
It is impossible to write the history of eugenics without the benefit or burden of hindsight. Ideas that seemed, in their day, the embodiment of progressive thought and of the rational application of science to human affairs, are coloured today by our knowledge of the use to which those ideas were put in the first half of the 20th century. The eugenics movement died soon after the second world war. Eugenic societies and journals, university laboratories and professorships all changed their names. For most people today, the label 'eugenics' is simply a term of abuse. But not for Richard Lynn. With a cavalier disregard for political correctness, he argues that the ideas of the eugenicists were correct and that we ignore them at our peril. ‘My objectives in this book’, he writes, ‘are to show that the eugenicists were right in their belief that natural selection has broken down and that, as a consequence, genetic deterioration is occurring in modern populations.’

At one level, Lynn's book is an extremely valuable source of information for social historians and others. He provides a clear, well documented and, as far as I can judge, accurate account of a great deal of evidence. There is no doubt that, for the past 150 years in most industrialized societies, there has been a modest negative relationship between fertility and parental social class, education and IQ. The effect has decreased over the course of the 20th century, but it has not disappeared. As Lynn is careful to acknowledge, it has not prevented the widespread increase in measured IQ that has been documented by James Flynn and by Lynn himself in most industrialized countries over the past 75 years. Lynn argues, reasonably enough, that this environmentally caused increase in test scores would presumably have been even greater had it not been counteracted by what he sees as genetic deterioration. But he does not fully acknowledge the relevance of another set of data which he reviews: that which documents the negative relationship between social class and education on the one hand, and infant mortality and life expectancy on the other. In 1980, the infant mortality rate in the US was twice as high in those born to parents with less than 11 years of education as in those whose parents had 16 or more years of education. In Britain, there was a similar twofold difference in the rate of infant mortality between those born to unskilled, and those born to professional parents, and mortality rates for men aged 15–65 were also nearly twice as high in the unskilled as in the professional group. It is not difficult to see that these differences in mortality might do something to counteract the small dysgenic trends in fertility that Lynn also documents.

But Lynn is dismissive. ‘Infants and children who die are easily replaced’, he writes, ‘and the magnitude of differential mortality in adolescence and early adulthood has become negligible. Most of the differential mortality by social class occurs in the second half of life . . . after the reproductive years are complete, so this has no selection effect. By the late 20th century natural selection by mortality was still present, but it was of negligible proportions.’ In fact this passage follows a couple of pages which carefully document two conclusions: first, that differences in infant
mortality between social and educational classes have increased in both Britain and
the US since 1930; secondly, that in many European countries there is a substantial
effect of education and social class on mortality rates in males aged between 35 and
44, and in Australia an effect of IQ on mortality rates of males aged between 22 and
40. These are not the ages by which most people would regard the reproductive years
to be complete, and if there is evidence that differential mortality by social class,
education or IQ occurs mostly in the second half of life, Lynn does not cite it.

Lynn’s further comments on mortality rates are not designed to reassure the
reader of his impartiality as an interpreter of the data he reviews. Disparities in health
care between poor and rich have been a cause of some concern to many
commentators for many years. Lynn will have none of it. It is high intelligence and
good character on the part of the mother that reduces infant mortality, which explains
why infant mortality rates in the US are higher for blacks than for whites. Similarly,
‘much of the explanation for the inverse association between socioeconomic status
and mortality must be that the higher classes are more intelligent and more
conscientious in their life styles.’

It is not only as a social commentator that some readers may find themselves
disagreeing with Lynn. His reading of the theory of natural selection will not be to
everyone’s satisfaction. The eugenicists’ argument rested on the belief that natural
selection had stopped operating in human societies and that biological deterioration
was the inevitable consequence. Thus Lynn writes: ‘Natural selection keeps a
population genetically sound . . . through the greater tendency of those with
genetically superior qualities to survive . . . and their higher fertility . . . [while] those
with genetically inferior qualities have greater mortality and lower fertility. Natural
selection operated in human societies up to the middle of the nineteenth century . . .
[but then] broke down.’ What on earth does this mean? Lynn talks of natural
selection as ‘the survival of the fittest’, but for a biologist ‘fitness’ simply refers to the
number of surviving offspring (or surviving kin when one talks of inclusive fitness).
‘Survival of the fittest’ is, in effect, a tautology. If it is true that those with lower IQ
and less education are producing more offspring who survive to reproduce, then they
are fitter than those of higher IQ and more education. Selection has not stopped
operating: all that has happened is that those whom Lynn regards as genetically
inferior are being selected for. The eugenicists’ argument does not rest on any
biological imperative, but rather on a particular set of value judgments. To encourage
the more intelligent to have more children, and to discourage or prevent the less
intelligent from having any, makes no sense unless one believes that measured
intelligence is a desirable characteristic. In the final chapter of the book, Lynn seems
to acknowledge this, for he staunchly defends the notion that there are ‘good’ and
‘bad’ genes, and is contemptuously dismissive of those who argue, for example, that
stupidity is as valuable as intelligence. People who spend their lives in universities
might well agree with him on this last point. But it is worth recalling that many
eugenicists’ arguments also rested on a further assumption: that it is for society or the
state, not the individual, to make these value judgments, and therefore for society or
the state to decide who should be allowed to reproduce.

