[page 27] **A Study on the Childbearing Behavior of Rural Korean Women and Their Families**

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INTRODUCTION

Pregnancy and birth as human experiences are central events of family life, of culture formation and the source of continuing existence of any society. During the latter half of this century the health care institutions of modernized nations increasingly monopolized medicine and thereby assumed major responsibility for childbearing as well. As a result the childbearing process, originally imbedded in the family with all primary responsibility resting with the family, became almost exclusively an issue of institutionalized health care. From the moment she realizes she is pregnant, a woman is oriented toward the hospital and the doctor. She becomes a “patient,” faithfully visits the prenatal care clinic, follows the advice of the doctor meticulously, and gives birth in the hospital. In other words, she assumes a sick role in which the responsibility for her own affairs is delegated to others.1

In most modernized societies the mother gives birth at the hospital and returns home with the newborn three to seven days later. Because modern medicine has taken the responsibility for childbearing from the family, it is not until after the birth that the modern family experiences the full impact of the birth on its structure and function. By being deprived of responsibility during pregnancy and birth, the family loses its chance to adapt and it loses an important center of family life. Just as the dying in Western societies are isolated from their social environment, so are mothers in labor isolated from their social environment in childbirth.

Modern medicine, where it effectively covers all childbearing processes, has reduced physical hazards to a minimum. It can be debated,

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[page 28] however, whether the textbook aims of obstetrics2 and the aims of Mother Child Health formulated by the World Health Organization3—which include emotional and social wellbeing—are indeed realized. It appears that “modern” mothers look forward to birth as if it were surgery rather than the most dignifying experience of womanhood. Modern women’s movements claim that we now have a generation of highly neuroticized childbearers,4 and that the alienation of childbirth from the family has led to a worldwide inability to breast-feed.5 Modern perinatal psychologists point out that this in turn has serious repercussions on mother-child relationships and the mental health of children in modern society.6

Korea, as a rapidly industrializing country, is exposed to strong mo-dernizing influences. In health care these include an emphasis on hospital delivery. Improved maternity care would indeed eliminate a major gap in health care, since the majority of Korean women still deliver at home without a trained attendant and are exposed to all the hazards of unattended childbirth.7 But not all modern approaches are good, and not all traditional attitudes are bad. Before Korea moves further in the direction taken by contemporary modernized societies, it is worthwhile to look for alternatives in maternity care based on a more sophisticated understanding of the meaning of childbearing in the cultural context, on a careful re-evaluation of the Western services model where it is now defunct, and on an appreciation of the healthy attitudes toward childbearing that are inherent to the Korean people.

The Korean family is still a major power against some negative de-velopments in Western maternity care. It is noteworthy that in the United States and Europe strong public movements are under way to reverse the trend of misapplied medicine in childbearing8 and that the medical profession is also increasingly concerned with the issue of technology versus natural childbearing.9 In Korea as well as in other modernizing countries there is still a chance to avoid the basic mistake that makes maternity care approaches in the West an issue of increasing concern.

In rural Korea the traditional family controls childbearing and effectively prevents the medical experts from including childbirth in their medical domain. Korean obstetricians care for only a fraction of the births that occur in this country. While it is important to overcome the conflicts that deprive mothers and newborn children of the benefits of modern care, it is equally important to develop alternative approaches to modern maternity care that are more suited to Korean cultural and family life. Such alternative approaches must be based upon research, especially from ethnomedical data.

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This study inventoried childbearing-related behavior in a rural Korean area, in its traditional aspects and in its relation to modern health services. It was the aim of the study to identify customs, beliefs, family interactions and decision-making strategies in normal and pathological reproductive processes in order to find behavioral factors which can help to differentiate sound as well as problematic attitudes toward modern childcare services and determine the barriers that inhibit Korean women from using the desirable aspects of modern health care during the procreative period.

An ethnographic approach was used to obtain the desired data. Thirty families, each with a pregnant woman, were chosen in fifteen different villages on Kanghwa Island within the area of the Yonsei University Kanghwa Community Health Project.10 Despite four years of project efforts in maternity care, 88% of the women still delivered at home and approximately 50% had no trained attendant.11 Nevertheless this compares favorably with nation-wide rural conditions where qualified delivery attendance is around 20%. Generally speaking, there is rarely a midwife or a doctor in reach of a rural Korean mother at delivery. The project’s maternity care program, however, has two government-employed midwives available at the two health subcenters of the target area. Further, the project identifies all pregnant women and does this relatively early, which was an advantage for sampling that no other rural area yet provides. The project made interaction observations more profitable than they would have been without such an organization. The regular contacts that the project maintained with all pregnant women through village workers and health subcenter staff made it possible to obtain medical data on the process of pregnancy, childbirth, and the postpartum period in addition to the ethnographically obtained material.

Twenty cases were selected from among all pregnant women who registered with the maternity care program within their first trimester of pregnancy in late 1977, and ten cases were selected from among those who had registered within the third trimester of their pregnancy in early 1978. These women were expected to give birth between April and August 1978. The differentiation in respect to registration was made to search for factors that determine the time of registration. These factors are important for the success or failure of the maternity care approach in the Kanghwa services model. The study presented here was conducted from March through August 1978. It followed each of the thirty families throughout the pregnancy, the childbirth, and the postpartum period.

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Ethnographic data and data on interaction with health services were collected by one specifically trained interviewer with a bachelor’s degree in sociology and an assistant. The medical data and supplementary ethnographic and family health services interaction data were collected by two specifically trained public health nurses who were employed by the Yonsei Community Health Project and who cooperated with the midwife in charge of the maternity care program in the project area. From the client’s point of view, however, the two teams could not necessarily be recognized as connected since the medical contacts by the public health nurses were part of the ongoing maternity care activities directed from the health sub-center in the township. The sociologist, on the other hand, was a new sight in the community and introduced herself as a researcher from Yonsei University in Seoul who was documenting traditional customs and beliefs in childbearing. Such a medically unbiased interviewer in the study team effectively balanced the data obtained by the public health nurses, who do have a medical bias and could obtain only medically biased information from the respondents.

This two-pronged approach assured worthwhile complementation of ethnographic and medical data. The public health nurses also interviewed all the medical personnel with which each family had medical contacts. The sociologist interviewed clients, their families, and all other relevant people in the community. In this way she could obtain an independent picture of the behavior of the clients toward the health services, including the public health nurses. She invested considerable effort into establishing a friendly relationship with the client and her family. This was achieved in almost all cases and helped to insure a good yield of data.

Wherever possible the interviews were recorded on tape and immediately transcribed. Further, the interviewers made field notes about aspects of the study that could not be taped. These were often made after participation in activities in the client’s home. The medical staff, in addition, kept the maternity care records. Nearly 200 interviews were obtained in this manner.

Investigators and research team met at least once a week. The transcribed interviews and observations were presented and discussed and further investigation and approaches were outlined for each case. The field staff worked with great interest and helped reflect the results on the background of their own understanding of the local culture. This was an invaluable aid for analysis and interpretation.

