perform a Caesarean at a time agreed by the parents, as opposed to conducting an unscheduled vaginal delivery at three in the morning" (De Jong, 2006:54-59).
"A growing number of women are asking for Caesars. Shocking. Or is it? Find out how mother nature's birthing plan can affect women's long term health and the benefits the surgical alternative can offer" (Living and Loving, 2009:27-29).
"I had a C-section to spare my pelvic floor muscles and urinary incontinence...knowing what I know now, if it wasn't medically necessary, I'd never opt for an elective Caesar again. The weeks of post-operative recovery were much worse than the 25 hours of labour pains" (Mol in Ryley, 2003:24-28).
"Whether you have one through choice or because of a medical emergency, a Caesarean is a big deal. Here's an overview of this increasingly more common procedure" (Klohn, 2003:34-38).
If you'd prefer a Caesarean to a natural birth, private hospitals can offer you an elective Caesar. This does not necessarily mean that a Caesarean is needed, but every mom has her own reasons for choosing this option. If you do opt for an elective Caesar, it's best that you weigh the pros and cons of each type of birth and make an informed decision" (Khumalo, 2005:65-66).

“Ask your doctor to let you go to at least your due date if the reason for the Caesar is not a serious medical or obstetric condition warranting premature delivery. It is by far best for baby to be born when nature intended, as the maturing of organs and body systems is then most perfectly complete” (Cox, 2006:55-57).
“Dr Gerrit Viljoen, says that the single most common reason why C-sections are performed is because patients request them - mainly because they are afraid that complications may arise during the delivery and they also want to avoid the pain of having a vaginal birth” (Van Vuuren, 2007:65-70).
Quote from a midwife: “You can even elect to have a Caesarean section, although this is major abdominal surgery and is best left for when it's required for the safety of Mom and Baby. This should preferably not be a choice because it is, in fact, an intervention required for complications of pregnancy or labour. In South Africa, it's become almost the norm to opt for an "elective" Caesar. A Caesar can save Mom and/or Baby when there are true threats to their safety, and it may well fit better into a family or doctor's schedule, but the risks involved with Caesareans should override these reasons for having one...foetal monitoring has a high rate of false positives” (Sister Lilian, 2011:68-70).
Quote from a midwife: “South Africa is one of the only countries in the world that readily sanctions Caesarean birth as an option. So, make sure you have all your facts. It really shouldn't be done for no good medical or obstetric reason, especially in first pregnancies which often go over the date” Sister Lilian, 2012:52-54).
“Over 70% of deliveries claimed in South Africa are C-sections. Increasingly, among privileged parents, the procedure is a choice. Without a pressing medical reason, moms may elect to have a C-section instead of a vaginal delivery. In light of this, one has to consider whether a C-section is best for the baby. Premature birth, respiratory problems, childhood obesity, asthma, surgical injury, lower risk of birth trauma…” Sidley, 2013:50-52).
“You cannot have elective Caesar in the public sector” (Gallet, 2014:32-34).
“A C-section has become an elective procedure rather than a necessity. According to one medical aid scheme's report, over 70% of deliveries in private hospitals in South Africa are done via C-section. Why would a woman choose major surgery over vaginal delivery?...conveniently plan the arrival of your baby. Don't allow a healthcare provider to bully you into having a C-section simply because it's more convenient” (Selepe, 2014:25-26).
“C-section can be a lifesaving procedure when issues in labour occur. However, when it's not medically necessary, it can put mothers and their babies at risk of severe complications while increasing healthcare costs. Despite this, the rate of Elective C-sections for non-medical reasons is on the rise. In South Africa, more than 70% of deliveries in private hospitals are done via C-section. A study published in the Journal of Psychosomatic Obstetrics & Gynaecology, involving more than 6500 pregnant women from six countries in Northern Europe, highlights a clear need for appropriate support and advice when C-sections are elected for non-medical reasons, and for the accurate communication of risks and benefits of C-section births. The research shows that women who have a fear of childbirth, depression, a history of abuse, or a previous negative birth experience were more likely to choose to have a C-section” (Living and Loving, 2016:15).
“Would the risk of childhood leukemia make you reconsider your birth choice? If a vaginal birth could protect your child against leukemia would you opt out of an elective C-section? Dr Mel Greaves, renowned for his work on childhood leukemia at the Institute of Cancer Research University of London, believes the most common form of childhood leukemia, childhood acute lymphoblastic leukemia (ALL), can be prevented. It requires only four measures - of which natural birth is the first and crucial step. Are you choosing a higher risk for leukemia when you choose a planned C-section? This might be the case. At South African state hospitals, where only emergency and medically indicated C-sections are allowed, a mere 10% of moms have C-sections, compared to 75% of Discovery's pregnant moms, according to Dr Noluthando Nematswerani of Discovery Health. Opt for a vaginal birth - if your health and baby allow for it” (Delport, 2019:11-13).

Table 15: Power dynamics in labour and birth
"Now you can actively participate in the birth of your baby in the safety of a hospital. Lying on your back with your legs up in the air to give birth is the second silliest position after standing on your head, say the Active Birth protagonists" (Perchman, 1991:28-31).
"Active birth enables the mother to move around freely and to take up any position which feels comfortable. This can mean that you experience less pain and may also have a shorter labour than if you were lying down...ask your midwife or doctor (Watson, 1994:30-31).
"To make the most of your baby's birth you need to look at all your options your medical practitioner should mention all options and offer advice, but it's up to you to weigh up the pros and cons, both medical and personal, and make your choice. You have to be assertive if you want a natural birth in a high-tech hospital, although it's not impossible to have one. The staff may be more inclined to use technology - speeding up a slow labour with drugs, for instance - whereas a midwife assisting with a home birth is less likely to do this. It's much easier to achieve natural labour in a low-tech hospital or at home, but there's the disadvantage that you may have to be transferred to hospital if, by any chance, a problem arises" (Wayman, 1994:35-37).
"Childbirth in the 90s is as alien to our mothers' experience as it's possible to get. In their day, Western women were given a raw deal in the childbirth stakes. The only way most doctors allowed them to give birth was on their backs, in a logic-defying position that made labour much more painful and exhausting than it needed to be. More women are rejecting conventional techniques and taking control of their baby's birth (McDonald, 1997:57-60).
Quote from a midwife: "Practitioners often believe that they have the sole responsibility for the eventual outcome of your pregnancy, with unnecessary intervention frequently being the unfortunate result. Many pregnant women also hold this view in the mistaken belief that pregnancy and birth are illnesses or 'conditions' that require expert medical intervention at all times. Do not be intimidated into thinking that your pregnancy and birth are best left to the practitioner alone" (Sister Lilian, 2004: 38-42).
"Although the nature of your pregnancy may dictate what type of care provider is your best bet, your personal preferences matter too" (Moore, 2010:68-71).
"Once you have chosen a caregiver, be aware of your right to have a full explanation of your reasons for his or her actions, and remember that you are free to ask for a second opinion" (Xanet van Vuuren, 2010:43-44).
"Squatting allows gravity to aid labour, and opens the pelvis for baby to move into the birth canal. Modern-day childbirth is commonly done semi-reclining, or lying flat, on a hospital bed...it caters much more for the medical practitioner's monitoring needs, than to facilitate the progress of a mother's labour or her comfort" (Gallet, 2014:22-24).
"For many women, making the decision about their method of delivery is difficult, especially if their expectations are inconsistent with medical opinion. Rather than panic, educate yourself on how the different delivery methods can affect you and your baby" (Selepe, 2014:25-26).
"These days, women have more choice in how and where they give birth, but many medical aids still prefer them to be in hospitals under the care of specialists. The traditional mindset may be that a woman should give birth in hospital, attended by specialists. However, in recent years, women are increasingly opting to give birth in active birthing units, supported by midwives - or even at home. South Africa still lags behind in the movement towards natural and home births assisted by midwives. This is borne out by medical aids' limited support for these options" Guedes, 2014:42-44).
"After two C-sections, Olwethu Leshabane decided to take back her power" (Witepski, 2018:58-59).

Table 16: Guilt regarding birth
Quote from a midwife: “There is no disgrace in asking for relief” (Neilson, 1978).
“It can be very disappointing for a mother to have her baby by Caesarean section - particularly when it's an emergency Caesar, for which she has had no opportunity to prepare. She may be left feeling that she has failed at the vital womanly function of giving birth and that she is somehow less of a mother” (Torngren, 1983:37-40).
“Pain relief will be available, as labour isn't an endurance test. So if at any point you can't tolerate the pain, ask for pain relief - no one will think you've 'failed'” (Living and Loving, 1999:80-82).
“Remember, whatever kind of pain-relief you choose - or don't choose - at the end of the day it’s your labour and you're free to change your mind” (Richley, 2003:36-38).
“If in the process of attempting a waterbirth at home, it becomes obvious that there is a need for medical intervention, the birthing couple has to quickly move to a nearby hospital. It’s important to recognise that necessity, and surrendering to receiving help is not a failure...conscious birth can take place in a hospital too, if we treat the newborn with gentleness, love and respect” (Torngren, 2008:69-72).
“When a baby is born through the vaginal canal, her lungs are compressed and mucus is expelled from her body, which helps prepare her for life outside the womb” (Van Vuuren, 2011:56-57).

