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Mother and Baby Are Fine

- A Qualitative Study on Marginalization, Gender Sensitive Healthcare and Quality in Swedish Obstetric Care

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Abstract

In recent years, insufficient obstetric care has been a highly debated topic in Swedish media and politics. However, despite reports on e.g. the country's high prevalence of birthing injuries, the recent closing of numerous maternity wards and a severe lack of midwives, the development of Sweden's medical birth outcomes has been stable. Thus, based on the assumptions that (I) said quality measurements do not include all relevant factors and (II) patriarchal societal structures impact on how quality of care is defined, this thesis investigates the concept of quality of care in the context of Swedish obstetric care from a gender sensitive healthcare perspective. With regard to the theoretical framework, a qualitative study is conducted combining semi-structured expert interviews and textual content analysis. The study's results indicate that Swedish obstetric care is in the process of medicalization, manifested in a shift from soft, traditionally female, to hard, patriarchal parameters and resulting in a pathologization of healthy, female bodies. In combination with the structural normalization of perineal injuries and a distinct lack of continuity of care in postnatal care, Swedish obstetric care does not live up to the relevant six criteria of gender sensitive healthcare. As external factors, such as strained working conditions for midwives, play a crucial role in these developments, the thesis concludes the distinct needs for nationwide guidelines for obstetric care and childbirth in order to ensure adequate healthcare for women. Finally, the concept of quality of care in the context of obstetric care needs to be reconsidered to include soft parameters such as women's experiences.

Key Words: Marginalization, Gender Sensitive Healthcare, Power Structures, Medicalization, Normalization, Quality of Care

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List of Acronyms

BB	Maternity Hospital (Barnbördshus)
BVC	Children's Healthcare (Barnvårdscentral)
EPDS	Edinburgh Postnatal Depressive Scale
GSH	Gender Sensitive Healthcare
MVC	Mother's Healthcare (Mödravårdscentral)
NBHW	National Board of Health and Welfare (Socialstyrelsen)
PT	Perineal Trauma
SCB	Swedish Office of Statistics (Statistiska Centralbyrån)
SKL	Swedish Municipality and County Council (Sveriges Kommuner & Landsting)
SMA	Swedish Midwife Association (Svenska Barnmorskeförbundet)
SPT	Severe Perineal Trauma
SWL	Sweden's Women's Lobby (Sveriges Kvinno Lobby)
VAS	Visual Analogue Scale
WHO	World Health Organization

1. Introduction

1.1 Research Problem

While they were there, the time came for the baby to be born, and she gave birth to her firstborn, a son. She wrapped him in cloths and placed him in a manger, because there was no guest room available for them. - Luke 2:6-7

While this biblical quote describes the birth of Jesus Christ in Bethlehem more than 2000 years ago, if the phrase “while they were there” was exchanged for “while they were on their way to the hospital” and the word “manger” was exchanged for “car seat”, it could have just as easily be the experience of a Swedish mother today. Although the medical birth outcomes in Sweden are better than ever, based on both national and international comparisons of hard, medical parameters, worrying reports concerning the country’s obstetric care and the treatment of women in labor have surfaced repeatedly. The topics of said reports vary from the lack of midwives and available maternity ward beds, the high prevalence of birthing injuries such as vaginal tears, to the recent closing of many smaller maternity units in favor of larger ones.

In recent years, Swedish obstetric care seems to have fallen victim to extensive dismantling due to severe budget cuts. However, what the media has titled a “crisis in obstetric care” does not only affect smaller, publically owned obstetric units such as BB Sollefteå, BB Karlskoga and BB Mölndal. Even private maternity clinics such as Södra BB and BB Sophia in Stockholm have permanently closed their doors during the winter of 2015/2016 (NBHW, 2017; SKL, 2016; SWL, 2017). Isolated from other reports, the closing of obstetric units might not provoke any major reactions except raising a few critical voices in political debates. But in combination with continuous reports of women giving birth in their cars; of women in labor being sent to adjoining counties due to the lack of available maternity ward beds, and of severe understaffing of midwives especially during (but not limited to) the

months of summer, the issues in Swedish obstetric care have over recent years raised what can only be described as a frenzy in Swedish media.