The materials from this study are abundant and require further detailed analysis and evaluation. However, an overview of the most out- [page 31] standing findings can be classified into two areas of observation: 1. Traditional concepts and behavior of clients and families concerning pregnancy, childbirth, postpartum period, and the newborn; 2. Interactions of clients and families with modern health services concerning pregnancy, childbirth, postpartum period, and the newborn.

This classification needs some comment. Any informant who showed traditional behavior could at another time express very modern attitudes. On the other hand, anyone with generally modern attitudes could on occasion harbor deep-rooted shamanist beliefs and traditional behavior. If the attitude of each informant were rated on a scale with the two end- points “modern” and “traditional,” it would fall at different times—and occasionally at the same time—on different locations on the scale. Also, it was not always clear whether an informant actually held a traditional belief or just provided information about it.

Because of the superimposed modernization effects, the findings were at times confusing. After decades of modern medical influences there are hardly any pure, uncontaminated traditional concepts in existence. Also the modern health services in the rural environment are influenced in their performance by their clients, behavior. Nevertheless, if this distinction can be made to some reasonable degree, the traditional concepts found in the first category can serve eventually as an independent variable to interpret the findings under the second category concerning interaction with modern health service.

TRADITIONAL CONCEPTS AND BEHAVIOR

People in general were not easily persuaded to talk about traditional beliefs and practices for fear of being ridiculed. But in areas where traditional attitudes are strong it was not difficult to obtain information. Also, when people were not aware of holding a traditional belief, information was easily obtained. They would,however,hold back information on concepts in which they still tended to believe even though the modernization process had proven them to be wrong. On occasion there was difficulty in soliciting information on a subject in which the informat was not particularly interested.

*Traditional physiology of pregnancy and childbirth.* There was surprisingly little interest by anyone, including the pregnant women them-[page 32]selves, in how the baby grows in the womb. Lack of information in this area was obvious. Old people, who knew about traditional concepts, were not easily persuaded to talk for fear of being mocked by the young ones. And while the young ones expressed outright disbelief in the old stories, they could not present modern alternatives either. The traditional understanding of the physiology of pregnancy and childbirth in Kanghwa was eventually documented as follows.

The baby inherits bones from the father and flesh from the mother. It is sitting in the baby-palace in an upright position on the cushion of the placenta. The placenta collects all the bad blood during the pregnancy that otherwise would have been evacuated by menstruation and it prevents the baby from being contaminated with it. The placenta actually is a big clot of bad blood, but the baby receives only good clean blood. The baby holds onto the milk rope that reaches into its mouth and sucks on it until it grows mature enough for birth. If the rope breaks before delivery, the baby dies in the womb.

When the baby is ready to be born, it begins to turn slowly in the mother’s womb until its head points downward. This causes the mother pain and is comparable to the first stage of labor. When the waters break they flow out, indicating to the baby the direction to move. The baby moves slowly in that direction and the mother helps it by using her strength. This is comparable to the second stage of labor.

Then comes the moment when the baby’s head can be seen—the “crowning” as it is called in English. The Korean folk expression for this is munul chabnunda, to grab the door. But if it is cold or otherwise frightening outside, the baby may move up again and cling there. This is a most dangerous development. But usually the baby is born after all. No baby ever remained inside. Finally the placenta comes out and with it all not be discharged by menstruation. It is best that this blood comes out completely. During childbirth all the mother’s bones become loose and the joints open up so that the baby can come out. One can help this process by opening the doors of cabinets and closets, and even by removing rings that might inhibit the loosening of finger joints.

After birth great care must be taken to restore the mother’s normal condition by seeing that she has rest, warmth, no drafts, and proper food. This process takes three months and during that time there should be no sexual intercourse. If one adheres strictly to such a practice recovery will be complete and even old illnesses that predated pregnancy will disappear. The milk flow starts around the third day. It takes that long for the milk- [page 33] rope to re-establish its position and get attached to the nipples so that the baby can suck successfully.

*Samsin.* From the literature it is apparent that the Samsin spirit governs fertility in traditional Korea. Legends concerning this spirit probably date back to prehistoric times and numerous rituals and rites are performed to this day to insure fertility for humans, animals, and crops and to safeguard the lives of children.12 Most frequently, the spirit is referred to as Samsin Grandmother, but on occasion informants of this study referred to Samsin Grandfather as well. In one instance the Samsin was considered to be a trinity of three monks that governed the room of the woman in labor, the kitchen, and the main entrance, and assigned to the child to be born a fortune in keeping with the performance of the family and the cleanliness of the house at the time of birth.

No reference was made to the Samsin during pregnancy. Any ques- tion that related pregnancy to the Samsin was not comprehended by the clients. This was surprising since it is apparent from the literature that the Samsin is considered to guard pregnancy as well. For the studied group, however, the Samsin was inconsequential during pregnancy. This was true even for the one client who had a previous stillbirth and was well indoctrinated by relatives and neighbors regarding the spirit’s role.

The inconsequential role of the Samsin during pregnancy was more than balanced by beliefs and practices at the time of birth and after. Frequently the attending grandmothers would gently strike the abdomen or lower back of the laboring woman and pray to the Samsin: “Please let our child be born fast and easy.” In one case, since the placenta was not expelled after thirty minutes, a sacrificial table was prepared for the spirit. In other cases ritual offerings and worship were dedicated to the Samsin on the. third day after birth. Many more such stories were documented from the neighborhood or from past experiences of informants. The Samsin coaxes the reluctant child out into this world with a hearty slap on the behind, and the dark birthmark that children of the Mongolian race carry for a while on their lower back is said to be, therefore, the mark of the Samsin.

The belief that the Samsin spirit is responsible and takes over, and that no interference whatsoever is justified, was powerfully expressed on several occasions by mothers-in-law. One client, when she gladly reported that finally she had sufficient breast milk for her child, was hushed into silence because such talk is offensive to the Samsin. The belief was [page 34] frequently expressed that because the spirit takes all in its hands, one does not need doctors or hospitals.

In many houses the child is considered an offspring of the Samsin, at least to the 100th day if not to the tenth year, so the responsibility for raising the child is not entirely with the parents, and failure cannot be blamed on them alone. Sacrifices to the Samsin are continued once the child is born, and especially if the infant becomes sick. One of the clients had lost a previous child within seven days of birth. Although she and her husband wanted to take him to the hospital, they obeyed the mother-in-law who considered that inappropriate for an offspring of the Samsin and prepared a sacrificial offering table instead.

Among the births in this study the death of one newborn occurred on the seventh day. Here, too, when the parents wanted to leave the house with the sick child to get care, an old villager advised them not to do so for then it would surely die, and so they stayed at home.

The Samsin, in summary, is a still powerful spirit that watches over everything connected with birth and the newborn. It prompts people to keep the house clean at the time of birth and to handle mother and baby in a hygienic and respectful manner. But its apparently jealous character still prevents people from seeking help for a laboring mother or for a sick infant.

*Traditional dangers for the newborn*. From bitter experience rural people are very conscious of the fragile life of a newborn baby. The old beliefs and customs designed to protect the child and to guard the family from grief now frequently militate against successful newborn care by modern health services. The beliefs made sense in the traditional context, and they still remain powerful determiners of behavior.