5.3.5 Frame five: Birth environment and medical practitioner

The last frame to be discussed is that relating to the birth environment and the medical practitioners involved in labour and birth. The birth environment is primarily related to either the home or the hospital. During the late 1970s of the magazine, the concept of active labour was introduced leading to a large emphasis on walking around during labour and asking the medical practitioner if you can give birth in a sitting/standing position, instead of the usual lying down position. This led to the introduction of active birthing units, which then seemed to become less common due to availability in the 1990s onwards. While both the home and hospital were considered places to give birth, there was a clear preference for the hospital. However, *Living and Loving* frequently encouraged the idea of giving birth at home, but specifically only for low-risk pregnancies. Giving birth at home was often written about in romantic language and backed-up with a host of benefits.

During the early years of the magazine, there was a clear working relationship between the midwives and doctors/gynaecologists/obstetricians. In most cases the midwives were present for the entirety of the labour and the doctor only was present for the actual delivery. In some cases, if the birth was low-risk and straight-forward, the midwife delivered the child and the doctor wasn’t present at all. However, as the years progressed, while not much changed in the public sector, this changed in the private sector. Midwives disappeared completely (moving over to private practice) and the birth and labour was overseen by the obstetrician. The magazine began to start writing about reintroducing the relationship between doctor and midwife in the private sector, and had a large emphasis on assuring readers that midwives can be the preferred medical practitioner of choice for low-risk pregnancies,

while doctors should focus more on the high-risk pregnancies. In 1999, the first mention was made of a doula. This birth companion was mentioned more frequently for home births, but also for other birth methods, even Caesarean sections. Overall, there was a sense in the later years of the magazine of a "returning to nature" and natural methods. This was particularly evident when discussing rising Caesarean section rates and elective C-sections. While it is clear the magazine was not against any medical practitioner or birth environment, all options were discussed for the entire duration of the magazine, and viewed as viable options, depending on the birth risk.

Examples of these two sub-frames can be seen below.

Table 17: Birth environment
"Home deliveries are not what most South African mums opt for when giving birth...the obstetrician agreed to let her go ahead with the home delivery instead of being in a clinical hospital ward. Here at home everything was relaxed and friendly, the birth seemed so natural and right. Somehow it was wonderful, but I wouldn't recommend it for everyone, it all depends on the health of self and baby" (Bowring, 1980:160-161).
"What does remain with me very vividly is the feeling that I built up during these two hospital confinements that this was not my way. That I would much prefer to hold my baby as soon as it was born at home. It was so difficult to find a doctor to attend the birth. I eventually discovered a wonderful midwife who agreed. There is an easing with more breathing space. I feel so relaxed, so happy. How different from last time. There has been no shaving, no enema, no internal examination" (Pantland, 1981:70-71).
"'Ah yes,' you may say (and so may your doctor), 'but what about complications?'Home is the best place to have that baby! The only real problem is how to persuade your doctor and all the other people concerned, to let you try it!" (Howard, 1981:204-205).
"A hospital delivery has great advantages. If anything goes wrong in labour - and it could - then immediate emergency action can be taken. The latest sophisticated machinery and drugs can be used, and also the mother can be given all the skilled obstetrical care she requires" (Living and Loving, 1982:46-48).
Quote from obstetrician/gynaecologist:"I have always believed that the safest place for a mother to be in labour is in a hospital, in case emergency treatment is necessary, but the best place for both her and her baby after the birth is at home" (Gidish, 1982:12-15).
Quote from a doctor: "Giving birth at home is a controversial matter in South Africa...and can be difficult to arrange...a good old-fashioned doctor who feels it's time to revive some good old-fashioned ideas on childbirth...in hospital you do it their way, or else! There appears to be little chance that home birth will catch on in South Africa in the same way that active birth has" (White, 1986:50-53).
"The Caesar moms were more likely to feel that the birth was a traumatic experience. Those few mothers who had their babies at home seemed to be the happiest with their birth experience, as all of them said they felt proud and elated after the delivery" (Living and Loving, 1987:38-43).
"Is home birth for you?...had the gynaecologists blessing...what impressed them most was the friendly, rather than 'businesslike' relationships they built up with the midwives over the months. Midwives have always delivered babies in provincial hospitals but by going into private practice they're breaking new ground in South Africa" (Living and Loving, 1993:38-41).
"Most first-time mothers opt for a hospital because doctors have discouraged home deliveries for years, saying they're simply not as safe, but now new evidence has turned that idea on its head. A report by the UK National Perinatal Epidemiology Unit says that the risk of drugs and technological treatment given to women during hospital births may actually outweigh the benefits" (McDonald, 1997:57-60).

“Studies show that women who give birth at home tend to have shorter labours and need less pain control, possibly because they feel more relaxed. Private hospitals - this is often the best option if you have an underlying illness or pregnancy that's not straightforward” (Moorhead & Kruger, 2000:38-41).
“Tranquility, intimacy and support are all part of the homebirth experience. Most women who have a homebirth want more control over the birth and about 30 percent opt for home births because they weren't happy with their hospital births. Monica’s pregnancy was uncomplicated and normal. When a mom-to-be is expecting more than one baby, the baby is in the wrong position or there are placental problems, a homebirth is out of the question. At no stage of her homebirth did Monica feel the need for drugs or an epidural. Only nine percent of women need drugs during a homebirth. Pain relief is available but usually in the form of homeopathy or acupuncture. Intervention with vacuum or forceps and episiotomies are the exception rather than the rule. Episiotomies are done in eight percent of home births whereas its closer to 60 percent in hospital births. Vacuum is used in about two percent of home births and 60 percent of hospital births. Most babies born at home are alert and strong after birth and have good Apgar scores” (Ryley and Wetscher, 2001:56-59).
Quote from a midwife: “Being born into familiar and tranquil surroundings at home can give your baby a very special start in life” (Sister Lilian, 2002:31-34).
“The fact is that women who have had a straightforward pregnancy and opt for a home birth, have far fewer interventions and are more likely to have a normal delivery” (Van Vuuren, 2007:65-70).
“While to some the idea is perfectly normal and others may think that it is completely crazy, a home birth provides the most natural and comforting environment in which to deliver. As far as complications are concerned, the statistic is that only 5% of births are complicated and may need special medical intervention” (Alexander, 2007a:61-63).
“Homebirth is not a new trend. If one considers how long women have been having babies, and for how long have they had their babies in hospitals, it is clear that the trend of turning birth into a medical event is far more current” (Alexander, 2007b:51-53).
“You may think that going natural all the way, free of medical intervention (no epidural or pain-relief drugs) and perhaps not even having a doctor by your side is unheard of in today's modern world. However, more and more women are discovering that there are alternatives that can enable them to naturally birth their babies at home if they so wish to and in a way that is far more beneficial for both mother and child” (Alexander, 2010c:62-64).
“By opting to give birth at home, more moms worldwide are discrediting the notion that labour is a medical problem that must be treated in a hospital. Fortunately, there are doctors who are supportive and who realise they're only there for complications (Guedes, 2013:52-54).
Quote from a midwife: “Home births often take half as long as hospital births because the mom isn't fighting the pain and the process. When anyone goes to hospital, they release adrenalin, which suppresses these endorphins and puts them in a state of fight-or-flight. This makes it likely that they'll need pain relief (Marsay in Guedes, 2013:52-54).
“Many women report their labour slows down as soon as they reach hospital. This according to Young, is because hospitals immediately bring on the fight-or-flight response, which stifles the release of endorphins. Whichever method you are considering, the most important thing is that the process relaxes you” (Living and Loving, 2013:46-48).
“She experienced such clarity that the hospital experience put a handbrake on her progression of labour and her ability to cope with it” (Guedes, 2017:20-22).

Table 18: Medical practitioner
"Obstetricians are specialist doctors that deal with the management of pregnancy and birth. You will need an obstetrician if you have a high-risk pregnancy that needs to be carefully monitored. Obstetricians are mostly hospital-bound practitioners, although some are in private practice as gynaecologists as well, and may be affiliated to a hospital (Khumalo, 2005:47-48).
"A midwife specialises in healthy pregnancies, where her role is to educate women. She will teach the pregnant woman how her body needs to work in labour, so that she will know what to expect when the time comes to birth her baby. An obstetrician is a doctor who specialises in the diseases of pregnancy, and is authorised to intervene and administer medication for any complications or ill symptoms that a patient may describe during pregnancy" (Alexander, 2007b:51-53).
"Midwives are trained to take care of the natural side of pregnancy with a hands-on natural approach to birth. Midwives usually have a much lower intervention record during birth due to lower stress levels in the mother. It is now widely recognised that the assistance of a doula decreases the duration of labour, the severity of perceived pain, the need for anaesthesia, and sometimes even a C-section. If the birth process goes smoothly, it enhances the postpartum experience - a speedier recovery after the birth and simpler breastfeeding" (Moore, 2010:68-71).
"Evidence-based research has shown midwives achieve the same outcomes as physicians without disrupting the natural birth process as often. Women who give birth under the care of a midwife are more likely to have: lower rates of C-section births, lower rates of induced labour, significantly lower rates of third and fourth degree tears from delivery as well as lower episiotomy delivery, lower rates of forcep delivery births, higher breastfeeding success…" (McDonald, 2019:20-23).

