Pregnancy starts with a literacy event: Pregnancy and antenatal care as textually mediated experiences
Uta Papen
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Pregnancy starts with a literacy event
Pregnancy and antenatal care as textually mediated experiences

Uta Papen
Lancaster University, UK

ABSTRACT As a literacy researcher my academic attention is usually focused on how other people use reading and writing in their everyday lives. In this article, for the first time I turn my researcher’s gaze onto myself. I present a portion of my autoethnography which aimed to document my becoming a mother as a ‘textually mediated’ experience. I discuss three aspects of this experience: 1) the role of the ‘Green Notes’, a personal maternity record, as an example of how the literacy practices of pregnancy and antenatal care are shaped by institutional norms and procedures; 2) the significance of my own reading and writing activities in the process of ‘making sense’; and 3) the role of reading and writing in what I have called ‘difficult moments’. The article concludes with a reflection on the potential of autoethnography for social sciences generally and literacy studies more particularly.

KEY WORDS autoethnography, pregnancy, literacy practices, antenatal care, Pregnancy Notes

Introduction

Pregnancy starts with a literacy event – the pregnancy test. Of course it really starts with conception, but since for the first weeks I wasn’t aware of being pregnant – and wasn’t expecting to have conceived – the ‘real’ thing started
with the test. In my case, this was a ‘clearblue’, a common brand, available in pharmacies and in supermarkets. Clearblue is clearblue, because the results (a ‘+’ or a ‘−’ sign in a small window) are in blue and they are supposed to be clear – as clear as they can be. Which they definitely were in my case. I remember that the result was visible immediately, it didn’t take the stated one minute for it to be displayed. And there was no doubt about what it said. (4 January 2006)

The above is the first entry into the research diary that I kept in 2006 while I was pregnant. I started the diary when I was nine weeks into my pregnancy and the last entry dates from the day before my son was born on 2 August. The aim of keeping this diary was to produce a record of my reading and writing activities in relation to pregnancy and childbirth. I wanted to find out in what ways my experience of pregnancy and childbirth was ‘textually mediated’ (Smith, 1999). I wanted to explore what roles (written and visual) texts played in the cultural and institutional worlds of pregnancy and antenatal care that I had become part of. Over the following pages I present parts of my autoethnography. At the same time, I reflect on my experiences of writing this autoethnography and I share my thoughts on the potential of autoethnography for social sciences generally and literacy research more specifically.

Literacy studies – research into the uses and meanings of reading and writing across cultures and historical periods – is an interdisciplinary subject populated by linguists, sociologists, psychologists, and, as in my case, social anthropologists. Contrary to what common definitions of literacy might suggest, not all literacy research is about the skills of reading and writing and how best to teach and learn them. As a field of research, literacy studies and in particular the branch of it that is known as the ‘New Literacy Studies’ (NLS) (Gee, 1996; Street, 1984, 1993, 2001) concerns itself not primarily with educational matters, but with the uses and meanings of written texts in everyday life and for ordinary people. This includes literacy in homes and families (see, for example, Barton and Hamilton, 1998), in public places (see, for example, Kalman, 1999), at work (see, for example, Belfiore et al., 2004; Papen, 2007) and on the Internet (see, for example, Knobel and Lanksheer, 2007; Lanksheer and Knobel, 2006; Lee, 2007). Literacy researchers like me regularly make use of two concepts: literacy events and literacy practices. The concept of ‘literacy events’ (Heath, 1983) refers to situations and activities involving the use or production of a text. In today’s society, more often than not, these texts are multimodal (Kress, 2003): they include written text, visuals and even voice and moving images. An example is reading a webpage. ‘Literacy practices’ refers to the meanings of reading and writing in specific contexts. What makes a particular literacy event meaningful are the values, norms, conventions and beliefs governing the
actions of those involved in it (Barton and Hamilton, 2000; Street, 1993). The cornerstone of the concept of literacy practices is that reading and writing is always situated in particular social and physical environments (Barton et al., 2000). These contexts as well as the people operating within them give meaning to the literacy event. In my own case, the context is made up of the cultural world of pregnancy and childbirth in the early 21st century, the institutional environment of antenatal care in England and my own biography.

The NLS takes as its subject matter many kinds of texts, including the kind of ‘ordinary’ and mundane pieces of writing which few sociologists and linguists consider a legitimate object of study. Literacy studies’ focus on the ‘ordinary’ has gone side by side with a search for new methodologies. Mostly, these are grounded in ethnographic and participatory research frameworks including, for example, the use of photography to document everyday literacy practices (Hamilton, 2000; Hodge and Jones, 2000). The present study is also concerned with what many might think of as ordinary and mundane acts of reading and writing. It too explores a new methodology that has not yet been used in literacy studies. However, in addition to the seemingly banal texts that I produced throughout my pregnancy (for example, lists of questions, scribbled diary notes, hastily written emails and broken sentences posted to a bulletin board), my autoethnography also includes more official and standardized texts. These are, for example, a consent form, leaflets received from midwives and doctors, books and medical articles and the Personal Maternity Record or ‘Green Notes’ (see below) which accompanied me throughout my pregnancy and which I will discuss later in this article. Before I present parts of my autoethnography, I explain how I came to this study and how I understand the methodology that I used.

**Writing about my literacy practices as a pregnant woman: how it began**

For the past nine years, I have studied the literacy practices of people in different situations and places, ranging from craft vendors in Namibia to adult learners in the north-west of England. An anthropologist by origin, I have always drawn primarily on ethnographic methods. Furthermore, I have always believed in the merits of the ‘telling case’ (Mitchell, 1984): the potential of a single story to evoke insights and questions that can be compared with other researchers’ findings and which offer theoretical and epistemological insight beyond the confines of the case in question.