To traditional people, the greatest danger for the baby is pujong, a condition that can be transmitted by any non-family member that enters the house, or even by family members who have been in contact with persons that have a pujong condition. Most dangerous are women during the mourning period. Pujong means unclean, and a concept of clean-unclean is here at work. The newborn child is in a way the essence of purity while mourning women in this context carry the stigma of impurity. A prostitute would be referred to as a woman with pujong, too. Such people transmit the condition to the baby and this endangers its life. This belief is so strong that the natural hospitality of the rural home to stranger and friend alike stops completely for at least three days after the birth of a child. The custom is frequently kept after the birth of a calf or piglets.

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The greatest danger from pujong is that there will not be sufficient milk for the child. The rationale behind this belief is indeed convincing. To isolate the family during the first days after birth gives it a chance to adapt to the new situation without outside interference and fosters a relaxed atmosphere that is supportive of the mother-child relationship and the “let-down” reflex that initiates milk flow. For the Korean baby, until recently, lack of breast milk was a death sentence. The traditional belief was protective and useful indeed, and it may have saved the life of many a child.

Pujong is believed to hold other dangers for the baby as well. Most important is the condition of kyonggi or fright disease. Yoon has reported about this traditional illness concept from another area of Korea13 and Topley described its equivalent in Hong Kong.14 Kyonggi is not a condition that modern medicine understands, but rural people know its etiology, signs, and symptoms as well as the prognosis, and since the disease is dangerous they are frustrated by modern medicine’s “insincerity” about it. There is a prodromal stage to kyonggi called nollaeda, to be startled. The Moro reflex, the newborn baby’s sudden extension of arms and legs when handled abruptly, is also referred to as nollaeda. One has to bathe the child very carefully, be very quiet in the house, and discard water without a gushing sound to avoid causing this dangerous condition.

Many households, even before birth, secure a supply of Kiunghwan, a herbal medicine, to calm the baby if it cries excessively or shows other signs of nollaeda, and prevent the condition from deteriorating further. If nollaeda develops into kyonggi, the situation is desperate. Two clients in this study had had experience with kyonggi and both had lost the child on the seventh day after birth. The signs were similar. The child started crying on the fifth day, cried incessantly, and finally died on the seventh day. Modern services were not consulted since it was kyonggi and the child was an offspring of the Samsin.

From descriptions of the symptoms, it is possible that kyonggi is similar to neonatal tetanus. The stereotyped pattern of crying, and the characteristic body posture and facial expression must have been recognized as a deadly condition that cannot be remedied and that is best left in the hands of the Samsin. Kyonggi can occur in older children as well. There is a quiet form where the child loses consciousness, and another form that goes along with crying. In any case this is the most dangerous condition a child can acquire and everything must be done to prevent it. Yet modern medicine is not trusted.

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*Sons and daughters and sex prediction.* Boy preference in Korea is often mentioned in family planning literature. With few exceptions all the families in this study hoped for a son. On occasion, if there were already sons, a daughter was acceptable. One son, however, was often felt not to be enough. As one grandfather in a family with only one son in three generations put it: “It is very lonely, and that is the greatest danger.” This view was expressed frequently by the clients, too. The life of an only son is considered sad and very lonely although he may have sisters aplenty. There is little appreciation for girls. In one family the mother-in-law definitely wanted the client to have a girl because her first daughter-in-law “could bear only sons” and she now desired a granddaughter. Nevertheless, she said that the client would have to bear sons eventually.

The study communicated the impression that there is still great pressure on women to bear sons and they feel a responsibility not to disappoint the family. Little can equal the misery and disgrace of a woman who has disappointed her family with a fourth daughter. On the other hand, a woman’s feeling of accomplishment after having borne a son and the elevation of her status in family and community is still equalled by nothing else in a rural woman’s life. Both could be observed among the studied clients.

None of the clients expressed the belief that sex prediction is possible, and none had gone to fortune-tellers during pregnancy. But many family members did, especially mothers-in-law. In one case where there were only three daughters, the mother-in-law went with the client before pregnancy to a temple where they made a generous offering of rice and money. During her pregnancy the offering was repeated by the father-in- law. The woman wanted an abortion but was persuaded to carry on. She finally bore a son and there was great approval of the method.

It is a favored sport among grandmothers and older village women to prognosticate the sex of a child. The shape of the abdomen is often considered an infallible sign of the sex of the unborn. If it protrudes the child is female. If it overhangs at the flanks the child is surely a male. The pregnant woman’s navel is equally significant. If it bulges out the child is female. If it is drawn in the child is male. The village women make their predictions with great confidence and with references to the many births about which they were right.

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*Attitudes in Pregnancy.* This study was begun with the stereotyped assumption, derived from Western clientele, that a pregnant woman is “of good hope,” looking forward to a “happy event,” and that she is entitled to much attention by her husband and family and the general public during this period.

This is not so in Korea. The lack of interest in the physiology of pregnancy and the inconsequential role of the Samsin during pregnancy make this apparent, and it becomes abundantly clear when attitudes during pregnancy are observed. The existence of pregnancy is practically ignored. A woman is expected to work in the field as always, up to the last moment. There is a saying that if a woman does not work hard during pregnancy she will have a big baby and a hard time at birth. Her eyes may be so swollen that she cannot see, yet she is not entitled to any special consideration. The only exception appears to be when she is expecting for the first time and the family is delighted to see her fertility proven. Then the husband may bring her special things to eat from the market to express his appreciation. But in subsequent pregnancies such extravagances fade out of fashion.

A woman may crave something special to eat but the husband may decide they cannot afford it. Fruit, bread, and cider were mentioned by some clients as things they craved and could not obtain. A woman’s diet generally is bland—rice, soup, and kimchi three times a day. Pregnant or not, she serves the better things to husband and children. One woman said: “Oh, yes, I would like to eat those things too, and if I just knew I carried a son, I would. But since I don’t, I’d rather give the meat and eggs to my first son.”

Pregnancy is not only de-emphasized, it is experienced as an embarrassing condition.15 All respondents interviewed on this subject agreed that this was so. Because of this embarrassment some women stayed entirely at home during late pregnancy, some would not go to certain places where the feeling of embarrassment would become overwhelming, and others tried to avoid being seen by men. The unanimous reason given for such behavior was that the abdomen protruded so disgustingly and that this was disfiguring. This reason in itself did not make much sense, considering the deep shame expressed in the women’s comments and behavior. Therefore they were asked if the embarrassment was not rather due to the fact that the protruding abdomen is a visible sign of sexual activity, which in traditional Korean culture has a dirty and shameful connotation detrimental to the idealized image of woman. Clients as well as research assistants [page 38] emphatically denied the possibility of such a connotation at first. But with further probing it became evident that practically everyone, women and men alike, had, in their puberty, indulged in dirty talk at the sight of a pregnant woman, a custom that apparently is widespread and continues among men into adulthood—until they have a wife themselves and yearn for a son. It is apparent that the cultural environment is powerful enough to embarrass the pregnant woman, to elicit a sense of shame, and to determine her shy behavior although she is not consciously aware of the reasons. In this context the style of the traditional dress of Korean women is noteworthy. It makes it impossible to tell if a woman is pregnant or not.