Considering these alarming reports painting a coherent picture of the ongoing problems in Swedish obstetrics, the heated debate and the nationwide demonstrations demanding better obstetric care, one would assume that there has been an obvious deterioration in the quality of care in recent years. What at first glance looks like a clear case becomes however more complex when looking at the statistics presented by the Swedish National Board of Health and Welfare. The NBHW measures the quality of obstetric care in six categories¹ and even though few show a slight negative trend in recent years, the general development during the past decade shows that the quality of postnatal care for both mothers and children has been stable. Thus, according to the quality assessment of the NBHW, Swedish obstetric care

This poses a dilemma: either, there are no negative effects on mothers and newborns and the Swedish media has created a frenzy based on a few negative examples, or the current quality assessment by the NBHW does not include all relevant factors determining the quality of obstetric care. Assuming the latter, the concept of quality in Swedish obstetric care becomes highly relevant. As the current quality assessment is based solely on hard parameters of care generally associated with measurable, generalizable and statistical data that is predominantly used in natural sciences, one can assume that the apparent issues are found within the soft parameters of care, generally associated with individual experiences and perspectives which are currently excluded from the quality assessment. Thus, based on the assumption that the current quality assessment does not include all relevant factors, the quality of obstetric care becomes difficult to determine. Therefore, this thesis sets out to analyze said assessment and Swedish obstetric care from a critically feminist gender

¹ The NBHW currently measures the quality of Swedish obstetric care in almost exclusively hard parameters including (but not limited to): share of first mothers that suffer SPT during labor; share of newborns that suffer care-related infections in neonatal care; share of life-threatening heart disease (newborns) discovered in birthing clinics; share of newborns with low Apgar-points; share of acute re-hospitalization after childbirth (mothers); share of newborns that suffer injuries during childbirth (NBHW, 2016).

sensitive health care perspective, with a distinct focus on both soft and hard parameters of care.

1.2 Research Questions

The main aim of my research is to analyze the quality of Swedish obstetric care from a critical feminist perspective. I intend to critically review the current quality assessment by the National Board of Health and Welfare from a gender sensitive healthcare (GSH) perspective and identify the potential societal structures that form the basis for its deficiencies.

- What are the deficiencies in Swedish obstetric care from a gender sensitive healthcare perspective?
- How does the current assessment of quality of obstetric care by the NBHW take the hard and soft parameters of care into consideration?
- How can the concept of quality in obstetric care be adjusted to measure quality of care from a gender sensitive healthcare perspective?

2. Literature Overview

This section aims to outline this thesis' (predominantly theoretical) literature overview. As I have chosen feminist theory as the base of my analysis, the chapter presents the concept of marginalization of women in healthcare within previous feminist research. For further explanation, a table presenting brief definitions of key concepts of feminist theory including - but not limited to – hard and soft parameters and gender roles, which are relevant for the context of this thesis, can be found in Appendix 1.

2.2 Feminist Theory: Marginalization of Women in Healthcare

The topic of healthcare has been researched from a theoretical, feminist perspective numerous times. For instance, Karin Johannisson (1994) identifies three major areas

of women's marginalization in healthcare. Firstly, women's gender role as the weaker sex leads to labeling the process of pregnancy and childbirth as a state of sickness. Secondly, women's ailments connected to their reproductive healthcare are regarded unimportant and therefore structurally normalized. Thirdly, based on their gender role, women are seen as having a tendency of overly embellishing their issues, which, in turn, has an immense impact on their medical treatment.

While there are other aspects of marginalization of women in healthcare, this thesis has, in line with Johannisson (1994), identified two seemingly contradictory themes that occur simultaneously as symptoms of the issue in question, i.e. the medicalization of obstetric care and the structural normalization of perineal trauma. However, in order to discuss why these two themes are central symptoms of the structural marginalization of women in healthcare, we first need to briefly address the power structures therein and the way gender roles affect women as patients.