At times, studying other people’s relationship with texts triggered an interest in my own reading and writing practices. This was in particular the
case over the past three years, when I conducted a study into the relations between literacy and health (Papen, forthcoming; Papen and Walters, 2005, forthcoming). Listening to people telling me about leaflets they had received from their doctors, websites they had found or letters they had written invited me to reflect on my own relationship with written texts in health care contexts. As a reflexive ethnographer (Davies, 1999), I had been aware that the way I approached my informants, the conversations I had with them, the points in their stories that resonated with me and which became parts of my analysis were closely connected not only with my academic interests but my own biography and experiences. At the same time, throughout this research the limits of conventional ethnography had become clear. Health and disease are personal matters, often distressing, frequently embarrassing and not necessarily an easy matter to dwell on in an interview or to gauge through participant observation. More importantly, these are emotional matters and what people told us was not always easily amenable to the kind of scientific dissection and analysis that the study’s research questions asked for.

Despite my awareness of the above limitations of conventional ethnographic methods when studying matters of health, when in November 2005 I found out that I was pregnant I did not immediately think of researching myself. My excitement and my joy about what had just begun were enough to distract me from any academic concern. However, this changed when I had my first appointment with a midwife later in December. During this meeting, I was given my Green Notes, a document that played a central role in my antenatal care and that was to become my companion for the next eight months, until my son was born (when rather mysteriously, it disappeared in the bureaucracies of the hospital where I gave birth). It was in the days and weeks after I had received my Green Notes – which henceforth took a prominent place on the shelves in my study – that I vividly remembered some of the conversations I had with participants in my earlier health research and that the idea to study myself was born. I wrote the first entry (see above) on 4 January 2006. From then on, I made regular entries into the diary and I systematically collected any other texts I used or produced throughout my pregnancy.

Looking back at how I felt in the early months of my new life as a pregnant woman, I realize that it wasn’t just the Green Notes that made me choose a notebook and start my diary. Diary writing and blogging, its modern equivalent, is frequently triggered by a significant change in a person’s life and it is often driven by the writers’ need to make sense out of something extraordinary and new. This was also true for me. Like many other women, in particular those expecting their first child, I experienced my pregnancy as a point of rupture and change in my life, a start of something both exiting and frightening (see Earle, 2000). Thus, from the
beginning, the diary was more than a research tool. Before I say more about the diary, the Green Notes and other texts, I will briefly discuss how I understand autoethnography.

Autoethnography

Autoethnography has been defined as ‘an autobiographical genre of writing and research that displays multiple layers of consciousness, connecting the personal to the cultural’ (Ellis and Bochner, 2003: 209). Autoethnography involves the researcher studying herself as an individual within particular social and cultural worlds. In so doing, she aims to generate insights not only into herself, but into the way her own experience is shaped by society and culture. Necessarily, then, autoethnography does not stop at introspection and story-telling but pursues broader analytical purposes. There is, however, in my view no reason why self-understanding should not be a legitimate part of what the researcher desires to achieve. The double purpose of autoethnography as research extends to autoethnographic writing. Autoethnographic writing can usefully be described as communication (Berry, 2006). Of course, all research and all ethnography is communication. What qualifies autoethnographic writing is that it aims to communicate at various levels, not just the ‘analytic’ or theoretical, but including the emotional; hence Bochner and Ellis’s emphasis on the ‘multiple layers of consciousness’ (see above) that are being evoked.

As an autoethnographer, I was both the subject and object of my research. I took on the dual identity of literacy researcher and pregnant woman. The insights I gained are generated from self-observation and self-analysis. As mentioned above, I kept my diary over a period of seven months, from early January to the beginning of August 2006. Throughout this period, I also collected data from a variety of other sources, including emails I sent, brochures, leaflets, books, websites and catalogues I read and notes I took. Some of these texts are ‘official’ in the sense that they belong to the domain of antenatal care in England. The most important of these documents are the Green Notes which I will discuss later in this article. Other documents are commercial or semi-commercial and thus addressed me primarily as a consumer. My email messages, notes and contributions to a newsgroup are mostly personal in nature. As data they are primarily interesting for what they show about how I engaged with the social world of antenatal care (e.g. how I saw my relationship with midwives) and how I reacted to the cultural norms, social expectations and medical discourses about pregnancy and childbirth that I was confronted with on a regular basis.

Engagement with dominant discourses of pregnancy and antenatal care
is one of several analytical themes that I identified in my data and which are central to how I experienced pregnancy and antenatal care. For reasons of space the present article does not allow me to discuss all of these in detail. Therefore, I have chosen three themes that in my view best illustrate the role of reading and writing in my life as a pregnant woman and expectant mother. I have chosen these three themes for two reasons. First, they stood out from my data as significant aspects of how I experienced pregnancy and antenatal care. They were continuous themes in my diary. Second, I expect them to be significant not only to my experience of pregnancy and antenatal care, but to that of other women. This is certainly true about the first theme: the role of official texts in the institutional world of antenatal care. In England, health care is a ‘textually mediated social world’ (Smith, 1999; also Barton, 2001) and no pregnant women can fully avoid the plethora of information leaflets, brochures, forms, scan reports and other documents that are part of how her antenatal care is organized and dispensed. I have called the second theme ‘making sense’. Making sense of what I experienced and developing a maternal identity were ongoing preoccupations. The need to make sense may be much less urgent for women expecting their second or third child, but I would expect it to be a common experience of anybody pregnant with their first child. The third theme is called ‘difficult moments’. This was not an ongoing theme in my diary. Instead it refers to a specific yet significant moment in my pregnancy. Whether and to what extent pregnant women face ‘difficult moments’, of course, varies a great deal. The reason I chose my moment is not only because of what it meant to me, but also because of the general significance of such moments (regardless of their precise nature) in human experiences of transition. My difficult moment refers to a decision my husband and I had to make regarding an amniocentesis, an invasive antenatal screening test that is frequently offered to pregnant women over 35 years old. A growing proportion of expectant mothers in England belong to this age group (Carolan, 2005a) and this makes the theme relevant beyond my case.