5.4. Further discussion of findings

While the major findings of the study have been discussed above, further discussion of the meaning behind the findings are to be explored. This is particularly important when comparing this study's findings to that of the findings of the research discussed in the literature review. The frames to come out of the literature review were birth means business, health care coverage, physiological birth, and birth is not a one-size-fits-all approach. Linked to these frames was the medicalisation of childbirth, birth being primarily in the hospital setting, birth being managed primarily by obstetricians and not midwives in the private sector, and the emergence of the elective Caesar. Through the data analysis, it is evident that all of these topics came up in *Living and Loving* magazine. It is clear that the findings from the literature review overlapped significantly with the findings of the data analysis. While the birth means business frame did not appear significantly, health care coverage was mentioned, and physiological birth and birth not being a one-size-fits-all approach, were particularly evident.

It was clear that elective Caesarean sections only became popular and an option in the late 1990s onwards. Before this, Caesarean sections were framed as medical procedures that became a reality only in emergency situations or high-risk pregnancies. It was interesting to find that in the early stages, it was written that doctors only allowed this procedure in high-risk instances, and that women could not request it. However, when Caesarean sections became elective, while *Living and Loving*

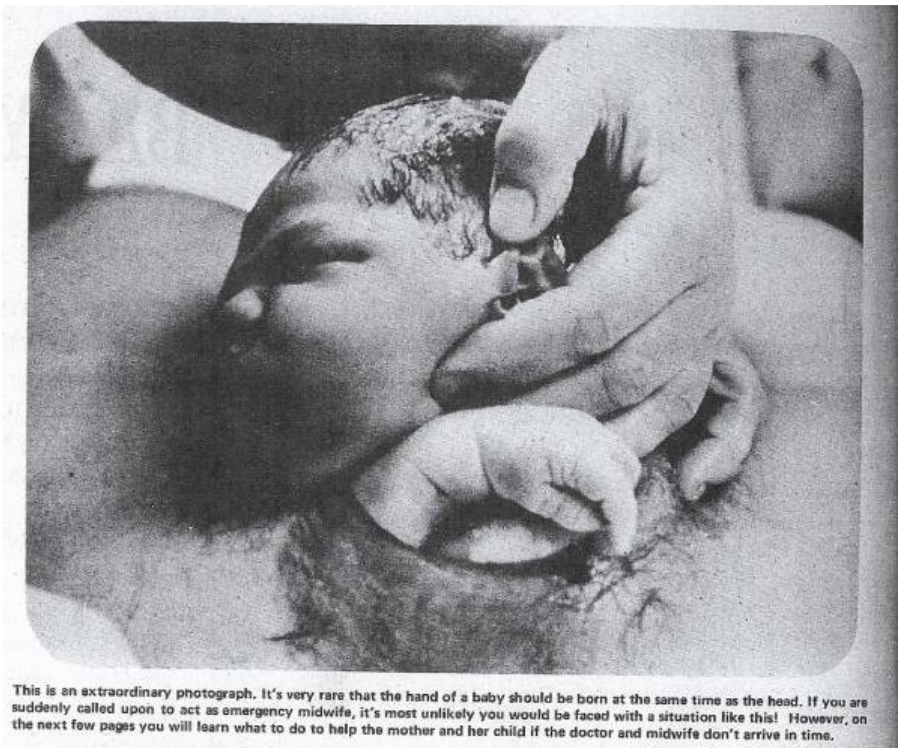
mostly continued to frame this procedure as a need for only high-risk patients, there were instances of women being framed as empowered when requesting this operation. There was a clear preference for vaginal birth in the early stages of the magazine, yet intervention was always evident, specifically enemas, pethidine injections, painkillers, and episiotomies. A frame that rang true throughout the magazine, especially when the necessity of episiotomies began to be questioned and intervention during birth began increasing, was women requesting more natural and physiological birth. Women were frequently encouraged to fight for births involving less intervention and to question the motives behind medical practitioners if they were pushing for interventions out of convenience or to avoid litigation.

Interesting findings in differences between the 1970s/1980s versus the 1990s/2020s was that vaginal deliveries were the norm for breech births and multiple births, except for high-risk instances, while this no longer became the case as the years went on, with most doctors not allowing a trial of labour. Hospital births were the norm throughout the magazine, but instances of home births remained constant. These home births were frequently written using romantic language and listing many pros regarding the birth. The assumption throughout the magazine was that most women desire a natural birth, yet those wanting intervention were assured to not feel guilty. As the years went on, there was a sense that the magazine editors sought to write in a more balanced manner and encouraged women to choose their own births, but the cons were frequently given for all intervention options, in the same breath.

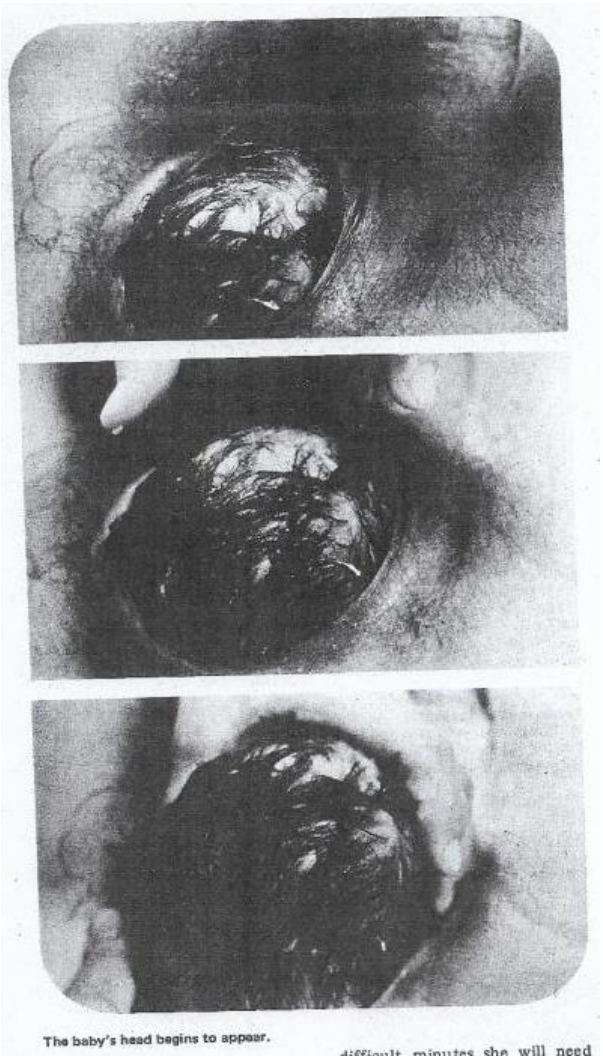
A final finding is linked to the frame of childbirth missing from life as an everyday event that emerged from a study discussed in the literature review (Luce *et al*., 2016). An assumed finding from the data analysis was that *Living and Loving* is a magazine that seeks to educate women on all aspects of birth and labour and to ensure birth is very much a prevalent and normalised event in society. This was especially evident in the 1970s and 1980s period of the magazine. Articles were lengthy, in-depth, backed up with multiple sources from varying degrees of expertise, and there were many inclusions of graphic images of both birth and labour. These graphic images showed the rawness and realness of birth. An assumption is that these images were included to establish childbirth as an everyday and not necessarily medical event, as well as to educate women on how birth works in the hope to ease fear. Examples of these images can be viewed below. However, this goal lessened significantly, which was evident in the later years of the magazine. Graphic images of birth were completely absent, articles lessened in length, fewer expert quotes were included, and articles relating specifically to birth decreased, with a focus on more short, punchy, generalised articles with a sense of giving equal balance to all sides and objectiveness. Images of breastfeeding moms became more romanticised and all instances of “nudity” such as bare nipples were completely removed. It was this move to more

objective, balanced, and romantic ideas of birth and labour that related most to Luhmann's theory of the media in this study.

Figure 1, 2 & 3*:* The birth of a baby - what to do in an emergency (*Living and Loving*, 1973:2-6).