When the peripheral environment assumes a hostile character and especially when she is pregnant for the first time, a woman finds comfort in the concern of other womenfolk who have had children themselves. Her mother-in-law and her own mother are of special importance. These envelop her with a sense of understanding in which she finds emotional refuge. Most of the observed clients lived in an extended family which included the mother-in-law. But even where the family was nuclear, the mother-in-law was never distant and usually asserted her influence. In a first pregnancy, the relation between mother-in-law and expecting woman deepens. The pregnancy brings these women together and makes the young mother appreciate a flood of advice on how to proceed through pregnancy.

The advice that has most bearing on behavior in pregnancy concerns food. There are numerous foods to be avoided. Every client had heard of at least some of them and many adhered to one or the other taboo. Chicken, duck, eggs, and octopus are among the foods to be avoided. Many other foods are enumerated as dangerous for various reasons. Most frequently they are believed to cause fetal malformation or danger of some spiritual kind. Two women in this study were subject to rigid control of their intake by the mother-in-law so that they would not take dangerous foods. Two other women felt very guilty because of their inability to control their appetites. One had eaten rice cake while preparing it for a birthday party in a relative’s house. Another had secretly eaten eggs although she knew she would not have sufficient milk later. On the other hand there was practically no awareness of the need for good nutrition in pregnancy.

The fact that the young woman is indeed fertile and fulfills her duty in this respect makes her more important to her new family and she does her best to live up to their expectations and follow their advice. This emotional interaction between client and family is an important aspect of [page 39] Korean rural family life. Despite the general de-emphasis on pregnancy, the interaction is enormously intense and the traditional character of its content makes it difficult for health services modelled after Western behavior patterns to reach these clients with an equally intense message.

In summary, pregnancy, as far as the health and activity of the woman are concerned, is considered to be a normal state. Although she may be seriously ill with toxemia, have a painful pregnancy neuritis, or be otherwise exhausted, she is not entitled to special attention and she does not expect nor want it. There is no concept of dangers to the health of mother and child, dangers that arise during pregnancy and which modern prenatal care can prevent. There is great confidence and an unassuming awareness by the mother-to-be that she can fulfill her role without any help other than that provided by traditional family resources.

*Delivery.* An interesting observation was that no woman or family prepared anything for delivery except baby clothing. In three cases not even this was done. Two of these women had had a previous stillbirth, were afraid of reoccurrence, and did not want to have to face the sight of useless baby clothing again. The third one said: “This is not my first baby, so what should I prepare?” None of the clients or their family members perceived the need to prepare the household in any other way, although some mentioned the convenience of having available the government provided kit for cutting the cord. Childbirth itself was taken rather matter of factly. Although the entire family seemed to be involved, little of the excitement radiated to the outside world.

The approximate day of confinement was known to all the women in the study, but many of them were surprised by the birth itself. Several women, although they had given birth before, did not recognize the signs of early labor. One woman, for instance, was sent by her husband from rice planting in the field to see a doctor because she complained of an aching back. When she heard from the obstetrician that she was in labor she went straight home instead of remaining in the hospital. Since so many people worked in her rice field it was inconceivable for her to indulge in the luxury of staying in the hospital to give birh. Another woman blamed her strong backache on the fact that she slept on the cold floor, and still another let her husband go to the field in early morning without bothering to mention she was having contractions. She found herself then in strong labor later in the day with no one around to help.

On occasion one had the impression that birth was an unwelcome interruption of activities considered more important, and that the woman [page 40] tried to hide the fact that she was in labor from the people around her and kept busy and active as long as she could. This could be understood as an attempt on the woman’s part to postpone as long as humanly possible that embarrassing stage of birth when she is utterly dependent upon other people. A mother-in-law, for instance, reported that the young woman withdrew after breakfast because she felt a little sick, and when she looked in on her a little later she was already in the crowning stage. Another young woman was surprised by contractions while she worked in the field in the morning, but she continued working until late afternoon and then could barely make it home.

There are many reports in the public health literature of Korea on women who deliver alone. In a national survey conducted in 1978 the frequency of deliveries with no one present at the woman’s side was 3%.16 In this study one woman delivered alone and even cut the cord herself. This accomplishment gave her great pride and the admiration of others. The practice of delivering alone seems to have been more frequent in earlier days. The motive seems to have been to avoid depending on others, even one’s husband or mother-in-law. Many older women reported that they had delivered alone, and they all took great pride in having done so.

Nowadays the presence of one female attendant is desired by most women, usually the mother-in-law or the woman’s own mother. In a few cases another female, a relative or neighbor, attended. In one case the husband attended. Occasionally there were as many as three women around to support the parturient, hold her, let her grab them for consolation, and for final attendance during the birth. The client feels dependent upon such a person, and the attendant is honored and challenged by the request. The lay attendant may be uncertain about whether she can attend properly. But in at least one case she was severely reprimanded by the woman in labor when she wanted to call in the midwife.

In about half of the cases in the Kanghwa Project the midwife was called, but this was done rather late in the course of childbirth. The young woman in labor may plead for the midwife to come but is often denied such comfort almost to the very end. The mother-in-law does not want the midwife to be bothered too early, and this is indeed a very serious consideration on the client’s part, too, as long as she has her senses together. To call the midwife is to call an outsider and impose upon her. In many homes no medical attendant is desired by the family for this reason. In addition, the suggestion of the presence of an outsider, medically trained or not, seems to be a threat of invasion of privacy. The two midwives in [page 41] the target area seem to have established their reputations by their strong mental disposition to guide client and household smoothly through the disturbing and somewhat chaotic period of childbirth rather than by their medical skills. In the pretest to this study two mothers-in-law responded to the question why the midwife was called in for birth with the answer that “the midwife is strong.” How is she strong? “Her mind is strong.” Not all mothers-in-law are ready to let such a rival step in and take over.

Delivery in the rural home proceeds in the same unassuming way as pregnancy does. The woman in labor is not expected to make much noise and if she does this is disapproved of and she later feels ashamed. The mother-in-law, a relative, a friend, or in rare cases a hired woman, takes care of the household while the woman is in labor. The kitchen has to be taken care of, water has to be boiled, the resulting mess has to be cleaned up, and then the traditional first meal has to be prepared for the new mother.

On Kanghwa Island, there are no rules for the actual delivery. The woman does whatever is most comfortable for herself. Women who were not attended by a midwife most frequently reported that they either knelt or squatted during the second stage of labor and during actual birth. They then leaned forward on their hands or over folded quilts, or held on to furniture or shelves. Some mentioned that they padded the floor with some clothing or a blanket so that the baby would “fall down softly” and not hurt itself.