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‘Race’ and Childbirth is from a series entitled ‘Race’, Health and Social Care that seeks to examine health and social care set within the context of race and culture. This book, by Savita Katbamna, aims to investigate the experiences of pregnancy and childbirth from the perspectives of two groups of South Asian women living in Britain: Gujarati Hindu women and Bangladeshi Muslim women.

Katbamna seeks to interpret and chart the ways in which these two groups of South Asian women negotiate care pathways between two contrasting maternity care models: the Western, male-dominated, medicalized model and the traditional South Asian, female-dominated ritualistic model. Within the traditional South Asian model, a pregnant woman’s female relatives retain the pivotal role, with the mother-in-law as the figurehead. By contrast, in the Western model it is the health professionals who occupy the central position in terms of control.

The book is divided into seven chapters. In the Introduction the main differences in the characteristics of the two groups of women are argued. According to Katbamna, Gujarati women have higher education levels, are more likely to be employed and have lived in Britain longer than Bangladeshi women (p. 4). Thirty in-depth interviews were carried out with South Asian women (fifteen with Gujarati and fifteen with Bangladeshi), in addition to in-depth interviews with community liaison workers and hospital case-note tracking. Katbamna acknowledges that her findings are based on a relatively small sample and they should therefore be viewed in this light (p. 128). Although qualitative research methods frequently provide extremely rich data, if a mixed methodological approach covering a wider spectrum of women from different ethnic backgrounds had been employed, this would have given more weight to Katbamna’s arguments, if still borne out by the findings.

Katbamna argues in her literature review (Chapter 2) that there is a gap in the literature on health about ethnic minorities, and that which does exist often falls into the trap of negative stereotyping of South Asian women and of classifying them as a homogenous group (p. 16). In Chapter 3, Katbamna suggests that the initial reactions of Gujarati and Bangladeshi women to their pregnancies are similar to those of white women. She outlines the ‘management’ of pregnancy in Chapter 4, which she states is culturally specific for both groups and that Bangladeshi and Gujarati women overall ‘manage’ their pregnancies differently, with Gujarati women being overall more influenced by the medicalized model. Bangladeshi women tend to resist the Western model, and medical intervention procedures, for longer which, Katbamna argues, lessens their struggle in negotiation. She argues that, of the two groups, Gujarati women are more torn between the two approaches and thereby find negotiation more problematic. Preparations for childbirth and postnatal care experiences are detailed in Chapters 5 and 6 respectively. Postnatal care arrangements in hospitals are described in Chapter 6 as being distressing for both groups of women due to a lack of understanding, and even racism, from nurses about the cultural differences in pregnancy practices regarding approaches to post-childbirth rest, dietary requirements and postnatal information. The issues outlined in the preceding chapters are brought together in Chapter 7, which closely documents case studies of two
Gujarati women. In this chapter Katbamna argues that once childbirth has taken place, the medical model withdraws leaving only the traditional South Asian model, thereby ceasing the conflict. Chapter 8 draws together and summarizes the arguments in the Conclusion.

Katbamna selected these two groups of women, Gujarati and Bangladeshi, because she argues that they represent two different sets of cultures, backgrounds, migration patterns and experiences within South Asian culture. However, it would have been useful to include a more diverse range of ethnic groups within this study. Katbamna warns us against the ignorance that can lead to classifying all South Asian women as a homogenous group when planning health and social care services. One possible criticism of the book is in the use of two case studies of Gujarati women. Katbamna earlier argues that there are crucial differences between Gujarati and Bangladeshi women and their experiences. In light of this, selecting a case study to represent each of the ethnic groups of women would have been more appropriate.