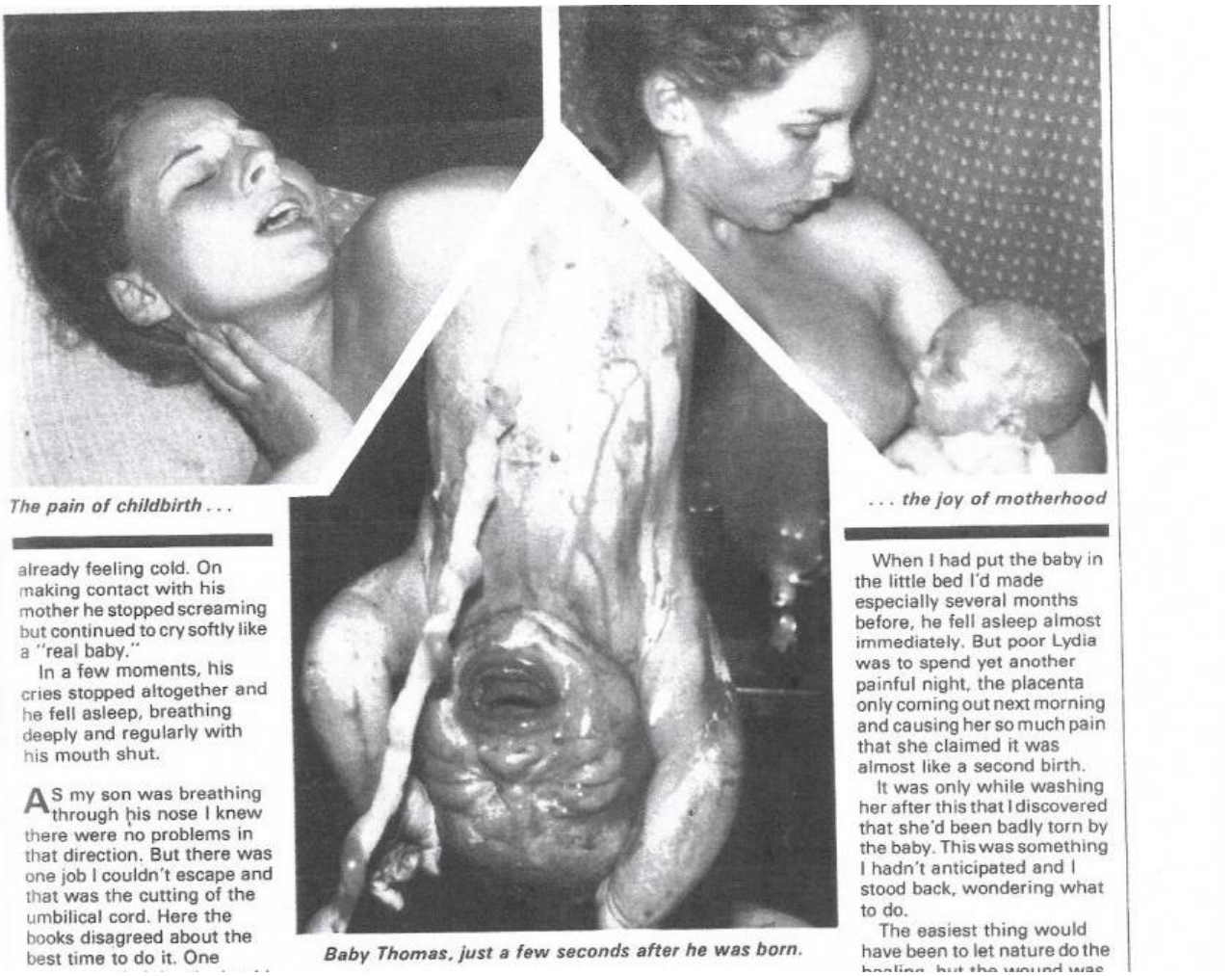
This is an extraordinary photograph. It's very rare that the hand of a baby should be born at the same time as the head. If you are suddenly called upon to act as emergency midwife, it's most unlikely you would be faced with a situation like this! However, on the next few pages you will learn what to do to help the mother and her child if the doctor and midwife don't arrive in time.



The baby's head begins to appear.

difficult minutes she will need

Figure 4*:* Baby of the deep blue sea (Source: *Living and Loving*, 1978:11).



The pain of childbirth . . .

already feeling cold. On making contact with his mother he stopped screaming but continued to cry softly like a "real baby."

In a few moments, his cries stopped altogether and he fell asleep, breathing deeply and regularly with his mouth shut.

AS my son was breathing through his nose I knew there were no problems in that direction. But there was one job I couldn't escape and that was the cutting of the umbilical cord. Here the books disagreed about the best time to do it. One

Baby Thomas, just a few seconds after he was born.

. . . the joy of motherhood

When I had put the baby in the little bed I'd made especially several months before, he fell asleep almost immediately. But poor Lydia was to spend yet another painful night, the placenta only coming out next morning and causing her so much pain that she claimed it was almost like a second birth.

It was only while washing her after this that I discovered that she'd been badly torn by the baby. This was something I hadn't anticipated and I stood back, wondering what to do.

The easiest thing would have been to let nature do the

Figure 5*:* Childbirth explained (Source: *Living and Loving*, 1978:63).

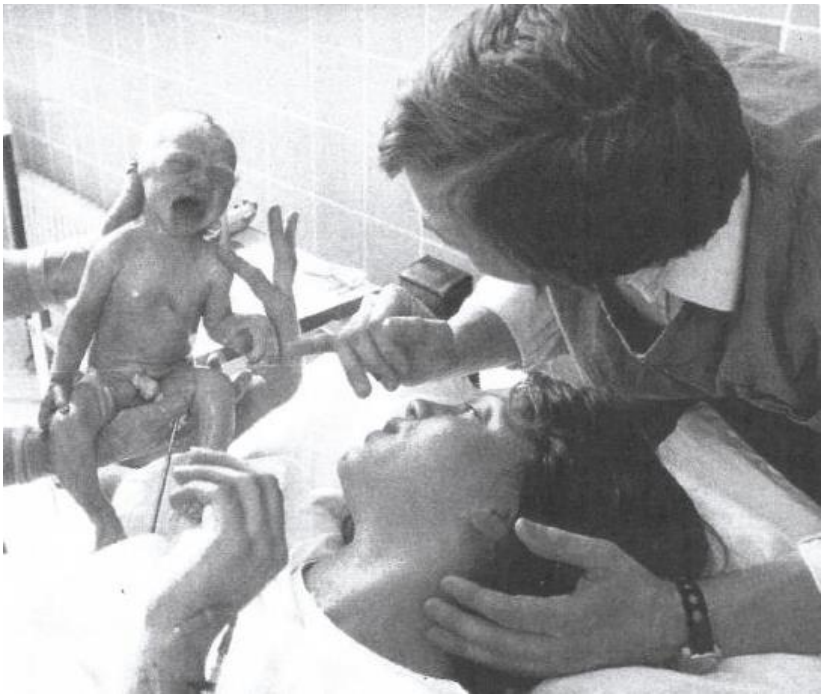


Figure 6*:* The birth of my baby by epidural Caesar (Source: *Living and Loving*, 1980:35).

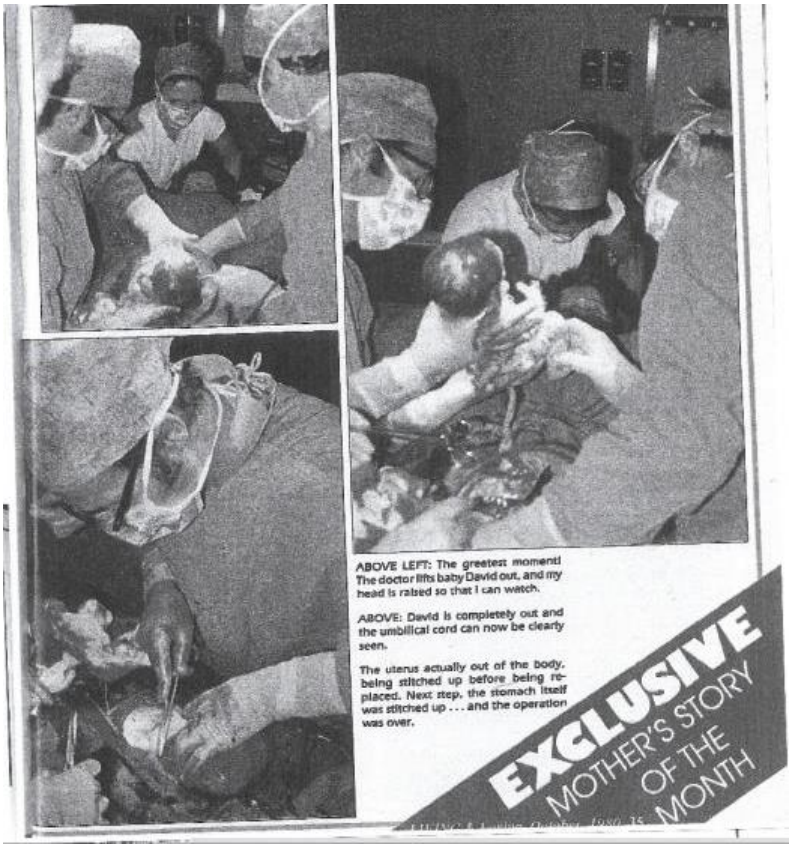


Figure 7*:* How a baby is born (Source: *Living and Loving*, 1985:45).