These reports are remarkable because for modern women the customary position at birth is supine, strapped to the delivery table in lithotomy position. In discussing this subject many Kanghwa women considered such a position impossible for themselves. It would hurt more and they could not imagine how to endure it. Indeed, the modern position at birth is in comparison an inconvenience and physical discomfort to the laboring woman. Modern obstetrics has lost sight of the natural position for at least 100 years.

After the birth there is no celebration. Small yellow earth molds are put up in front of the main door so that no one will enter, and the family isolates itself from the outside world. Gladness, appreciation, or joy was never expressed about the safe birth and the newborn baby, as is customary in the West. Asked what they felt when they saw the newborn, the mother and attendant or husband most frequently expressed weariness and the burden of having to raise another child. On occasion a father was overcome by a sense of overwhelming wonder about new life when he saw [page 42] his son “fall on the ground and look around with wide-open eyes, every-where.”

*Postpartum concerns*. In all families the placenta was handled with a kind of care and attention that is unfamiliar to modern health workers. It was either burned, buried, or disposed of in the sea. But the procedures of discarding were always elaborate. The courtyard was especially cleaned for the purpose of burning it. In every case where it was burned, rice husks were used. Since this was the only source of fuel, the burning took twenty-four hours and three rice sacks of husks. The ashes, in most cases, were discarded on the road in a long black line, and in one case on a three road junction. If it was discarded in the sea, it was tied to a stone and submerged. In some houses the umbilical cord, or the whole placenta, was dried for medicine. After a local hospital delivery, in two cases, the placenta was handed to the family for appropriate disposal.

The main reason given for such elaborate handling was that beasts or even humans would eat the placenta otherwise. Of course, like the embar-rassment caused by pregnancy which was explained only by the protruding abdomen, this explanation is not satisfying either. It is worthwhile mentioning, therefore, that traditionally the placenta in Korea received much reverence. This is still apparent in the elaborate placenta graves of some kings and in the old porcelain jars which were used to contain buried placentas. An anthropologist with whom the findings were discussed commented that the burning of the placenta with rice husks may well have metaphoric implications since rice husks enshrine the grain until it is ripe, and rice grains play an important role in fertility rituals in Korea. One young father carefully scanned the husks so that no rice grains would be burned with the placenta. He could not give a reason for his act, but in such a context it seemed to make sense.

Another custom was observed as faithfully as the disposal of the placenta. Little molds of yellow earth were set up in front of practically every house after birth, a practice called hwangt’o p’iuda. It indicates the birth of a child and its sex—usually three molds for a girl and five for a boy.

The more frequent custom in other rural areas of Korea is to hang a straw rope across the main entrance of the house where a birth has taken place. This rope suspends pine branches and red peppers if the child is a boy, and pine branches and charcoal for a girl. The custom is understood by the community as a request not to enter the house, and it is connected with the powerful belief that an outsider will bring serious danger to the child and prevent the mother’s milk from flowing.

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Although some families, especially Christians, do not adhere to such a belief, they still use yellow earth molds to keep strangers out. In such a case, as long as the health services are permitted access for care of mother and child, this practice cannot be faulted. The story, however, is different where the traditional beliefs dominate. Even the midwife is here regarded as a carrier of gloom. Mourners are a special threat and since they cannot be differentiated from ordinary people, no one is allowed in. The mid-wives in the target area respect the request not to enter the house in order not to upset their otherwise good relations with the clients, and to keep friendly relations with the family for the benefit of later postpartum consultations or emergency calls- Health workers, generally, are little aware of such customs and beliefs and may unknowingly provoke resentment. In Kanghwa, a young MCH worker was wearing a little white ribbon in her hair indicating the death of a family member. She found out the hard way that she was not considered an appropriate person to care for mothers and newborn in her target community.

After birth the mother is expected to be kept warm, to be protected from “the wind,” param, and to rest for a prolonged time after birth. The postpartum period is especially important for the maintenance and restoration of health. The elaborate considerations and practices during this period make the lack of concern for the mother during pregnancy all the more apparent. Two women in this series had become pregnant simply to remedy their poor physical condition. By going through a complete procreative cycle and then strictly adhering to postpartum prescriptions, they expected to restore their health. Many other women and their families in the series were extremely concerned with their postpartum health. The following beliefs are related to this: during childbirth all the bones and joints become loose, and rest and warmth are required to restore them to their normal condition. If one “meets the wind” at this time, one can expect to become seriously ill; if not immediately so, then in old age. Strokes and rheumatism are the dreaded later results. One of the women who gave birth in a hospital was seriously upset because the doctor and nurse were concerned only with the baby “while the wind was blowing right on my lower parts.”

The nursery in the rural home is usually hot and sticky because no window or door is opened for several days to prevent exposure to the wind. The mother is covered with thick blankets even in the middle of summer. She is often inconvenienced by this and sweats profusely, but she either keeps with it because she believes it to be truly for her own good, or she upsets her mother-in-law and husband by prematurely “meeting the [page 44] wind” and exposing herself to danger by getting up too soon. The appropriate period for complete rest after delivery was considered to be seven days, one month, or even three months by different respondents. In fact, however, few women stayed down longer than seven days. Those who had no servant and had already borne one or more children were up and around before the seventh day to do their chores. One woman was in the field again on the third day after confinement.

All the women ate seaweed soup and rice after delivery, to the exclusion of practically anything else, for at least three to seven days and sometimes longer even though on occasion they were not able to stand the sight of it. This custom of eating seaweed soup after birth in Korea is so old and ubiquitous among all classes and walks of society that nobody appears to be able to give a satisfactory reason for it any more. It is sometimes said that to do otherwise would cause the teeth to fall out, and since seaweed is soft it is the only food one can chew. Mothers-in-law consider seaweed important for the generation of new blood and for cleaning out the old blood. It is also a good food for the milk flow.

One client stopped eating seaweed soup when she did not want to feed her child at the breast, and it had to be bottle fed. A Korean nutritionist assigned no particular nutritional value to the seaweed for mother or child but offered the explanation that it was bulky and might be considered as filling the “emptiness” left in the abdomen after birth. It is also noteworthy that seaweed or seaweed soup is always an ingredient on the Samsin offering table. Further probing of this issue may well shed more light on the traditional meaning of birth in relation to family and the Samsin in Korea.

In summary, pregnancy and birth, in the traditional context, are de- emphasized. Although pregnancy and the pregnant woman are of no particular concern, the fact that a woman is pregnant, in other words fertile, is of immense importance and interest to the traditional family, and the course of pregnancy and actions taken are therefore determined by the family. The young woman may contribute very little. Her duty is to give birth to the child, and that is all. The family takes over care, responsibility, and decision making. And the family with its traditional behavior here often stands in opposition to what modern health services seek to achieve.

[page 45] INTERACTIONS BETWEEN CLIENTS AND MODERN HEALTH SERVICES

The modern health services available to the clients of this study consist of the drugstores in the vicinity, the local health subcenter, the local obstetrical clinics in Kanghwa City, and the hospitals on the adjacent mainland. In the target area two government-employed midwives are available, and maternity care in the periphery is organized by the project so that midwives and village health workers provide repeated contacts for all clients and their families for education, risk screening, and care.