**Forms, files and folders: antenatal care as a textually mediated institutional world**

Shortly before the beginning of the Christmas holidays in December 2006, I had my first appointment with a midwife. This was, as I had been told, my ‘booking’ appointment. Its main purpose was to explain the process of antenatal care to me, to set up a patient file and calculate my due date. My entry into the surgery’s register of pregnant women was complete when I received my Personal Maternity Record, or my Green Notes, as my midwives called them: a booklet that was personalized for me and which I
was to keep until the day my son was born. These notes are ‘hand-held’, that is, as a patient I was in possession of the notes and I was responsible for keeping them. They complemented the patient file which was kept by the hospital. Antenatal care in England is structured around either a doctor or midwife as the main provider of care and the person who the pregnant woman meets regularly throughout her pregnancy (NICE, 2003). Variations occur depending on local policy and the woman’s individual circumstances. Women whose pregnancy is uncomplicated can expect between seven and 10 antenatal visits (NICE, 2003). Most women have their first antenatal visit, their ‘booking’ visit, at around 12 weeks gestation. This is usually followed first by monthly meetings with their midwife. From 29 weeks these turn into fortnightly visits and weekly visits in the last four weeks of pregnancy (Rowe and Garcia, 2003). There are differences to this pattern of routine visits depending on the local Trust’s policy. In my own case, fortnightly visits were the norm until my son was born. Any concerns the midwives have can result in them referring the pregnant woman to an obstetrician. Although every expectant mother is given a designated midwife who is seen as her main carer, in most areas of the country she is likely to see several different midwives throughout her pregnancy and she cannot expect to know who will deliver her baby. Some areas, however, offer continuity of care by a named midwife.

What the Green Notes look like

The Green Notes included three types of texts. The opening pages resemble a form that I had to complete with information about myself and my husband and our families’ medical histories. The second type consisted of my antenatal carers’ brief reports of their meetings with me (see Figure 1) and the records of my antenatal screening tests. The third genre included several pages with information about screening tests and other matters of pregnancy that were addressed directly to me as the expectant mother (see Figure 2).

We can see from Figures 1 and 2 that the Green Notes are a hybrid text containing different genres and written in different styles. I will show later why the hybrid nature of the Notes was a potential source of difficulty for me.

The role of the Green Notes in the process of antenatal care

When I first received my Green Notes, their significance was not fully clear to me. Over the course of the first three months of my pregnancy, I learned of the central role they played as a structuring agent, serving the organization of my antenatal care from the National Health Service’s (NHS) point
Figure 1  A page containing records from my midwives’ consultations with me.
Prenatal Screening and Diagnosis

The first half of pregnancy is a time when various tests are offered to check for potential problems, by blood tests (pages 6-7) and ultrasound scans (pages 8-9). The tests listed here are the ones usually recommended in the NHS. We can list only brief points here, but further information can be found on www.preg.info, and additional leaflets may be available from your midwife or doctor.

Do not hesitate to ask what each test means. The choice is yours and you should have all relevant information to help you make up your mind, before the visit when the test(s) are actually done.

Blood Tests

Anemia is caused by too little haemoglobin (Hb) in the red blood cells. The Hb is usually determined as part of the full blood count. Hb carries oxygen and nutrients around the body and to the baby. Anemia can make you feel very tired and you will be less able to cope with losing blood at the time of delivery. If you are anaemic, you will be offered iron supplements and advice on diet.

Blood group & antibodies This test tells us whether you belong to Group A, B, O or AB; whether your blood is Rh Positive (Rh+) or Negative (Rh-); and whether you have any antibodies (foreign blood proteins).

If you are Rh Negative, you will be offered blood tests to check for antibodies. If your baby has inherited the Rh+ve gene from the father, antibodies to the baby’s blood cells can develop in your blood. To prevent this, you will be advised to have ‘anti-D’ injections where Down’s Syndrome screening has been done as part of a booking visit.

Rubella (German Measles). Rubella infection early in pregnancy can damage your baby. A test is offered to check your immunity (ability to fight infection). Most women are protected by routine rubella vaccinations given in childhood, but if you are not immune, you will be advised to be vaccinated after the birth. Inform your midwife or GP if you develop a rash.

Hepatitis B is a virus which infects the liver. If you are a carrier of the virus or have become infected during pregnancy, you will be advised to have your baby immunised at birth to avoid infection.

Syphilis is a sexually transmitted disease which is now relatively rare, but on the increase, and can seriously damage your baby if left untreated. If detected, treatment can be offered with antibiotics to control the infection and to help protect your baby.

HIV The Human Immunodeficiency Virus affects the body’s ability to fight infection. This test is important because any woman can be at risk. It can be passed on to your baby during pregnancy, at birth or through breastfeeding. Treatment given in pregnancy can help prevent the risk of infection being passed from mother to child. A negative test does not affect past or future life assurance claims.

Sickle Cell and Thalassaemia are serious blood disorders that can be passed from parent to child. You will be offered a blood test if you are living in an area with high occurrence of the disorder, or if there is an increased chance of you being a healthy, silent carrier. This is the case if you or your family come from Africa, the Caribbean, India, Pakistan, Bangladesh, South East Asia, China, the Middle East, or Mediterranean countries (e.g. Greece, Italy, Turkey, Cyprus). The results may require the baby’s father to be tested.

Additional blood tests (should be recorded on page 1). They may be offered as necessary, for example to check for:

- Chicken pox. The effects of this are more severe if caught in pregnancy. It can cause problems in the baby if caught before 20 weeks and be passed to the baby if caught within 10 days of the birth.
- Cytomegalovirus (CMV). Prevention involves careful hygiene especially thorough washing of hands.
- Parvovirus (slapped cheek syndrome). This often causes a red rash on the face and is mostly seen in children.
- Toxoplasmosis is caused by an organism that is found in cat faeces, so always wear gloves when gardening or changing cat litter. Also make sure that all food is washed and thoroughly cooked before it is eaten (see also page 18).

Tests to Screen the Baby

Most babies develop normally, but unfortunately about 2% have a significant abnormality. Screening tests can show if there is an increased chance that your baby has a problem, such as a neural tube defect. Down’s syndrome is the best known of these. However, none of the tests available today are completely accurate. Agreeing to a screening test does not mean you have decided what to do if a problem is found. Some couples simply prefer to know in order to be prepared, whilst others may choose to terminate their pregnancy. You will be offered additional support and counselling to be aware of all your options.

Neural Tube Defects e.g. Spina Bifida. An opening anywhere along the baby’s spine can result in paralyses of the lower limbs or a collection of water on the brain (hydrocephalus). An important warning sign is a raised AFP (alphafoetoprotein), measured in your blood serum which may be taken for the Down’s syndrome test (see below). The diagnostic test is a detailed ultrasound scan (see p. 8).

