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► **To cite this version:**

Elsa Boulet, R. Guilloux. How power relations impact pregnancy and childbirth: Knowledge, Healthcare and Work in France. *Ethics, Medicine and Public Health*, 2025, 33, pp.101032. 10.1016/j.jemep.2024.101032 . hal-04815653

HAL Id: hal-04815653

<https://hal.science/hal-04815653v1>

Submitted on 3 Dec 2024

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Short report

How power relations impact pregnancy and childbirth: Knowledge, Healthcare and Work in France

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ARTICLE INFO

Keywords:

Domestic labour
Information
Intersectionality
Perinatal care
Social inequalities
Working conditions

ABSTRACT

Based on a constructivist approach to human reproduction, this focus analyses the ways childbirth in mainland France is framed by natalist and health policies and by social inequalities. Beyond the tension between naturalness and technicality, birth is subject to a diversity of power relations. We focus here on power dynamics around class, sex and race, which impact the access to and the quality of perinatal care. Drawing on qualitative and quantitative studies, we show that women and couples have unequal access to information during pregnancy, for several reasons. Firstly, the standardised length of antenatal consultations. Secondly, differences in understanding of information that is implicitly adapted to the most educated and affluent social classes. Thirdly, the ambivalence of the information, which oscillates between autonomy and injunction in terms of how the baby should be delivered and fed. Fourthly, pregnant workers have little knowledge of their reproductive rights. We also show that the provision of perinatal care is unequal despite a supposedly universal health insurance system. Racially minoritized women are subject to more complex administrative procedures and to more medical interventions. In addition, health and diet recommendations, and alternative birthing methods, are better suited to the individualistic logic and material conditions of the middle classes than those of the working classes. As far as working conditions are concerned, women in arduous occupations use sick leave as a means of protection, whereas women in less arduous occupations take maternity leave later than the other women. Lastly, men's involvement in domestic tasks during women's pregnancies remains occasional and limited to the physical dimension of those tasks, even more so as the assignment of women to domestic labour is reinforced by healthcare professionals. Finally, we contend that equal care for all pregnant women can only be achieved if the social dimensions of health are fully taken into account.

Childbirth via MAP techniques is often opposed to so-called “natural” or “spontaneous” childbirth. On the contrary, we would like to draw attention to what these two configurations have in common. Procreation has been constructed in France as an essentially feminine responsibility: medical investigations into infertility have focused on female bodies [1], as have public health measures aiming at promoting natality and new-born health [2,3]. Maternity continues to be naturalised, even when women become mothers through MAP [4], whereas paternity more readily appears as a social status [5].

If pregnancies can be lived as an intimate couple project, they are nevertheless integrated into an **institutional framework of birth policies** which combines two major strands (we focus here on metropolitan France). First, a pro-natalist family policy formalised in the Family Code of 1939 promoted the model of the “[heterosexual] family of at least

three children, in which the mother stays at home” [6]; this inscribes France in a “conservative regime” [7]. Second, since the 1970s, a public health policy was implemented in the form of different perinatal programs centred on security, the most recent (2005–2007) emphasizing the “humanization of childbirth”. Despite this institutional framework, “the information received by the parents is plentiful and sometimes contradictory. The parents’ living places offer very diversified and heterogenous organizations and resources” [8].

In this paper, we argue that power relations of class, gender and race frame the experience of pregnancy and childbirth in contemporary mainland France: the access to health care and reproductive rights is unequal, as is the treatment received by patients in the healthcare system. Two sociological concepts guide our reflection. *Procreative work* belongs to a feminist and materialist tradition that refutes the supposed

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Received 23 August 2024; Accepted 26 November 2024

Available online 2 December 2024

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naturalness of childbirth and the dissymmetry between paid “productive” work and unpaid “re-productive” work (domestic, parental) assigned to women. This notion is useful for studying the “production of children” as a complex of activities involving multiple dimensions (biological, sexual, domestic, sanitary, professional, etc.) [9]. *Intersectionality* [10] sheds light on how different power relations combine and influence one another: relations of class (in the socio-economic sense), race (as a process of assigning people to supposedly homogeneous categories) [11], and sex (in the sense of the masculine/feminine opposition).

Enlightened choices? Social inequalities of access to information

Health professionals, whether based in hospitals or surgeries, midwives or doctors, play a role in disseminating information to women (who may also inform themselves through friends and relations, the internet, etc.). This information work does however encounter several obstacles. Firstly, the **temporal constraints** in care work: the standardised duration of consultations does not always allow for detailed exchanges. Secondly, access to information delivered by health professionals is unequal despite a supposedly universal care system. The early prenatal interview (EPI), set up since 2007, consists in a meeting with a professional (often a midwife) who responds to the woman’s or couple’s questions and identifies any difficulties (psychological suffering, economic vulnerability, conjugal violence, etc.). In theory, EPI is systematically organized, yet less than one woman in three (28.5%) reported to have participated in one [12]. Information concerning comprehensive support during pregnancy and childbirth (a single midwife provides care before, during, and after childbirth) remains difficult to access and is mainly reserved for **privileged social classes**. Antenatal courses (ACs) are financed by Health Insurance and offered to all patients, though only attended by one woman out of two. Women having a medium or high level of education, and professionally active women, are over-represented as beneficiaries of both the EPI and the ACs [13]. In this regard, it is important to take into account how class intersects with race. A study carried out in Parisian public hospitals showed lower levels of participation among poor migrant women. The healthcare professionals interviewed explain this trend drawing on **cultural reductionism**: “They are already surrounded by other women”; “They do not ask as many questions as we do.” However, adapting to the conditions of migrant women (creating specific groups, using an interpreter, offering a single information session) increases the level of participation and willingness to speak up [14]. By contrast, wealthy migrant women who attended a private clinic in Paris benefited from a translation service and thorough information from their healthcare providers [15]. Thirdly, the **information transmitted is ambivalent**: it is supposed both to promote the patients’ autonomy by disseminating medical knowledge and to orient their behavior. For instance, women are supposed to choose between bottle feeding and breastfeeding, but the 2006–2010 national program of health nutrition proposed that the EPI promote breastfeeding [16]. The ACs provide explanations about the physiological process of childbirth, but they also prepare patients for the organizational functioning of the hospital, thus facilitating the work of careers and legitimizing medical interventions [17]. Furthermore, the ACs often take a rather scholarly form that is less adapted to less well qualified or non-Francophone participants [14].