These services are not yet mature and lack the technical supervision of obstetricians and a structured relation to a referral institution. But they reach every client and are, in terms of frequency and quality of contact, somewhat better than can be expected in other rural areas. This made interaction observation between clients and health services more fruitful. It permitted differentiation among positive and negative aspects of interactions, and allowed definition of some underlying problems that inhibit more effective maternity care.

*Barriers of understanding between clients and services.* Before all other problems, there are barriers of understanding and communication between modern health services and clients. These concern the meaning of childbearing, the benefits that can be obtained from modern health services, and a confrontation of authority about decision-making between family and health care providers.

First of all, there are conceptual misunderstandings about the meaning of childbearing. For the clients and their families it is basically a family affair, a normal and healthy process of family life that is of no concern to outsiders. For modern medicine it is a domain of health care. This conflict is aggravated by the approach that modern health services take to these clients. Pregnant women and parturients are indiscriminately labeled “patients” and are expected to assume a sick role—in other words, a dependency attitude toward health services—before they can obtain the whole extent of modern benefits. We have seen that this is in contradiction to the women’s desires to remain independent; the important role of the family in decision-making is ignored altogether. Here, modern health services and traditional clients are at odds with each other.

As an example, take the case of a woman who had five previous deliveries which were all very hard and three of which ended in stillbirths or neonatal death. The reason was a contracted pelvis. She did not go for prenatal care even once since she was “perfectly healthy” in pregnancy[page 46] and going was therefore not necessary. She added: “If one goes to the hospital, they could not correct the bones, could they? Even if one would break them, one could not correct them.”

Modern medical services have, of course, already reached into the traditional realm of childbearing. They are a factor for change. In general terms, there is great appreciation among the clients of their availability in emergencies. This is a significant improvement as compared to the old days. The above-mentioned client was appreciative of doctors and mid- wives in general since they had helped her in her home deliveries.

But there is little appreciation for the health services’ capacity to prevent such emergencies. The above-mentioned client delivered this time in a hospital. Since she had never been there before and arrived in an advanced stage of labor, neither she nor the doctor had had a chance to consider a caesarian section on the basis of her previous obstetrical history. The child was born alive but was limp, did not cry, later could not suck, had convulsions, and developed a torticollis.

As a further example another case may serve. In her previous pregnancy this client noticed that the fetal movements stopped during the seventh month. She then went to a private clinic four times and was delivered of a stillborn baby. In the recent pregnancy, since she was “healthy,” she did not go for prenatal care. She came down at term with a footling, partial abrupture of the placenta, and considerable blood loss. During the protracted birth and in the face of much bleeding, the mother- in-law lost confidence in her ability to attend and called the mid wife. This saved the baby from probable death and the mother had merely to recover from her anemia.

Although the family considers childbearing normal, it is becoming increasingly customary among mothers in the project area to go to the midwife for prenatal care. This does not mean that the interactions at this service level correspond in their content with prenatal care in a modernized environment. The client goes only if she can think of a problem that bothers her. She almost never goes merely for a routine examination. She often seems to have the feeling that she is asking a favor of the health worker rather than demanding a service from a health agency.

Here it should be re-emphasized that the midwife as delivery attendant is usually called not because of her obstetrical skills but because of her ability to guide the household through the unsettling period of childbirth. In only 50% of the births in the target area is such service desired. Delivery attendance by the midwife, too, is requested with the feeling of asking a favor rather than demanding a medical service. Decisions, such [page 47] as to give or not to give an injection, to call or not to call a doctor, or to transfer to a hospital, are without question considered a family prerogative. The midwife can suggest, but she cannot decide. If she does, she clearly oversteps her limits and the consequences bear on her reputation.

Encounters between families and health services over a pregnancy or childbirth problem are fraught with emotional strain for both. As a result, either one may react irrationally and thus contribute to a negative outcome. Such emotional behavior is caused by the confrontation between the authority of the family and the authority of the health service. Both feel responsible for the sole right to make decisions. Both feel threatened by the other’s demands. Either one may take over, without consideration of the other’s authority; but the family is more likely to do so than the representative of the health service, who depends on the income and reputation which the clients provide.

This situation is exemplified by an event in this study. The client, whose previous three births had been attended by the midwife, went into labor and her husband called the midwife. When she arrived, the child had already been born. The mother-in-law had taken over and forbade the midwife to enter. The midwife left, but she was called back a little later because the placenta had not come out and the client was hemorrhaging. While the midwife tried to master the situation with placenta delivery, infusion, and shock preventive measures, the mother-in-law in self-defense talked about how good it was for the bad blood to run out- The client had a hemoglobin count of 6.5gm% the next day.

*Decision-making in delivery attendance.* The study showed that the client herself usually has little influence on who will attend the delivery, where it will take place, and whether there will be any medical attendant. Where she presented her own views on the subject, they became merely one further point of view in the family discussions. The home visits of health workers, however, seem to have considerable influence. Also, in general, the woman is comparatively free to go to the health subcenter for prenatal care, and she usually desires to do so. The women who took advantage of the midwife’s counsel brought home information about their condition and about birth that was taken up by the family council and seemed to sway the opinion of its members. In at least one case it resulted in a definite change of opinion, from medically unattended to medically attended birth.

But there are still a number of women whom the family does not allow to go for prenatal care. The mother-in-law of one client with a pre-[page 48] vious stillbirth said that since the client had gone there the last time and the result had been bad, this time she had forbidden the client to go. Frequently it was argued, even by clients themselves, that prenatal care consultations are useless and a waste of time and energy.

The final decision on delivery attendance is most often made by the mother-in-law, and more often than not it is left open until actual delivery begins. The most frequent answer given by clients and other family members as to who would attend the delivery was that it would depend upon the conditions encountered at the time. If the birth appeared to be difficult one would, of course, call a qualified attendant or go to a hospital; otherwise birth would have to occur at home. If the woman had already experienced an uncomplicated, medically unattended birth at home, she confidently faced the ordeal with little desire for having someone outside the family attend. If the woman was inexperienced and expecting for the first time, she might occasionally appear to be insecure, but she still trusted the family judgement and arrangements for her more than the warnings and advice from the health care institutions. For her mental stability, this is the best thing she can do under the circumstances. Sometimes the pain was dreaded, but a woman never appeared to have a sense of danger for herself, though dangers for the child were perceived on occasion. This was especially true for the five women who had had stillbirths. They appeared to be comparatively confident, and even among them there was little awareness that such sad experiences can generally be prevented by properly applied modern medical service.

*Breast feeding and formula feeding.* Many women knew that the milk starts flowing from the third or fourth day post partum. But others did not know that. They became uneasy if the baby did not receive a full supply of mother’s milk right after birth, and they started to bottle feed immediately. It would appear that such anxiety, the availability of commercial formula, and the great “health improving value” assigned to formula by the media have already led to a reduction of breast feeding in rural Korea. At least two babies in this series were fully on the bottle soon after birth and many more mothers supplemented the breast with formula from the beginning. One of the bottle fed babies was found to be severely malnourished six weeks after birth.