Down’s Syndrome. Babies with this condition have an extra chromosome 21, and are at increased risk of heart and bowel problems and learning disabilities. The overall risk increases for older mothers. The risk is best assessed by one or a combination of screening tests which are available either on the NHS or privately. Currently, screening policies are under review by the National Screening Committee.

BLOOD TESTS — measure ‘serum markers’ and use other factors (your age, weight and scan dates) to try to work out your chance of having a baby with a problem. This includes the Double, Triple or a combination of tests and is taken at around 16 weeks.

Amniocentesis Scans — measure the fluid at the back of the baby’s neck at around 12 weeks. The presence of extra fluid increases the chance that there is a chromosomal or heart problem. The risk is assessed in combination with blood tests.

Figure 2 Page 6 of the Personal Maternity Records offers information about blood tests and antenatal screens.
of view. Whenever I saw a health care provider in relation to my pregnancy, I had to bring my Green Notes. At each of these meetings, a record of what had happened was added and signed by the midwife or doctor. Other documents were physically attached to it, for example, results of antenatal tests and scan reports. The Notes were used to keep a record of my baby’s growth in the uterus and to monitor both my baby’s and my own health. Over the course of the nine months my Green Notes became thicker and thicker.

Many different people were involved in my care and these were located in different physical spaces. The midwives who I saw regularly had their office in my local surgery in Lancaster. Scans and antenatal tests were carried out partly in our local hospital, partly in a specialized unit in Manchester. At a later stage in my pregnancy, I decided to give birth in a hospital in Kendal, 25 miles north of Lancaster, not in my local hospital. My Notes ‘travelled’ with me to all these places and points of care and they served as both reference and record for each new step in my antenatal care. From the health care system’s point of view, the Notes (as also my patient file that was kept in the hospital) afforded traceability of what was done when and with what result. In case of a problem, they could be referred to and used as evidence. In their brief records of their meetings with me, the midwives wrote down important information pertaining to my own health and that of my unborn baby. For example, my blood pressure was noted. Evidence of the baby’s heartbeat and foetal movements were reported as well as in the later stages of pregnancy the baby’s position in the womb. The Notes materialize a chain of health care interventions which from a literacy point of view were reading and writing events. The physical object – the Notes – made these durable and portable (Barton and Hamilton, 2005). But the Notes also inscribed and thereby ‘fixed’ certain interpretations of my pregnancy and how I felt. For example, I noticed that the midwives’ brief commentaries on their consultation with me could include a phrase such as ‘well’ (referring to my physical wellbeing at the time of the visit) or ‘all well apart from intermittent discomfort abdomen’.

Because the Green Notes served as a frame of reference for all actors involved in my antenatal care, they had to be kept meticulously. This was not always the case with my Notes. At an early stage in my pregnancy, a disruption in the communication between different providers had occurred and a record of my blood group was not available. As a result, I was frequently asked for my blood group. When after several weeks and a few phone calls and questions on my side I finally obtained the missing record, I decided to insert it into the Green Notes. But I also realized that for the sake of easy communication, it was best for me to simply know what my blood group was. This incidence shows me taking an active stance in ensuring that my Notes were complete. I had not been explicitly asked to
fulfil such a role, but did this on my own initiative. My desire to ensure the record’s completeness resulted from my lack of understanding of how exactly records were kept by the local NHS. I was concerned that at a later stage a document might be missing and that this would complicate my care.

I have already explained that the Notes were hand-held by the pregnant woman. Thus, because they were in my possession, I was at least partly responsible for them. As the above example shows, I willingly accepted this responsibility and thus became a participant in the institutional literacy practice of keeping the notes. But my role was ambiguous. I had to make sure to bring the Green Notes to all my appointments with midwives and doctors and I was invited to carry them with me at all times in the last weeks of my pregnancy, when labour was imminent. However, I was not certain whether all their content was addressed to me. Page 12 of the Notes contains a brief glossary of the abbreviations used by midwives and doctors in their reports and I assumed that this glossary was included for the sake of the mother-to-be. In theory, I could use it to make sense of my carers’ notes. But nobody ever explicitly invited me to read these notes or the glossary. At the end of each meeting with a midwife, I could see them writing their brief reports. But they never told me what they were writing. Nor did they check with me that I agreed with what they put. Because of this, I didn’t feel I had any stake or ownership in the records they produced. Noticing that at each new consultation the midwife or consultant first read the record of the previous one made me conclude that the reports were really addressed to them and their colleagues, not to me. This impression was reinforced by the way they were written. I could decipher the midwives’ notes with the help of the glossary. But the records of important screening tests contained many abbreviations and medical terms which made them difficult for me to fully understand.

Because of the way my care was structured (not one but several midwives, not one but three different technicians who performed my scans, one obstetrician in Lancaster, another one in Manchester), it was obvious to me that the Notes played a crucial role in the organization of my antenatal care. This confirmed my feeling that they weren’t really for me. The consequence of this was that I could not see how the midwives’ and consultants’ brief reports could work as part of a strategy to improve communication between myself and my antenatal team. Nor did it seem to me that they served to ‘engage’ me in the process of antenatal care and support informed consent. This is, however, how their purpose is described by the cover letter that accompanied the Notes. Having my own record, the letter explained, would give me ‘more information and control over what happens’ to me and my baby during pregnancy. Only in the last weeks of my pregnancy, I once made an effort to understand my midwife’s report in my Notes. This happened shortly after one of my last visits to her on 6 July
2006, when I tried to remember what she had said about my baby's head being 'engaged'. Engagement means how deep the baby's head sits below the brim of the pelvis. This is an important step on the baby's way towards birth: 5/5 means the head is still free, whereas 2/5 (as it said in my Notes) indicates that the head is engaged. I used the glossary (see above) to understand what my midwife had written.