2.2.1 Power Structures & Women as Patients

Simone de Beauvoir (1949) describes women's limited role as potential mothers with the overpowering task to reproduce, which on a societal level is viewed as the only way for a woman to fulfill her gender-given "fate". Furthermore, she emphasizes how "women's issues" are generally not taken seriously in healthcare, and describes the structural normalization of birthing injuries in general, (de Beauvoir, 1949). In a similar tone, Karin Johannisson (1994) discusses the connection between women's gender role and the existing power imbalance between doctors and patients, magnified by traditional gender roles. She elaborates that women's weaker position is confirmed by the patient role, whereas the male role is challenged when showing weakness even within the context of healthcare, as this lies in stark contrast to the traditional male role.

However, Johannisson (1994) also describes that women generally are seen as "better" patients as they are taught to obey authority figures such as doctors. Mitchell (from: Stage, 1979) agrees with this statement by stressing that "(...)[Women's] weakness, instable emotionality, tendency to psychological change

due to nervous issues (...)” (Johannisson, 1994, p. 256) makes women easier to deal with and more susceptible to arguments. According to Roberts (1981, 1985, 1990, 1992) and Doyal (1995), the sex of the doctor does little to impact the hierarchical relationship, as even female doctors are part of the biomedical structure and thus premier the male gender role over typically female traits (Johannisson, 1994; Roberts 1981, 1985, 1990, 1992; Doyal, 1995).

In line with this, van Wijk et al. (1996) point out that gender differences in the way symptoms are presented to healthcare-professionals play a crucial role in manifesting these power structures between patients and doctors (Meeuwesem, 1988; Davis, 1988). According to their research, women are likely to talk about their symptoms in a narrative style, whereas men generally present their symptoms in a seemingly more objective manner (van Wijk et al., 1996; Meeuwesem, 1988; Davis, 1988). According to Birdwell et al. (1991), a patient’s style of presentation of symptoms has a direct altering effect on the physician’s diagnostic approach, as doctors are significantly more likely to take patients with factual presentations more seriously.

2.2.2 Medicalization of Pregnancy & Childbirth

Over the past centuries, in most western countries childbirth has moved from the female domestic area, the home, to hospitals. While homebirths are possible in some countries, obstetric care in general has become increasingly influenced by medical technology to the point that medical interventions have become the norm. While many obstetrical interventions were introduced based on an actual or a perceived need, the routine use of medical intervention during pregnancy and birth does carry negative connotations. In recent years, the topic has been closely connected to feminist debates on obstetric care, partly due to a rise in feminist discourse regarding women’s right to self-determinate their bodies and their treatment during pregnancy and birth and to the subsequent resistance against medicalization (Bailey, 2002; Parry, 2008).

At this point, it is crucial to stress that medical advances have had predominantly positive effects on both pregnancy and childbirth. Maternal and infant mortality

have drastically decreased, the survival rate of premature babies has increased and the early detection of possible complications has led to safer births. Developments in the field of safe abortions and contraception are crucial when it comes to women's empowerment and women's right to safe choices concerning their bodies. Hence, this section will merely discuss the over-medicalization and pathologization of healthy pregnant and birth-giving bodies.

Medicalization can be defined as the “biomedical tendency to pathologize otherwise normal bodily processes and states. (...) [It] leads to incumbent medical management [and is] a social process whereby an expert-based biomedical paradigm dominates discussion of health and frames it in negative ways, usually as illness” (Parry, 2008, p. 785). In other words, when female reproductive processes such as pregnancy and birth become medicalized, the body is framed as pathological even during unproblematic pregnancies, contributing to the creation of a bigger issue (Bergeron, 2007). When natural processes are portrayed and treated as disease, they become defined on a scale that reaches from normal to pathological, which can not only create the false need for medical supervision but also alienate people from regular human experiences (Bergeron, 2007). As a direct result of labeling reproductive processes as states of sickness, women's bodies are portrayed as weak and in need of medical assistance during both pregnancy and childbirth (Johanson et al., 2002; Bergeron, 2007; Munro, Kornelsen, & Hutton, 2009).