Formula feeding was observed in most cases neither to meet hygienic requirements nor nutritional standards. Almost every mother who used the bottle put in a little less milk powder than the instructions required because it seemed “too much” and “it is so expensive.” There is usually [page 49] only one bottle and one nipple available in the house. These are boiled once in the morning and then must last through at least twenty-four hours and six feedings. At summer temperatures above 30 °c with no refrigeration available, the hazard to the newborn from contaminated bottles is obvious.

*Doctors and hospitals.* If it is found during prenatal care that the baby is in a breech position or that the pelvis is too narrow for uncomplicated delivery the client is usually advised to deliver in a hospital. This information may strike unbelieving ears. It contradicts the assumption, especially among the older members of the family, that childbearing is normal and goes the better the less it is interfered with. The hospital is simply not considered a place in which to give birth. This is so evident to everyone that the respondents find it difficult to think of reasons for not wanting to go to a hospital. Only people who know or can imagine what hospital delivery implies can give such reasons. Among the reasons are: “It is a great inconvenience to go there and then come back at the time of childbirth”; “One does not know the people in the hospital”; “There are male doctors in the hospital, and childbirth is so embarrassing even with only women around.” Other reasons are that people in the hospital are indifferent or even unkind, that food and care are bad, and that postpartum care of the mother, which in the traditional context is so important for her recovery, is incomparably better at home. One major factor seems to be that in some hospitals there is no warm ondol floor, which is deemed essential for postpartum recovery.

When a complication is diagnosed which makes hospital delivery desirable, a decision has to be made by the family whether the client should go to a hospital or not. The immediate hope is that there is a remedy, manipulation, or medicine that may change the condition, or that the diagnosis was wrong. In such case there is much bargaining with the local health workers which too often leads the midwives into manipulating a breech baby into vertex pesentation and fixing it by tight bandaging. One respondent, the sister-in-law of a client in this study, had had a stillbirth after such a manipulation and bandaging six months earlier. The bandage was so tight that she could neither sit, stand, nor lie down. She did not sleep for four days and finally took the bandage off. She delivered a white-stillborn baby the day after.

If there is clearly no way out of a complicated problem, and the logical step would be to decide upon hospital delivery, there is the temptation to ignore the threat and to trust the old ways. There seem to be sufficient [page 50] success stories around that justify doing so. And there is an abundance of information about how things go wrong if one trusts the health services indiscriminately. The grandmother in one of the study families shared her terror with whoever would listen of how her niece was taken to a hospital, treated with an icebag instead of heat, and died as a consequence. Another client had experienced with her own body how in the hospital after birth they had “let that wind blow right on the lower parts.” The staff was unkind and inconsiderate enough not to listen to her complaints so that she later developed severe edema.

If the family decides to delegate authority for care in childbirth to a hospital, it often does so with misgivings and suspiction, ready to revise the decision any time, and possibly to look for a better alternative. The family appraises an alternative helper on moral qualities as much or more than on medical qualifications. It is of great importance how well this helper measures up to traditional standards, whether he is willing to let family members share medical decisions, and how much he respects the family’s authority. This is in contradiction to patient care in Western societies, and it is in contradiction to modern health personnel training, which is based on the assumption that decision-making must be done on the basis of the client’s condition alone. The student does not learn to take into consideration the family’s viewpoints, which are concerned primarily with the wholeness of the body of the client who needs a caesarean section, with the inability to pay for such services, and other more mystifying reasons. Doctors often feel severely restricted by family interference, but they can expect overwhelming gratitude or bitter resentment and disdain to be based on their ability to cope with a traditional family’s expectations, rather than on their medically correct treatment of the client’s condition.

Some of the clients in this study who decided on hospital delivery apparently did so with the intent of giving themselves a treat rather than getting qualified medical attention during the delivery. The expectation seemed to be that one can demand service for one’s money, as one can in a hotel, in addition to the medical care.

One client demanded a caesarean section when she could no longer control her expression of pain in the unfamiliar environment. She felt bitterly humiliated that she was not granted this request. She resented the hospital, had difficulty adjusting to her child, and was emotionally unable to recover from the experience for months. This may have been aggravated by a basically unstable personality, but it exemplifies the kind of expectation prevailing among clients about the hospital.

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Another client was quite surprised not to find the tender attention and care in the hospital she was used to in her other childbirths at home. She had gone to the hospital for medical reasons, but apparently she expected that she would be taken care of much better emotionally, too, than at home. She experienced the place as cold, the people as inconsiderate, and the service as bad. She was not given an infusion when she requested one, and the doctor and nurse did not stay with her when she wanted them to. It was incomprehensible to her that she was not the permanent center of attention for the hospital staff as she used to be for her family during childbirth at home. She summarized her experience by saying: “If someone wants to die, then one should send him to the hospital.”

*Field workers and peripheral services*. The midwife is stationed at the health subcenter, conducts prenatal care consultations there, and attends the deliveries to which she is called. Within the Kanghwa Project she is kept in permanent contact with each client in her target area through nurses’ aides and village health workers who were, for the purpose of this study, re-enforced by trained public health nurses. If a client is discovered to have a medical or obstetrical problem, the field staff follows her up at home with particular attention to the family. This is usually appreciated, but not always. From this study it appears that such home visits were an important factor in influencing the family’s positive attitude toward the health services. The workers had sufficient knowledge and stamina to insist on the necessity for medically qualified attention at birth against the family’s economic or traditional reservations, and they had sufficient experience in communicating with rural people not to override family decision-making, but rather to let them come to their own conclusions.

But these workers and the midwife do not have an obstetrical referral institution available to which they can introduce clients with complications, and where they can help clients and staff to communicate more effectively. An ability to communicate between people from the village culture and the second-level health service workers would make the workers more effective intermediaries for overcoming conflict.

Also, in the absence of adequate and sensible obstetrical supervision and guidance, the health workers are tempted to yield to those demands and expectations of their clientele which are not in the best interests of health and which may be very dangerous. An example is the indiscriminate use of oxytocin and related drugs in childbirth. Rural people know these medicines as “labor promoting” drugs. Most drugstores will sell them to anyone who asks for them. On a [page 52] test inquiry in a local drugstore to find out what they sell to speed up delivery, the interviewer was shown ampules of Oxytocin 10 units and Sparein. The nurses and midwives in the project reported that in practically every delivery they are requested by family or client to give a “labor promoting” injection. Among villagers the opinion prevails that the least a health worker can be expected to do is to give an injection. Not to do so indicates the worker’s incapacity, and if the worker argues that an injection involves dangers for mother and child, this is considered to be evasive talk by means of which she tries to hide her inability. One midwife in the target area has made it a custom to inject saline solution in order to protect her reputation.

In addition, the midwives may have gotten somewhat lax in observing the proper indications for using oxytocin. An example is a woman who had a previous stillbirth and this time experienced somewhat weak contractions during the first stage. She was given 0.5ml Orasthine by the midwife at home, who then, when she realized there was no progress, was conscientious enough to take the woman to a local clinic. There the fetal heart sounds became weak and after transportation to an obstetrical department on the mainland the heart sounds disappeared and her second stillborn baby was delivered by vacuum extraction. She had a contracted pelvis and was in need of a caesarean section to begin with.