Thus, overall, for me the Notes were associated more with the professionals – my carers – than with me. As a literacy practice, they were shaped by the needs of the health care providers and the culture of work of the NHS. Reflecting on them now, with the more distanced eye of a researcher who is familiar with current health policies and debates, I see them as an only partially successful step in a new patient-centred health communication policy (NHS, 2000). At the time, I did not feel that because I possessed my own record I was empowered or could ‘control’ my own case, as suggested in the cover letter (see above). On the contrary, as the ‘administrator’ of these notes (as my husband called me), I was aware of my ambiguous role: I needed to look after them and was supposed to make myself familiar with some of their content. But other sections were the responsibility of my antenatal carers and my role was limited to ‘holding’ and ‘transporting’ them. Fiedler (1996), writing about antenatal care in Japan, suggests that the ‘maternal and child health book’, a document that appears to be similar to the Green Notes and which is also in the possession of the pregnant woman, allows her to participate as an agent in her antenatal care. My own experience is that the fact that such a document is held by the expectant mother does not guarantee such a role but that it is more likely for the woman to remain in a marginal position vis-à-vis her antenatal care.

The Green Notes’ ambiguity is the source of a potential conflict that is engrained in the NHS’s recent policy to better inform and involve patients in their health care. The goal of this new ‘informed patient’ policy (Henwood et al., 2003) is to provide better information to patients and to make them more involved in their health care, taking responsibility for certain of its aspects. Amongst others, the policy has led to initiatives such as ‘NHS Direct Online’, an Internet-based information service for patients. With regards to antenatal care, current guidance of practice for providers also emphasizes the importance of good communication and points out that the expectant mother can expect to be given ‘clear information and explanations’ during antenatal appointments (NICE, 2003: 9). As a pregnant woman, throughout the nine months I was given many leaflets and brochures by my health care providers (in addition to the information contained in the Green Notes) and I will return to these in the next section. I also received a lot of information orally. I was invited to make myself informed about any aspect of pregnancy and childbirth that was relevant
to me. At certain times during my pregnancy such information became very important, as I had to take crucial decisions regarding my unborn baby's and my own health. This was, for example, the case in relation to the amniocentesis, which I will discuss later in this article.

The Green Notes can also be seen as a surveillance tool in the Foucauldian sense. We can assume that for a health care provider, the goal of patient information is likely to be compliance rather than an informed decision that can potentially result in disagreement with the medical view. The Green Notes and other leaflets on pregnancy I was given supported specific behaviours. They conveyed information but also appealed to an expectant mother's responsibility for her own and her child's health. This is, for example, the case of a letter offering pregnant women and their partners support to stop smoking, which I received. Framed within a discourse of support, the letter nevertheless appealed to the expectant mother's sense of duty to look after her health.

In the early stages of my pregnancy, my midwife also gave me two guidance leaflets on what foods to avoid in pregnancy. I took some of this advice with a degree of humour – signalling my opposition to this form of surveillance – as I saw the extent to which the advice reflected culture-specific norms. I remember joking with my friends about the likelihood that French women worry much less about which cheese to avoid in pregnancy than their British counterparts.

My midwife – as is common practice in my local NHS trust – visited us in our home. During this visit, she talked me (or rather us, as my husband was present and thus became a co-recipient of these messages) through several sections in the Green Notes. She also gave me additional leaflets on some of the topics we talked about. I certainly felt there was an element of surveillance in the midwife's visit to our house. I made sure to have tidied up and cleaned the house before she arrived, thus giving an excellent example of how surveillance works in the way Foucault described it: without needing to be coerced, I had turned the 'inspecting gaze' onto myself and had made myself conform with what I believed was expected of me (Foucault, 1980: 155). The visit was not presented as an option and the reasons for it were not explained to us. My own interpretation simply was that our house – and by extension ourselves – were to be checked out for our suitability as parents.

In the previous paragraphs, I have discussed the Green Notes with regards to their administrative function. This was, however, not the only role they played throughout my pregnancy. Over the course of the nine months, they gradually took on an additional meaning. Through their continuous presence in my study, they gradually became part of my own world, or, to be more precise, my new world as a pregnant woman. As an artefact they were a physical symbol of my new identity and life as a
pregnant woman. This was particularly the case in the last weeks before my son was born when, following advice from my midwives, I carried the notes with me at all times. Of course, their role had also changed because by then I was heavily engaged in my autoethnography and I was keen to explore their significance as a structuring agent in my antenatal care.

Making sense

I like Thursdays

‘I like Thursdays’, my diary entry from 20 January, is about a book that I had bought in December and which I read regularly. The book Expecting: Everything You Need to Know about Pregnancy, Labour and Birth (McGrail and Metland, 2005) is written by two mothers who teach antenatal classes and work with new parents. They are also the editors of a website for pregnant women and their partners which I briefly used at a later stage in my pregnancy. Expecting has a chapter for each week of the pregnancy. Because on every Thursday I entered a new week of my pregnancy, I liked Thursdays: there was a new chapter to read and something new to discover about my experience.

Reading served two main purposes. It satisfied my curiosity and my new interest in matters relating to pregnancy and childbirth and it helped me deal with fear and anticipation. This was particularly important during the first trimester, when I experienced the kind of emotional rollercoaster that – as I know now but didn’t know then – is perfectly normal for every pregnant woman to go through. During the first trimester I was very preoccupied with the possibility that my baby might not be healthy, a point to which I will come back later in this article.

My eagerness to inform myself and my willingness to spend considerable amounts of time searching for and reading information about pregnancy and childbirth is far from uncommon, in particular amongst older mothers. Several researchers have found that mothers over 35 years, especially those expecting their first child and who are well-educated, tend to be well-resourced (Carolan, 2005a; Gottesman, 1992; Viau et al., 2002). Research has also found that they think of antenatal education as contributing to their maternal identity (Koehn, cited in Carolan, 2005b). Undoubtedly, a woman expecting her first child experiences physical and emotional changes that can be frightening, particularly because she has no previous experience that could serve as a reference (Earle, 2000). This was also my situation. Reading about pregnancy and childbirth was part of my new identity as a pregnant woman. At the same time, it was simply a strategy that I have always used when confronted with new experiences. In that
sense I see my desire to be a well-informed expectant mother as a continuation of my earlier self.