Finally, a majority (70%) of women living in France are employed during their pregnancy [12], which raises the question of **information about the rights of pregnant workers**. A study carried out with women living in the Paris region showed that pregnant employees rarely knew their rights [18]. Confusion between sick leave and prenatal leave, uncertainty regarding authorisations of absence for medical reasons, feelings of illegitimacy to ask for modifications in working conditions all indicate the enduring hierarchy between so-called productive and reproductive work. The lack of information cannot here be dissociated from the very concrete power relations that structure paid work:

pregnant workers were rarely informed of their rights by their hierarchy, and modification of working hours or work stations was often informal.

Universal care? Social inequalities in perinatal health

In theory, the French social security system guarantees a universal access to care. Specific measures enable, for example, women in **extreme insecurity** (without a visa and/or without health insurance) to benefit from prenatal care and to give birth in a maternity ward. But once they have gained primary access to care (i.e., they have entered into the healthcare system), secondary access (i.e., the rolling out of healthcare) [19] can become very complicated if they try to negotiate better conditions, facing the risk of being “blacklisted”, or when suspected by the care staff of participating in networks of paternity trafficking [20].

A study carried out in three maternity hospitals, in and around Paris, showed how assignation to **racially minoritized groups** can lead to active selection strategies from healthcare professionals: delaying meetings, or complexifying the administrative procedures [21]. A study comparing rates of caesarian section between native French women, mostly from the upper middle class and lower middle class, and immigrant African women, mainly from the working class or in disadvantaged situations, shows that the latter have higher rates of caesarean section, they also receive “simplified preventative messages, and fewer initiatives are undertaken by care providers in response to abnormal measurements” [21]. While, these authors insist, the data requires confirmation, they at the least engender a feeling of discrimination on the part of the women concerned. By contrast, a study conducted in a private clinic attended by wealthy women, among whom African women, showed that the latest received the same treatment as White patients [15]. A. Nacu explains why healthcare professionals tend to interpret the behaviour of migrant women in the light of their supposed “culture”: first, because classifications and protocols are typical of clinical work; second, because “culturalism becomes for the healthcare professionals a resource to give meaning to this complexity, but also, above all, to deal with the contradictions and pressures that these professionals must confront on a daily basis when treating an insecure population” [21].

If insecurity is perceived by healthcare professionals as a risk factor, social inequalities are rarely questioned. For example, **recommendations concerning everyday hygiene** are based on the implicit model of the middle classes: they suppose that women have comfortable financial means and that they consider health to be the result of individual actions. But members of the middle class adhere more often than those of the working class to this individualist definition of prevention: the latter, who face harsher working and living conditions, tend to valorise present satisfactions (for example alcohol, tobacco, food), even if those may lead to the degradation of one’s state of health. Further, the members of the working class consider that their living conditions are important factors influencing their health, more important than their individual behaviour [22]. Regarding **alternative birthing methods**, the Inter-association Collective for Childbirth (CIANE) showed that these are “discriminatory”: continuity of care and home birth is “a luxury reserved for the privileged” [23], even though a substantial proportion of working-class and middle-class women express an interest in it.

Taking class into account also means to investigate the **conditions of paid work**. The analysis of early sick leave and late prenatal leave sheds light on important inequalities: in conditions of equivalent health, women in unskilled, insecure jobs are over-represented among those who stop working before the 6th month of pregnancy (in total, one third of pregnant women in 2016). On the contrary, women in managerial roles are more likely to take so-called “late” prenatal leave (at the end of the 8th month of pregnancy) [24,25]. In other words, in the absence of efforts to adapt working conditions, sick leave is a form of compensation which avoids or limits the degradation of women’s health [26].

Women’s labour is not limited to the sphere of paid work: as statistics

show, **women** continue to carry out the majority of **household and parental tasks** [27]. Pregnancy could be a “time off” for women who are invited to rest and to avoid certain physical activities. But a study carried out in the Parisian region showed that this respite was only relative: male partners occasionally take on certain tasks, those which they perceived as requiring physical strength, but dodge others which are nonetheless described by women as tiring (cleaning toilets, carrying a child) [18]. As regards medical institutions, the discourse on domestic labour is ambivalent. Midwives, for example, invite women to “get help at home”, without questioning their being assigned to a role of housewife. Further, the brochures handed out to pregnant women reproduce this image of the devoted mother, and the plentiful advice directed at them aims above all to make them into “good mothers”, taking care of their health to guarantee that of the baby.

Conclusion

Faced with evidence of the importance of health inequalities relating to childbirth, the French public authorities have proposed to “formulate a coherent public health discourse for the first 1000 days” [8]. However, “one must certainly acknowledge that defending health equality loud and clear is not producing it in reality” [28]. To achieve this goal, the social dimension of health must be taken fully into account by the health care policies and healthcare providers: possible solutions might include improving information for all parents, guaranteeing the effectiveness of pregnant workers’ rights, and rolling out promising experiment in access to healthcare for the most disadvantaged and migrant women.

Funding

None declared.

Declaration of competing interest

None declared.

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