But the midwives are not the main promoters of the oxytocin hazard. They are, on the contrary, very much concerned about its use by laymen and the pressure on themselves to inject it. The main hazard of oxytocin injecting comes from lay people. In each village the study team could confirm at least three and up to ten lay people who know how to give injections and who can be called upon to do so. One midwife guessed that in six out of ten deliveries which are not attended by her but by lay people, and which she contacts for postpartum care afterwards, someone has given an injection of oxytocin during labor. Even in cases where the midwife attends, someone may already have injected the drug before her arrival.

DISCUSSION

These findings are based on a first general analysis of the materials. A more detailed analysis later is expected to give a more sophisticated understanding of the sources and characteristics of traditional behavior, and of the area of interaction with modern health services and the problems involved. But it will require several months of work to do so. The dis-[page 53] cussion at this time will therefore be brief and relate to the more obvious findings.

*Advantages and problems inherent in traditional behavior.* The findings have demonstrated how childbearing in Kanghwa Island is still imbedded in the traditional life style and world view. The procreational period is an integral part of family life with intense interactions in which the family gives emotional support and security to the pregnant woman and is itself strengthened in structure and function. For the woman and her family, childbearing and childbirth are an expression of health. Conceptually, they have nothing to do with the doctor, the hospital, and those who care for the sick. There is little perception of danger, and where there is some awareness of problems, there is little knowledge of the benefits that modern medicine can provide and how to go about soliciting them. The authority for decision-making and care lies with the family, especially with the mother-in-law―not with the pregnant woman herself. The procreational period is a mutual, almost sacred experience in family life, which centers around the expecting mother and culminates in childbirth.

There is a strong tendency to conceal pregnancy from strangers. The woman with the protruding abdomen is likely to withdraw and hide herself. And finally, during childbirth and the early postpartum period, she is entirely separated from any contact with the outside world. The point has been made that this behavior is beneficial for the smooth establishment of mother-child relations, for uncomplicated breast feeding, and for re-consolidation of the family after the arrival of the new member. There was a time when such behavior was an essential contribution to the survival of newborn infants. Within this context the young mother in her humble, self-denying attitude has retained a role of dignity and self-understanding that is lost in modernized society. This behavior compares favorably with the often insecure, dependent, even neurotic attitudes of modernized mothers and their families. It is in essence sound and healthy behavior, but it does not correspond to the style of modern services as they are offered. Neither of these aspects are recognized by modern medicine or by health planners.

Of course, there are manifest dangers for the health of mother and child in such behavior, and these are recognized by modern medicine and by health planners. But they nevertheless find it difficult to implement adequate strategies for avoiding these dangers. The underlying problem is that the causes of such behavior are ignored. From the findings of this study, among the causes are that in pregnancy there is little awareness of[page 54] the nutritional needs of an expecting mother, of the need to prepare the household for hygienic delivery, of the need regularly to screen a woman’s health for impending hazards, and of the need for a trained attendant at birth who can differentiate a normal from an abnormal labor, prevent catastrophic conditions through timely referral, control excessive postpartum hemorrhage, and save the newborn from a multiplicity of hazards to health and life. There remains much to be done by modern health services.

The conceptual divergence about childbearing between the family and the health services and the ignorance of underlying causes of client behavior has in the view of the authors delayed improvements in maternity care in Korea during the last decade in the face of otherwise great progress in obstetrical care. This delay in the improvement of maternity care with methods patterned after those of Western cultures is a demonstration of the strength of traditional family authority in childbearing. It is a worthwhile question whether efforts to break this authority so that health services can function more effectively need to be changed. This question is especially important since family sociologists in Korea are of the opinion that the changes in family life accompanying modernization will not result in a Western-type nuclear family.17 It is therefore pertinent to ask if a more fruitful compromise could not be worked out that would protect the beneficial aspects of traditional childbearing behavior and eliminate the blatant health hazards as well.

Yet this would require more astute recognition of the crucial importance of the cultural environment.

Pregnancy and childbirth are aspects of life that are deeply value laden in any culture. These values can be expected to differ from culture to culture. For the young woman, pregnancy and childbirth are an initiation experience which involves a change of her status in the family and society, which is also determined by culture. Marriage, childbirth, the first job, and a number of profound changes in an individual’s life are among such initiation experiences. They have been termed by the French sociologist Van Gennep “Rites of Passage.”18 They are integral life experiences, and related behavior follows culturally preformed patterns.

The nine months of human pregnancy culminate in the dramatic act of childbirth. A new human being comes into existence and this is accompanied by a profound change of function and responsibility for the mother and all other family members. The anticipatory period of pregnancy is experienced by women and families of different cultures in different ways. In Spanish-Mexican culture, for instance, pregnancy is a [page 55] condition that makes a man publicly proud of his woman, and a protruding abdomen is something to show off. We have seen that in contrast the pregnant woman in Kanghwa behaves very shyly and becomes withdrawn, and that the family assumes an emotionally protective and sustaining role. For a pregnant Western woman the role of the family is negligible in influencing her behavior, but she is strongly influenced by modern medicine. This came about as a result of modernization in the West and occurred together with the great scientific discoveries in medicine, which as a consequence eventually brought childbearing under medical control. This was, in a way, a counterproductive development since it initiated in the pregnant woman a sick role behavior, a tendency toward dependency upon medical institutions, and made her a “patient.”

How modernizing changes will ultimately affect the behavior of Korean women and families in relation to pregnancy and childbirth cannot presently be predicted. But it would be prudent, where services are being designed, that the plans be sensitive to existing behavior and the direction of its changes. Otherwise, long-term results of health services for mothers and newborn children will probably be disappointing.

CONCLUSION

In context of the observed traditional village culture, even in its process of change toward modernization, childbearing is an integral part of family life, family formation, and family evolvement. Modern health services remain in almost total ignorance of these aspects of childbearing in the cultural context. The demands of the modern services on the family to give up control over childbearing for the benefit of the physical health of mother and infant are experienced as disruptive of family life. Modern medicine and modern health services may indeed introduce here a factor of potential social pathology if present approaches persist.

We find ourselves confronted with the need for reconceptualizing childbearing in modern medicine and health services in order to free them from potentially pathogenetic trends that are inherent in the practice of treating childbearing as a pathological condition, and a pregnant woman as a patient. It would appear worthwhile to protect the independence and dignity of the Korean mother, but to instill in her at the same time knowledge of the benefits that the modern services can provide and a sense of responsibility to utilize these services for the benefit of her own and her child’s health. It appears that the family has a legitimate right for res-[page 56] ponsibility and care, too. If the family can be taught and induced to make intelligent demands on modern health services, and if Korean maternity care services can be designed to support the healthy traditional responsibility by appropriate public education, and to supplement it with appropriate, acceptable services, then an outstanding, culturally adapted modern maternity care services model could be evolved.

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