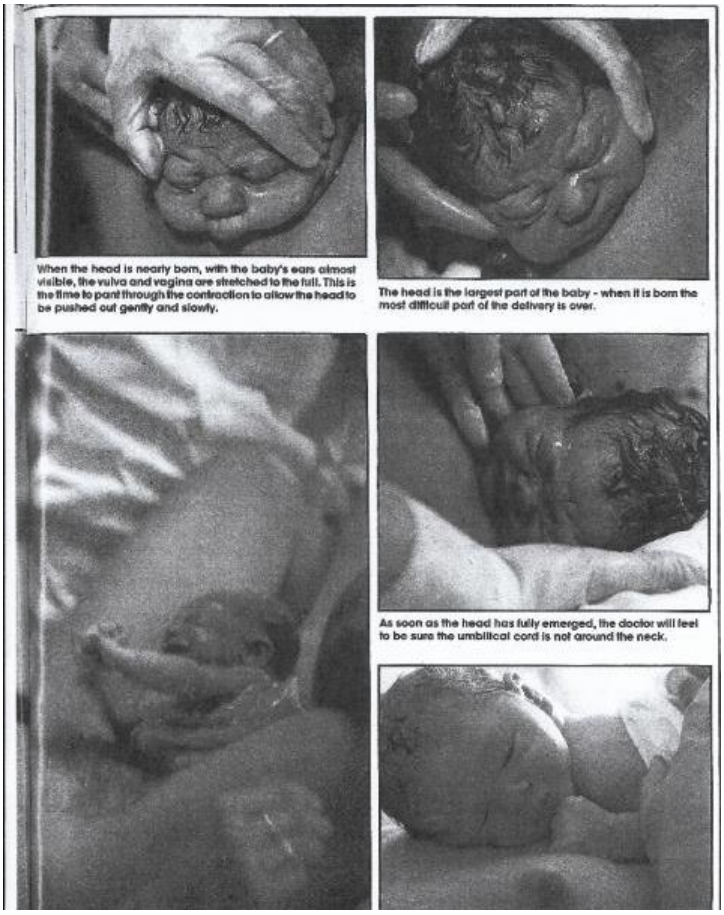


Figure 8: Step-by-step Caesar (Source: *Living and Loving*, 1989:55).

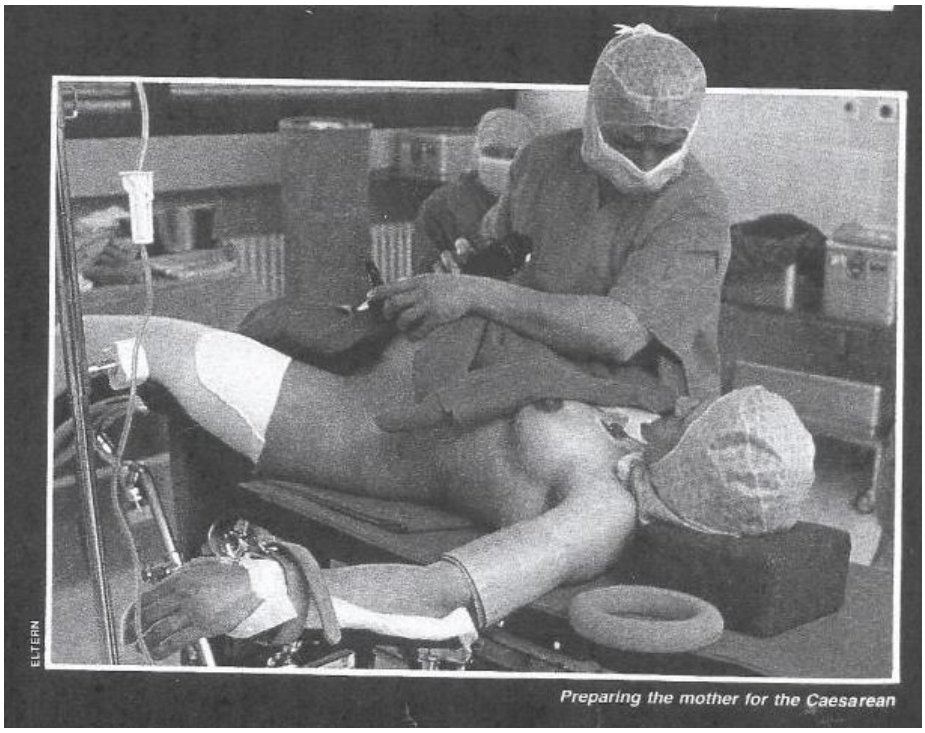


Figure 9*:* What's birth like for the baby? (Source: *Living and Loving*, 1989:58).

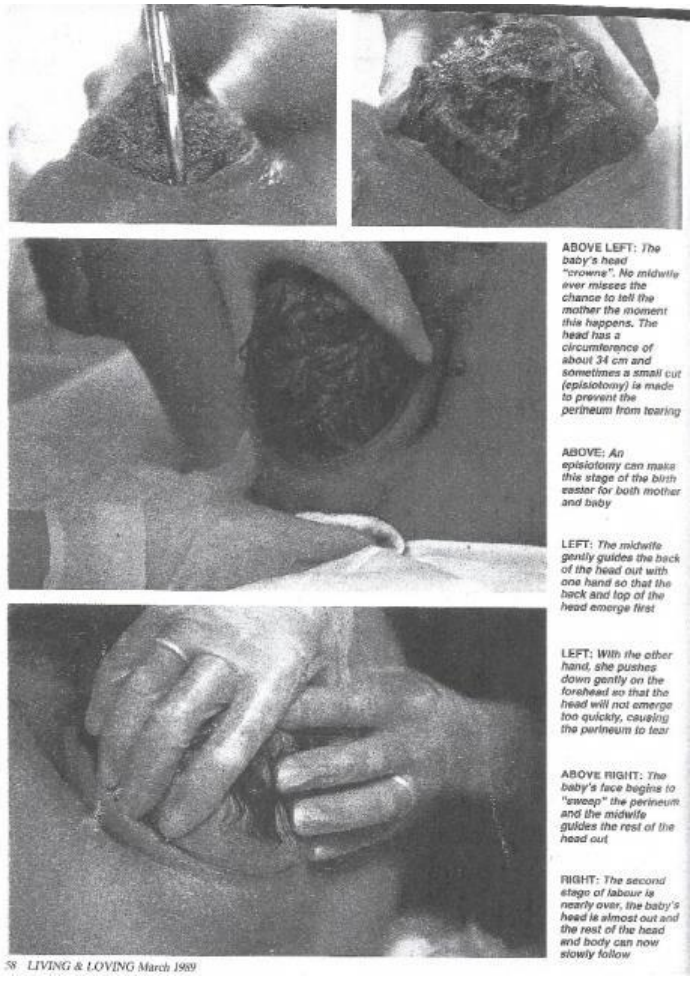


Figure 10*:* By special delivery (Source: *Living and Loving*, 1992:43).

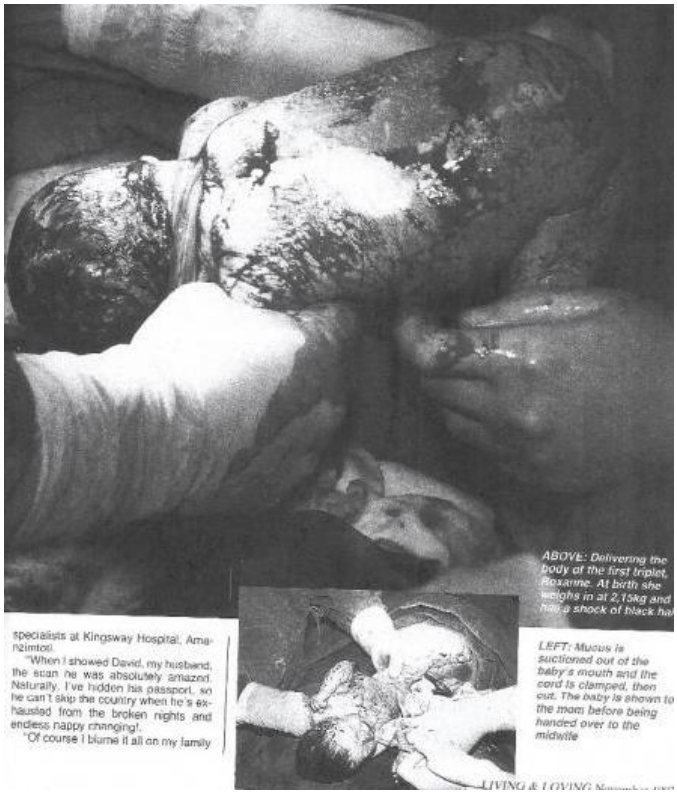


Figure 11*:* When a child is born (Source: *Living and Loving*, 1993:28).