In her conclusion, Katbamna argues several key points. She draws from her findings that South Asian women experience sexism and also racism at the hands of British health professionals who seek to discredit any ideology other than Western medical ideology (p. 133). She reasons that, although superficially Gujarati women did not appear to fully embrace their own traditional childbirth practices, this was due to an effort to be accepted rather than a lack of valuing their own cultural belief systems.

The book is well written, uses accessible language and will appeal to academics, students and health professionals as well as those with a general interest in race and health care. ‘Race’ and Childbirth makes a valuable contribution to the debate on the increased medicalization of pregnancy within the sociology of health and illness, such as those espoused by Oakley (1976, 1980, 1984). Within the current climate of questioning the medical profession, this book asks why most pregnant women, including women of ethnic minorities, do not question medical authority. This is put forward as being primarily due to a perception of the supremacy of medical knowledge and also because of the inaccessibility of other information. Katbamna, however, concludes by arguing that regrettably the paramount struggle for most South Asian women in Britain today remains to be able to access health services at all, due to language barriers and racism, and that this has to take precedence over the questioning of medical practices and authority.

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While this volume is an outstanding account of changing family demography in Canada, many of the characteristics identified by the author generalize to other industrialized nations: greater incidence of divorce, greater fluidity of partners into and out of relationships, and greater participation of women in paid work have
changed, and continue to change, family relationships. Beaufot examines the social demography and organization of Canadian families and how they have changed in the second part of the twentieth century. The first chapter considers the relations between family and work from a range of perspectives including Durkheimian, Marxist and feminist ones. Chapter 2 considers earning and caring and gender differentiation within Canadian households, while Chapter 3 describes how earning and caring have changed. Chapter 4 builds on this, developing two major themes: variations in the work patterns of individuals by gender and family status, and family strategies for the organization of work and family. Unpaid work, in the form of childcare and care of elderly, is the subject of Chapter 5. Chapter 6 attempts to reconcile the paradox of childbearing in industrial and post-industrial society: generally, children are both costly and valued in Canadian society, but as elsewhere, economic calculus does not fully explain the observed fertility trends. The question ‘why have children?’ is raised but not adequately answered by the author. Chapter 7 deals with the impacts of changing family patterns on children and youth, while Chapter 8 considers the policy dimensions of this work, putting forward models of family policy for Canada.

This is a well written, thoughtful book, which presents a wealth of interpretative analysis, and makes an important contribution to the studies of households and of gender inequality. This book should be of interest to all those concerned with demographic processes in Canada, and industrial and post-industrial society generally.

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This short book presents a joint statement by WHO/UNFPA/UNICEF and the World Bank on a very serious and important topic: maternal mortality (the definitions of several categories of maternal deaths according to ICD-10 are given in a separate Annex).

In a brief preface it is said that ‘worldwide, nearly 600,000 women between the ages 15 and 49 die every year as a result of complications arising from pregnancy and childbirth’ (p. 2). Maternal mortality is clearly characterized as not only a ‘health disadvantage’ but as a ‘social disadvantage’. It is also stated that ‘vertical, stand-alone programmes’ of intervention have had only limited success over the past decade. This is why the four agencies joined their efforts to establish ‘the common purpose and complementarity of programmes . . . designed to reduce and prevent maternal and neonatal mortality and morbidity’ (p. 2).

The book is arranged into ten short sections dealing with important issues of maternal mortality. It addresses human rights related to safe motherhood (2); discusses measures of maternal mortality and medical causes of deaths (3); discusses factors underlying those causes, such as low socioeconomic status and poor nutrition (4); discusses the implications of maternal death for family life (5); gives some
examples of intervention policies to reduce maternal mortality in different countries (6); calls for actions to ensure safe motherhood (7); and describes approaches for implementing those actions (8, 9).

In the last section (10) it is concluded that for reducing maternal deaths a national policy should be instigated, which will ensure three important changes: (i) a societal commitment to guarantee safe motherhood; (ii) improvements in availability and quality of health care; (iii) attention to the educational and nutritional needs of girls and women throughout their lives.

The statement is addressed to a broad range of readers, from governments and policymakers to community members and the four agencies’ personnel. It is designated to help them in ‘decision-making at national and local levels’ (p. 3) when dealing with maternal mortality issues.

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