As a theme, ‘making sense’ moves my autoethnography from a pre-occupation with the institution’s (the NHS’s) literacy practices to my own literacy-related activities. Because I knew very little about pregnancy, childbirth and baby care, I felt a great need for information. As both my physique and my emotions constantly changed, I drew heavily on texts to help me make sense. In the book *Expecting* (as well as in the other documents I read) I found the language of description that I needed and the structure that allowed me to construct a (more or less) coherent narrative of my experience. At the time of my pregnancy, I had few friends nearby who shared my experience and because I lived abroad I could not rely on family members for regular guidance and support. In the face of this entirely new experience, I had a strong desire to find out that what I experienced was normal, in the sense of being shared by others (see Earle, 2000). Reading books and other documents helped me with this. Living abroad and expecting my first child also meant that I had no understanding of antenatal care in England. *Expecting* also served as a reference guide for understanding the culture and structures of antenatal care in the country where I lived. No surprise then that the book became my best companion, as I say somewhere in my diary.

But *Expecting* wasn’t the only book I read. My regular visits to our local bookstore resulted in a small but growing collection of texts on pregnancy that also included books given to me by friends. These came with a specific ‘tag’: a comment by a friend explaining why she had liked this book or which section she had found specifically useful. Reading all this material involved me in a lot of ‘vernacular learning’. This was self-directed learning and at times moved me towards complementary views on pregnancy and childbirth. In the latter half of my pregnancy, for example, I became interested in yoga and meditation for labour.

Although usually an avid reader of fiction, I did not read any novels or other fictional texts on the topic of pregnancy or motherhood. I also made relatively little use of discussion websites for pregnant women. Such sites can be an important space for lay patients to act as health care providers and in that sense are also places where mothers-to-be critically engage with the views imparted by their midwives and doctors (Drentea and Moren-Cross, 2005; Hardey, 2001). I tried one of these sites, choosing first to join a discussion amongst women expecting their child in the same month mine was due, later joining a group of pregnant women over 35. In both cases, I found it difficult to relate to the other women online, who seemed to be part of an already established community with their own shared interests and concerns.

Overall, I tended towards factual and scientific genres. This may be a
reflection of my own background as an academic. I also rejected the various
documents of a commercial or semi-commercial nature that I received from
the NHS. When the midwife visited our house, she not only gave me NHS
leaflets and a book about pregnancy produced by the NHS. She also
presented me with a plastic folder containing a collection of leaflets and
brochures from companies such as Pampers and Vitabiotics, a provider of
vitamins for pregnant women. There were also product samples and tokens
for the purchase of pregnancy and baby-care products at reduced price.
That these brochures and samples were given to me by my main antenatal
carer in my view was a sign of the encroachment of commercial discourses
into public health care that I object to. They were also a symbol of the
commercialization of pregnancy and motherhood which makes mothers-to-
be a key target for advertisers. I nevertheless had a look at the folder, but
soon relegated it to a corner in my room. The main reason I kept it was
for research purposes.

Writing also played a central role in my sense-making, as can be seen
from the following quote from my diary.

How much of this is literacy research, how much is personal reflection?
(23 January 2006)

The research diary, as the above entry shows, soon turned out to be more
than a record of my literacy practices. Writing in itself was an act of
meaning-making. Sitting down at my desk, pen in hand, was a way of giving
meaning to my experience. It was in part through the diary that I created
the narrative that I needed. Writing about my experiences helped me build
my new identity and it was in writing that I also negotiated the relation-
ship between new and old (i.e. pre-pregnancy) selves. Our identities are
always shifting and a big part of the identity work which we engage in all
the time is adjusting our sense of selves to new circumstances (Giddens,
1991). As a regular activity, writing my diary became part of my evolving
maternal identity, in the same way as reading and information searching
was (see above). At the same time, because I considered my diary to be a
research tool, it afforded continuity with my ‘old’ (and much better known)
identity as a researcher.

From an academic perspective, the diary fulfilled a double role: it was
both data and research record/analysis. In writing, I presented data and
analysed it. The diary ‘reified’ a particular version of my experience (Barton
and Hamilton, 2005). As with the records of the midwives and doctors in
my Green Notes, my own record made durable the version of my experi-
ence that I constructed while keeping my diary. This was, however, not set
in stone. Conversations with friends (whether on the phone or by email)
provided additional space for reflections on what I experienced and the
account that ended up in my diary was often the result of a longer process.
of discussion involving others and other texts (e.g. websites, book sections, etc.). My meaning-making process has carried on beyond the time I kept the diary. While writing this article I carried on reflecting on my experience and I reviewed my earlier interpretations of some of the things that happened to me. The double role that the diary had from its beginning continues. In addition, it also serves as a memory device.

Dealing with difficult moments

During the first meeting with the consultant I was very nervous. I kept on thinking that I must remember what she was telling us. This wasn’t for research purposes, this was for me, for us, so that I would remember the percentages and risks she was talking about. K. remarked afterwards that I hadn’t been very articulate when talking to her. In this situation my emotions (my worry that the baby might not be healthy) guided what I could and couldn’t do, how I ‘performed’. I certainly wasn’t a rational actor or performer. I was a pregnant woman full of emotions. (11 January 2006)

I have already mentioned my fears that my baby might not be healthy. The above entry was written after my husband and I talked to an obstetrician about any risks to our unborn baby. We discussed whether to have an amniocentesis. This invasive procedure allows DNA samples from the amniotic fluid to be tested for genetic disorders. It is available to every woman, but usually recommended only if there is a specific risk and depending on the mother’s age. During the meeting, the doctor provided us with a lot of information about the possible risks for our baby. She showed us the general statistics for our age group and for women at her hospital. She invited us to compare these statistics. She then performed the nuchal translucency scan, a common screening test that presents no danger to the foetus and is used as an indicator for the likelihood of Downs Syndrome occurring. On the basis of our nuchal translucency scan, the obstetrician recalculated the risk for our baby. Her aim was to help us decide whether to have an amniocentesis or not. The procedure itself brings with it the risk of inducing a miscarriage. In the diary, I explain that throughout the consultation I was anxious to retain all the information we were given. But I didn’t take any notes and I did not write down any of the figures and percentages the doctor gave us. Coming back from Manchester, to my dismay, I realized that I had already forgotten the names of the three main disorders the amniocentesis is able to detect.