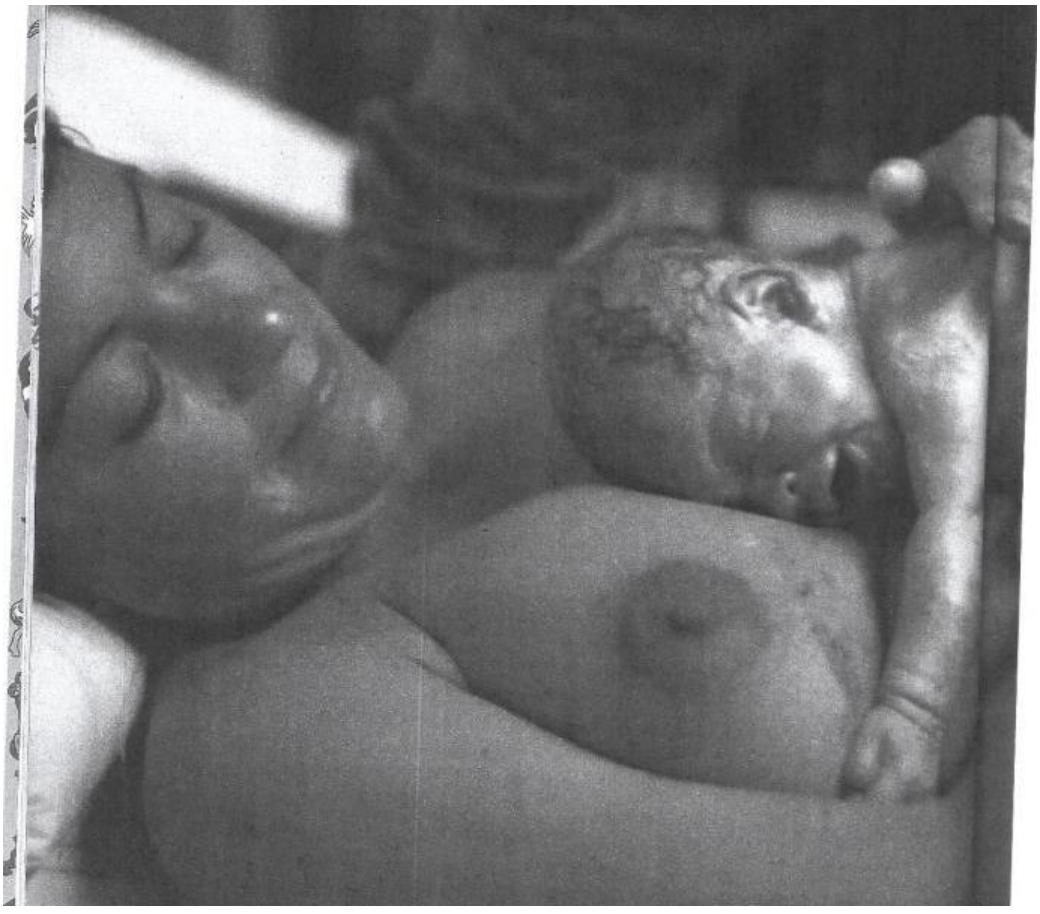
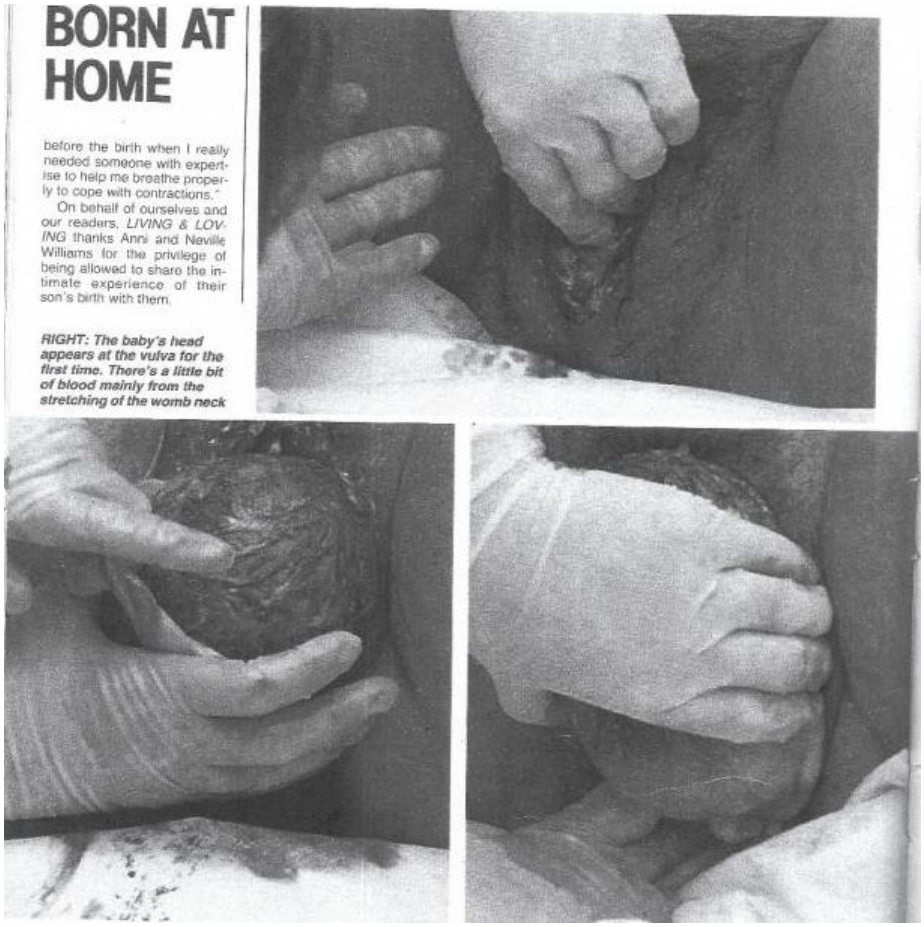


Figure 12 & 13*:* Born at home (Source: *Living and Loving*, 1993:43-45).



BORN AT HOME

before the birth when I really needed someone with expertise to help me breathe properly to cope with contractions."

On behalf of ourselves and our readers, *LIVING & LOVING* thanks Anni and Neville Williams for the privilege of being allowed to share the intimate experience of their son's birth with them.

RIGHT: The baby's head appears at the vulva for the first time. There's a little bit of blood mainly from the stretching of the womb neck

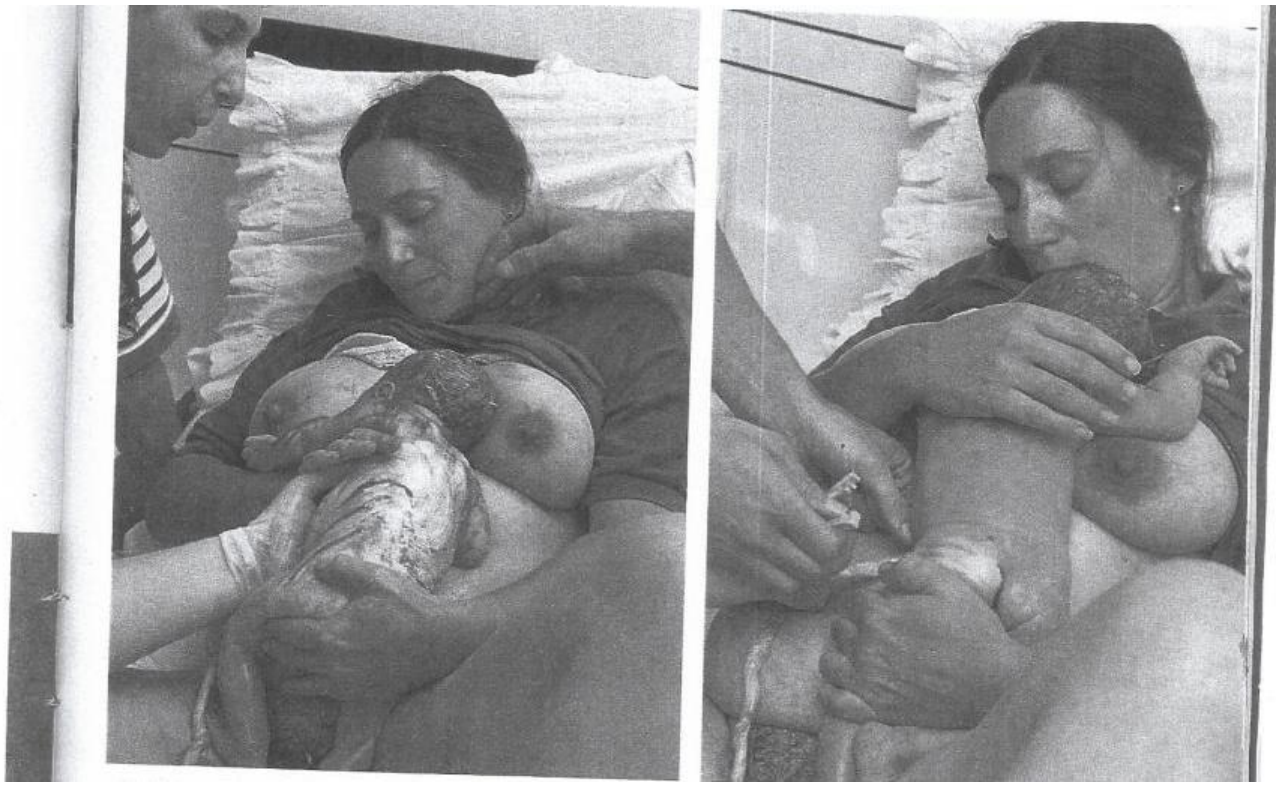
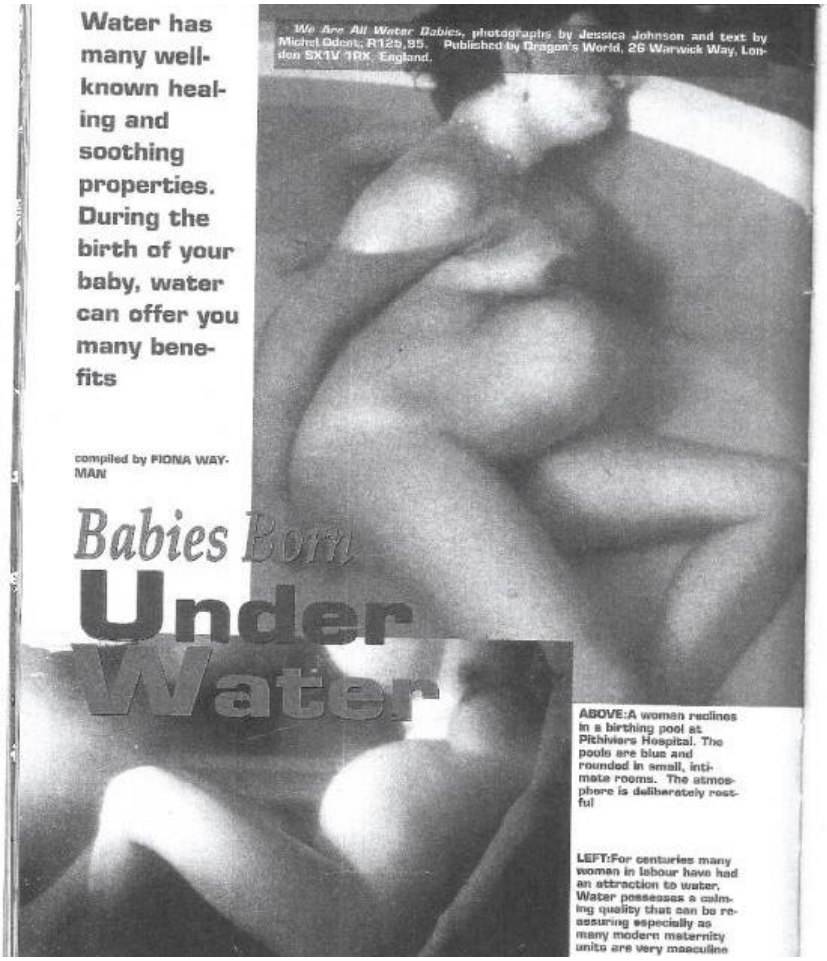


Figure 14 & 15*:* Babies born under water (Source: *Living and Loving*, 1995:22-24).



Water has many well-known healing and soothing properties. During the birth of your baby, water can offer you many benefits

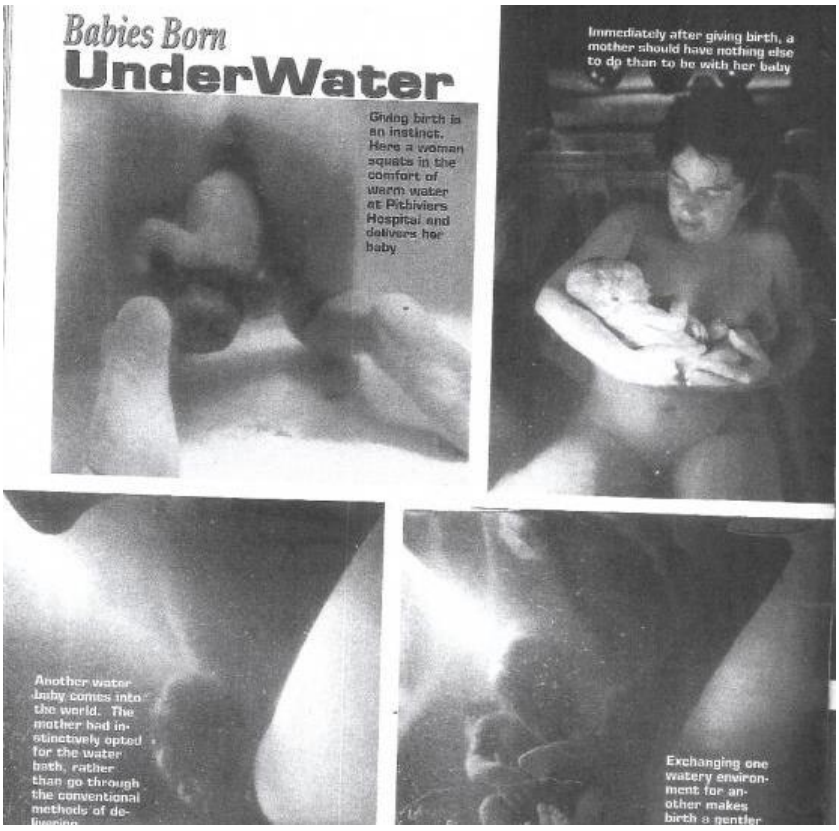
compiled by FIONA WAYMAN

We Are All Water Babies, photographs by Jessica Johnson and text by Michel Odent; R125,85. Published by Dragon's World, 26 Warwick Way, London SW1V 1RX, England.

Babies Born Under Water

ABOVE: A woman reclines in a birthing pool at Pithiviers Hospital. The pools are blue and rounded in small, intimate rooms. The atmosphere is deliberately restful

LEFT: For centuries many women in labour have had an attraction to water. Water possesses a calming quality that can be reassuring especially as many modern maternity units are very masculine



Babies Born UnderWater

Giving birth is an instinct. Here a woman squats in the comfort of warm water at Pithiviers Hospital and delivers her baby

Immediately after giving birth, a mother should have nothing else to do than to be with her baby

Another water baby comes into the world. The mother had instinctively opted for the water bath, rather than go through the conventional methods of de-

Exchanging one watery environment for another makes birth a gentler

Figure 16*:* A child is born (Source: *Living and Loving*, 1999:23).

Figure 17: Born into love (Source: *Living and Loving*, 2001:56).

5.4.1. Theoretical analysis

Luhmann's theory of the media features distinct binary codes (Gren & Zierhofer, 2003:619). As discussed previously, the mass media system binary codes are information versus non-information (Artieri & Gemini, 2019:567). In simpler terms, this can be understood as the media representing a false reality due to the personal choice and selectivity of what to include and exclude in publications. There was a clear sense from *Living and Loving* magazine to represent birth as a normal event part of everyday life, however, this competed with the preference for publishing articles that showed unusual and shocking events, instead of "boring" the reader with lengthy, generalised details regarding birth. For example, there were substantial examples of births in the home setting, but that were unplanned because the labour was so fast; while many of the Caesarean section births were featured because they involved high-risk pregnancies involving women with disabilities or unusual ailments. This preference of reporting on unusual events is a contributing factor affecting the results of the data analysis. By *Living and Loving* choosing to frequently feature articles demonstrating unusual and titillating births, there is evidence of media selectivity, which alters the representation of reality.

Later, the magazine moved more towards shorter and punchier articles, including less imagery of real and raw births. Reporting on medical intervention in itself leads to drama and allows for the medical practitioner to swoop in and save the day as the "heroic professional" spoken about in the literature review (Luce *et al*., 2016:6). The issue with removing imagery and reporting on birth in an attempt to entertain, is that birth is removed from life as an everyday, normal event. Fear regarding birth and labour also appeared frequently in the data analysis, and fear cannot be overcome nor can women make an empowered choice regarding birth if they do not know the true realities of it.

While the magazine was evidently a major source of information on birth and labour, there was evidence of media selectivity, framing and Luhmann's social systems theory through a preference for the unusual and the desire to appear objective, especially as the choice for more medical intervention became a reality for all women. This later point was especially true in the later years of the magazine in an attempt to present more balanced writing. This issue is known as false balance or bothsidesism (Dixon & Clarke, 2012:359). This was evident in various articles when discussing intervention and elective Caesarean sections, specifically in the same breath as discussing women's rights and empowered choice regarding birth. There was a general sense that the magazine did not want to appear as "taking a side" and therefore represented all birth choices as equal in terms of satisfaction, risk, and necessity. This issue too, disallows women to make empowered and informed choices regarding birth and labour if they are not correctly presented with the true realities and risks of each birth choice and intervention.