I am a regular note-taker. I take notes in exam board meetings, meetings of teaching and research committees, I make to do lists and when I go to
academic conferences I always come back with a stack of paper covered with handwritten notes. In my private life, I am also a note-taker. And so was I as a pregnant woman. I took notes when the midwife came to visit us in our house. Before I went for my routine appointments with my midwives, I prepared lists of questions to ask them. My husband and I were the only couple who took notes during the antenatal classes we attended together. I underlined sentences in my favourite books and I used post-its to remind me of specific passages in other books. On my way to hospital, while already in severe pain, I still managed to keep a record of the timings of my contractions.

Writing for me is a coping strategy. I write to memorize and I write to clarify my thoughts. I also simply enjoy writing. Nevertheless, in the above meeting with the consultant, I didn’t write anything down. I kept my pencil and notepad in my handbag. Yet, I know I would have felt more in control if I had taken notes. My usual coping strategy had not worked.

As I illustrated earlier, I read a lot about pregnancy and labour. My behaviour is not unusual. Carolan (2005a) has found that health professionals respond to women like me by giving them a lot of information and by focusing on detailed medical-oriented advice. This is also what the consultant in Manchester did and in that sense she had correctly ‘read’ my needs. I certainly self-identified as a woman who wanted to take an informed decision and I am sure that this is how I presented myself during the consultation. However, what I had not anticipated was the amount of fear involved in having to take such a decision. The first-time mothers over 35 participating in Carolan’s study told her information can be empowering but also terrifying. Like them, I wanted to know, but was also scared by what I was told. As an ‘older’ mother (I was 40), the first months of my pregnancy had been dominated by fear for my baby’s health. I spent many hours informing myself about genetic disorders and the risks for older mothers. These readings confirmed and at times aggravated my worries. The meeting with the consultant was a crucial moment in the first trimester and it was only after I had had the amniocentesis and had received its (positive) results that I stopped fearing for my baby’s health. In retrospect, I believe that I did not take notes during the consultation simply because I was too anxious. It is likely that what I needed most at that stage was not precise information about risks, but reassurance that everything would be fine. Yet, at the time, this was not clear to me and in my conversation with the consultant I tried to hide my emotions and to present myself as a rational patient in the process of taking an informed decision.

Sitting in the consultant’s office, I was not only anxious, but also embarrassed. In most of my everyday roles I am relatively confident. This is what I am accustomed to. But here I was in a situation that left me with little confidence and I was aware of my limited knowledge about genetic
The above was the most significant ‘difficult moment’ I experienced throughout my pregnancy and which I reflected upon in my diary. A related moment of difficulty happened a few weeks later, when I was back in Manchester for the amniocentesis and had to sign a consent form, a common literacy practice of health care. When I entered the consultant’s office, she invited me to sit with her in a corner of the room that was furnished with armchairs. She sat opposite to me and explained the procedure and its risks to me. While she did this, she held in her lap the consent form. From where I sat, I could not read the text of the form and she did not share the paper with me. Only after she had finished her explanations did she hand the form over to me, with an invitation to sign it. This presented me with a dilemma. I felt that I was invited to sign the form quickly, but I really wanted to read it carefully and take my time before giving my consent. The preceding process was a form of literacy mediation (Baynham, 1995; Malan, 1996) – the consultant ‘reading’ the form for me – that I had not specifically asked for. I have no doubt that it was intended to be empowering, but in the actual context of the situation, this was only partly achieved. I took a quick glance at the form, recognized in the text some of the points the consultant had just talked me through, and signed it.

But I wasn’t comfortable with the way this literacy event had developed. I would have preferred a different process of mediation, giving me time to read the form carefully before signing it, or perhaps looking at it together with the consultant while she explained its content. In the instance, I felt rushed to sign the paper. That I consented to the way things were done reflects my own lack of power and assertiveness in this institutional context that invited me to trust the consultant’s mediation of the content of the form. Emotions also played a role in this literacy event. I had come for the amniocentesis and, knowing it to be a procedure with risks and discomfort for the pregnant woman, I was rather nervous.

Conclusions: the potential of autoethnography

Writing up my autoethnography I have realized how much I learned about myself and the importance of literacy in relation to my pregnancy through this research. I became aware of the many purposes reading and writing fulfilled throughout my pregnancy. It satisfied my need for information and it was part of my developing identity as a pregnant woman and expectant
mother. In many situations (but not the one discussed above) it made me feel more in control and less anxious about what I experienced. Both reading and writing were parts of my engagement with what for me was a new cultural and institutional world. The diary, for example, is placed at the interface between the institutional world of antenatal care and my own personal world of experiencing pregnancy. Although my relationship with my midwives and other carers was generally very positive and there was little conflict, reading and writing helped me affirm my position in my encounters with the institutional world of antenatal care.

So I learned a lot about myself by conducting this autoethnography. But what did I learn about the role of literacy in relation to pregnancy and childbirth more generally? In the introductory section to this article, I declared with confidence that autoethnography always goes beyond introspection. But do I fully agree with the claim I made? For sure, I am aware of the claims of self-indulgence frequently brought against autoethnographers. When I presented my autoethnography to two academic audiences, I made sure to explain that I was aware of the limits of this approach. So what contribution can autoethnographers make to theorizing in relation to wider social and cultural issues of contemporary interest?

Some researchers, it seems, believe that autoethnography can only contribute to theorizing about broader social issues if it involves not only the researcher but other informants (Anderson, 2006). Others appear not to see much merit in autoethnography. They criticize its romanticism and believe it to be unable to provide insights beyond the personal experience (see, for example, Atkinson, 1997). The autoethnographer is seen as self-indulgent and neglecting her broader social and analytical responsibilities as part of the wider (academic) community. I suggest that what drives autoethnographers is exactly the opposite: a search for new methodologies that offer new ways of understanding social and cultural life as different people experience it. Conventional social science research struggles, for example, to capture and to communicate the emotional experience of everyday life in all its facets. Conventional ‘realist’ academic writing often provides lifeless accounts failing to engage readers (Tillmann-Healy, 1996). Sparkes (2002) rightly points out that these stories’ academic value (e.g. their merit in providing sociological insight) must therefore be questioned. I have already mentioned the limitations of my earlier research on literacy and health in accounting for what I have called the affective side of reading and writing in everyday life. Yet, this same research project taught me how central emotions are to how we deal with the textually mediated nature of much of our contemporary lives and the demands and constraints this imposes on the individual. Autoethnography can help us understand the emotional side of literacy, as this article has shown.