5.5. Summary

This chapter provided a lengthy account of the findings of both the qualitative and quantitative content analyses. Graphs were provided to demonstrate the results of the quantitative data. The findings of the content analysis were discussed according to most prominent frames to appear in the data. A further analysis of the findings was then provided to attend to topics that may not have related specifically to the frames of the data analysis. Lastly, the data findings were discussed in relation to the theoretical points of departure, namely Luhmann's theory of the media. In the next chapter, the concluding remarks of the study will be discussed. This will include any limitations of the study, as well as recommendations for future research on this topic.

Chapter 7: Conclusion

7.1. Introduction

This chapter provides concluding remarks of the study and addresses how the aim of the study was fulfilled, specifically by addressing the research questions. The limitations of the study and the recommendations for further research on this topic are provided.

7.2. Conclusion

The aim of this study was to discover the dominant message concerning childbirth in the South African pregnancy and baby magazine, *Living and Loving*, and to determine whether this message changed over the years. By completing this study, it was brought to light whether *Living and Loving*, a health magazine that educates women on the scientific phenomenon of birth, had an evident, dominant focus on a specific type of childbirth. While it is clear through the data analysis that the magazine did not have a single dominant message, but rather a number of messages, it can be said with confidence that *Living and Loving* is a magazine focused on educating women on the various types of birth and options during labour in order so that they can make an informed and empowered decision. With that being said, it seems that the editors of *Living and Loving* celebrate medical advancement and necessity, but discourage women from leaving all of the decisions up to the medical practitioners. A specific extract taken from the data that backs up this statement is: "State of the art technology and your midwife's skills have equally important roles to play" (Sister Lilian, 2002:38-42). Labour and birth are not medical problems, but can require medical treatment and emergency interventions. This statement given by Sister Lilian sums up the overarching message that *Living and Loving* sought to provide women with when they are deciding on their birth plan. The magazine acknowledged that, as the years have gone on, medical advancement has been extreme and the options that are endless for South African women in the private sector, can often confuse rather than empower and be of benefit (such as the overuse of foetal monitoring). The point was not that medical intervention is never necessary, but rather that it has become the norm and that this is the issue, as it is frequently used when not required. There are a number of reasons for this overuse, some including: fear of pain; convenience for medical practitioners; convenience for setting a birth date; a distrust of vaginal or "natural" birth; the move away from the midwife and doctor relationship; fear of litigation; all births being treated as high-risk; and the overall medicalisation of birth.

Medical practices that benefit a large minority of high-risk mothers are applied to the majority, if not all, in the hospital setting. While many women may welcome medical intervention and actively pursue it, it is then the responsibility of both the media and the medical professional to educate all women on the benefits and risks of each intervention. The solution is not for the woman to be the one

to choose her birth plan and labour in the sense that the medical professional does not have a say. This would be irresponsible since the medical professional has a high level of expertise. However, in the same way that it would be irresponsible for a woman to stubbornly refuse necessary medical intervention just because she desires a natural birth, it should be equally irresponsible for a medical professional to allow or even encourage a woman to have a highly-medicalised birth out of convenience or fear, especially when she has a low-risk pregnancy and both her and her baby would benefit from a vaginal birth. The point is that the norm for birth should not be medicalised if the majority of women are capable of giving birth without intervention. It has been observed in the past that women released themselves completely to their medical professionals as they were deemed to be the ones with the knowledge and expertise. While there is nothing wrong with this, today, there is a greater likelihood that the woman will experience a medicalised birth unless she specifically asks or even demands a more natural one. From the findings, this is perhaps because medical professionals fear litigation and/or because doctors, obstetricians and gynaecologists are trained specifically for high-risk births. The medical advancement and procedures performed by these professionals is to be celebrated, but there is a clear difference in opinion between doctors and midwives. An obvious solution would be for medical doctors and midwives to return to the setting in which they were equal partners in delivering babies. This partnership was evident in the 1970s and 1980s of the magazine, with many low-risk births being solely attended to by the midwife, while high-risk pregnancies were attended to by the doctors. However, this partnership disappeared in the 1990s and 2000s of the magazine and is the reality of the South African medical private sector today. If a woman seeks to have a midwife-led birth for her low-risk pregnancy her only option is to find a midwife with her own private practice or give birth in a public hospital. The evidence from the data analysis demonstrated that midwives use less intervention than doctors and often allow women to be pregnant and labour for longer. Women experienced greater birth satisfaction and lesser degrees of postnatal depression and difficulty related to breastfeeding. In no means, can this be viewed as the reality for all midwife-led births, however, the magazine made it clear that this birth option is being taken away from women in the private sector, and unnecessary medical decisions are more prominent in the private hospital setting in South Africa.

It should be said that medical doctors are not solely to be blamed for this move to medicalised births. Medical culture pervades popular culture and the media. While it was evident *Living and Loving* actively sought to represent birth and labour in all its different settings, and to provide women with the information to become active participants in their birth, it became evident that as the years progressed, the magazine chose to present all birth options as equal, in a sense, and they sought to appear more balanced in their writing. It was disappointing to see when the magazine began

shortening articles and completely removing all imagery of birth. Fear is one of the pervading reasons women choose medicalised birth as they do not seem to trust their bodies in giving birth vaginally. With the media removing the rawness of birth from its pages, this fear cannot be challenged, but instead fear of the unknown grows. The impact of the medicalisation of birth was seen in the dominant message given by the magazine. In other words, the dominant message changed as medical discourses of society changed. The message became softer and more balanced. This may be due to the magazine wanting to stick with the times and to appear more objective as the world demanded women be given the option to choose any birth they desired. It may also be due to the move towards childbirth being defined as a medical event in the Western world and the medical institution gaining "official acceptance of that definition" thus gaining a "monopoly over the treatment of childbirth and make hospitalisation almost universal" (Treichler, 1990:116).

As an overarching result, women receive an extremely confusing message: "demand more natural childbirth because the female body is capable of giving birth, but birth is extremely dangerous and so it can only be considered safe under continual monitoring and intervention within the medical setting surrounded by medical doctors and experts". On the other hand, while the magazine itself positioned itself actively against guilting women for choosing medicalised birth, there remains a large pressure on women to give birth vaginally, and there still exists the idea that having a Caesarean section is choosing the "easy way out". Other solutions the magazine suggested with regards to these issues was: hospital births with more home-like features such as those seen in active birthing units, a greater understanding of low versus high-risk pregnancies where low-risk pregnancies are seen to by midwives and high-risk pregnancies are seen to by medical doctors, a desire from all medical professionals for more physiological births that are not necessarily viewed as medical events from the get-go, the movement towards childbirth not being controlled neither by professional autocrats nor by haphazard romantics, all obstetrics being trained in natural birth, the high medical insurance issues to be addressed, women allowed to give birth in different positions and not be hooked up to monitors unless necessary in high-risk births, and lastly, more support for home births for low-risk pregnancies with medical doctors as backups for complications. Through analysis of the data, the results allow for consumers of the magazine to make more informed decisions around childbirth.

7.3. Limitations

The biggest limitation of this study is that the research topic relates primarily and almost solely to the medical private sector of South Africa. Births are fairly non-medicalised in the medical public sector with instances of low intervention and low Caesarean section rates. Caesarean sections are only performed in emergencies and cannot be requested, and births are led by midwives with doctors only being called in for the actual birth, sometimes not at all for low-risk births. Therefore, a note has to

be made on privilege. The issue of highly-medicalised births in South Africa is primarily a problem for the privileged, in other words, those who can afford private medical aid. One might suggest then why not all women simply give birth in public hospitals where they will be seen to by midwives and receive fairly non-medicalised assistance. However, South African public healthcare is considered to be underdeveloped, understaffed and even dangerous in instances due to "long wait times, poor quality of care compared to private healthcare, rushed appointments, old facilities, and poor disease control and prevention practices" (Young, 2016:2). Many of these issues are traced back to the apartheid period whereby the healthcare system was "highly fragmented, with discriminatory effect, between four different racial groups (black, mixed race, Indian and white) (Baker, 2010:79). Therefore, it is important to acknowledge that many of the issues discussed in this study can also be understood as socioeconomic problems and do not apply to all, in the sense that many cannot even afford for it to become a problem for them.

7.4. Recommendations

A recommendation for further research on this topic would be to investigate the media's representation of childbirth and labour in more general media sources, such as magazines or online media that does not focus specifically on birth and pregnancy. This would be in order to gain an understanding of the messages women are receiving in the media that they absorb the most. This is important specifically for women who have a minor understanding of the pros and cons of various birth plans and who are not actively seeking to be more educated on this topic before giving birth themselves. There is an assumption that women who read *Living and Loving* magazine have a general understanding of birth and/or aim to become more enlightened on the topic. However, those that do not have this desire would form a general understanding of birth based on the media that they consume most. An interesting study would be to analyse how the most popular sources of media represent birth in order to determine whether this dominant message differs to birth-specific media sources. However, it is important to note that there are some in society who are not necessarily influenced by the media due to lack of exposure to media sources.

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