There is a strong tradition within autoethnography that refuses to
analyse and theorize in the way conventional social science does. ‘Evocative autoethnography’ (Ellis and Bochner, 2006: 445) seeks its merits in a different epistemology offering narrative texts which describe the personal emotional experience of one person. The goal of this scholarship is to create emotional resonance with the reader and through this to enable the reader to develop understanding, knowledge and even theory (Ellis and Bochner, 2006). Autoethnographic accounts are considered valid if the experience described is lifelike and believable, and engaging its audience at a personal level provoking feelings and thoughts. Starting with personal experience, evocative autoethnography aims ‘to touch a world beyond the self of the writer’ (Bochner and Ellis, 1996: 24). The kind of analysis or theorizing it invites its audience to do, however, is neither ‘disembodied’ nor ‘distanced’, and it rejects ‘definitive descriptions and analytic statements about the world as it “truly” exists outside the contingencies of language and culture’ (Ellis and Bochner, 2006: 435).

Autoethnography shares with other postmodern forms of qualitative research this turning away from the certainties (and arrogance) of the ‘grand narratives’ of modernist social science. This is partly what made it attractive to me. But it was also autoethnography’s potential to capture the emotional experience of everyday life and the desire to produce an account that resonates with others’ feelings that drove me towards this method. My above account of some of my experiences as a pregnant woman has confirmed my belief in the role of autoethnography in social sciences. Bochner (in Ellis and Bochner, 2003: 217) points out that autoethnography offers researchers a tool to challenge the ‘rational performer model’ underlying much social policy but also social research. In my previous research on patients’ experience with reading and writing in health care contexts, I had already begun to seriously doubt the reality of the rational actor model which underlies current health policies in England. One woman told us about her inability in the light of her husband’s freshly diagnosed terminal cancer to follow their consultant’s suggestion to write down the questions they had for him. Other informants explained that to search for information and to try to know was ‘dangerous’ because the more one knew the more frightened and worried one would be. These people did not fit the ‘informed patient’ ideal of current health policies. Their stories are similar to my own experiences when sitting in the obstetrician’s office in Manchester. During the meeting, I struggled to fulfil the role of the articulate, well-informed and ‘health care-savvy’ (Hart and Lockey, 2002) patient that I had believed myself to me. I found it difficult to make an ‘informed decision’ and, if anything, my decision (to go for the amniocentesis) was informed by emotions (fear). I was, as I put it in my diary, a pregnant woman full of emotions, not a rational performer.

But let me come back to the question of whether autoethnography can
engage with theoretical issues of broader social significance. The autoethnographic text I am writing (I understand the present article to be a moment in this ongoing process of writing) is situated in the personal. But, as Jones (2006: 1018) explained in relation to his experiences as a coach, such accounts can ‘enable others to read of a culture through witnessing my concrete, detailed experience with it’. Autoethnographers do not just write about themselves; they write about their own thoughts and feelings about specific cultural phenomena. As individuals we are always part of a larger social and cultural body. Therefore, even ‘pure’ autobiography is never just about the self (Sparkes, 2002). And it is herein that lies the method’s potential to connect with others. Jones rightly points out that his experience of coaching, a context where he was stigmatized (because of a speech impairment) and where he struggled to position himself vis-à-vis others and their dominant cultural norms, is ‘an occurrence typical of social life’ (Jones, 2006: 1018). I believe the same to be the case with my experience. How I experienced antenatal care and pregnancy was shaped not only by my own personality and background but by the social environment I am part of. Much of what I experienced was located within a cultural context not at all untypical for our social lives. My autoethnography provides a specific perspective on social phenomena shared by other women and it offers insights for contrast and comparison. Albeit a singular case, it sheds light on a shared phenomenon: individuals positioning themselves within the social and cultural worlds they inhabit.

Antenatal care is a highly structured social world, populated with norms and conventions which every pregnant woman in England encounters. As do other pregnant women, I had to negotiate my place within this world. My desire to belong and to be accepted without being fully constructed and constrained by its parameters is a conflict all too common in many contexts of contemporary life. Working on my diary and other data, I became aware that I had wanted the midwives to like me and to think of me as a good, easy patient. If possible, I avoided conflict. This is a personal experience, but it also stems from gendered social expectations and is likely to be shared by other women. It is an example of how the personal is socially shaped. I also expect other women to have similar feelings towards their Green Notes, feeling only partly involved and empowered by the current structures. My example offers insights into how other patients react to the health services’ new policy of inviting patients’ greater involvement in their care. My mixed reactions to this policy echo other researchers’ findings (Henwood et al., 2003). On the other hand, my reaction to the parameters I have described here must be at least to some extent unique, because of the particularity of my circumstances and personality. For example, I would not expect that my great desire to inform myself is necessarily shared by other pregnant woman. It is possible that I differ from many other expectant mothers, in
particular younger ones, in my relatively limited use of online networking facilities (see above). But, as Ellis (in Ellis and Bochner, 2003) explains, as a member of a culture, the range of how we can feel and act is always limited by what is culturally available to us. Therefore, I end on a confident note: autoethnography has an important contribution to make to ethnographic research and to how we understand our lives.

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**References**


UTA PAPEN is Lecturer in Literacy Studies at the Department of Linguistics and English Language and a member of the Lancaster Literacy Research Centre. She is particularly interested in social and cultural aspects of literacy and in cross-cultural research on the role of reading and writing in everyday life. In her current research, she looks at the role of literacy in relation to pregnancy and antenatal care. Recent publications include Adult Literacy as Social Practice – More than Skills (Routledge, 2005) and Literacy and Globalization – Reading and Writing in Times of Social and Cultural Change (Routledge, 2007). Address: Department of Linguistics and English Language, Bowland College, Lancaster University, Lancaster LA1 4YT, UK. [email: u.papen@lancaster.ac.uk]