As stated by Cohain (2007) and Lothian (2006), studies show that seemingly benign medical interventions during both pregnancy and the birthing process have a tendency to generate complications, which in turn lead to the need for further medical intervention. As medicalization begins early in pregnancy (e.g. with prenatal care and monitoring processes), the concept of female reproduction is transformed into a permanent at-risk condition in need of monitoring (Benyamini et al., 2017). The findings of Benyamini et al. (2017) relate closely to Parry, who in 2006 stated that “(...) the medicalized birth is so ingrained in our society that people can think of no other way to frame their experiences” (p. 464), thus shifting the concept of a normal birth and pregnancy (Lothian, 2006; Munro et al., 2009; Parry,

2008). This shift creates a sense of insecurity for women, as birth becomes an event to be medically managed. Hence, women's confidence in their ability to give birth naturally risks being lost (Bergeron, 2007).

According to Scamell et al. (2017), the expansion of medical technologies in the field of obstetric care, in combination with the international shift from homebirths to hospitalization, has created unprecedented conditions for a socio-cultural shift towards a biomedical model of childbirth. This creates a situation where a woman cannot make a free choice about her own birthing experience, which Lowe (2004) and Lothian (2006) interpret as a form of disempowerment. The academic interest in this consists of a predominantly feminist critique of the process of medicalization of obstetric care (Scamell et al., 2017). It raises the argument that, despite offering women more choices such as C-sections or anesthesia, freedom of choice is not possible within the confines of medicalization as the process as such is based on the patriarchal control of women's bodies (Bergeron, 2007; Parry, 2008).

According to the WHO, empowerment in the context of healthcare entails "(...) a process in which patients understand their role, are given the knowledge and skills by their health-care provider to perform a task in an environment that recognizes community and cultural differences and encourages patient participation" (Bissell, 2004).² Within feminist theory, however, the concept of empowerment in the context of healthcare has connotations that surpass this definition. Since the start of the WHO's advocacy for patient participation in 1977, there has been a distinct focus on different measures that aim to strengthen patients' position in healthcare and their influence on medical treatment decisions (Ong et al., 2000; Svenaeus, 2000; Winblad Spångberg, 2003; Little et al., 2001; Little et al., 2001:2; Markson et al., 2001; Holmström & Röing, 2010).

² An interesting side note to the organization's introduction of the concept of empowerment in the context of healthcare is that the WHO themselves point out that the term "empowerment" is culturally charged: "(...) The term chosen to engage and involve patients will depend on what is appropriate for the specific culture of a region or community. Patient empowerment might be the preferred term from a patient advocacy point of view. However, the less emotionally charged and challenging term patient participation might be a term more acceptable to many HCWs [Health Care Workers], patients, and cultures" (WHO, 2008). There is no further explanation as to why the term empowerment is considered emotionally charged. Furthermore, contrary to this, the terms of patient participation and empowerment in health care are generally not used interchangeably in studies on the topic, which makes the WHO's statement even odder.

However, many feminist scholars argue that the concept of patient-centered care cannot work within the constraints of medicalization, as it does not enable patients to frame their experience within any other context than viewing their body as pathological and in need of medical assistance (Richardson & Carroll, 2009; Smith & Robertson, 2008; Wilkins & Savoye, 2009; van Wijk et al., 1996). Therefore, as patients cannot be viewed as having all relevant information, they cannot make educated choices (Parry, 2006).

2.2.3 Normalization of Perineal Trauma & the Norm of Motherhood

The extent of complications experienced by a woman following perineal trauma (defined as trauma to the area between anus and vagina during vaginal delivery^{3 4}) is directly correlated to the severity of the trauma and the appropriate treatment (Kettle & Tohill, 2008). Depending on these, some women remain asymptomatic following SPT or PT (henceforth referred to as SPT), while others experience severe physical symptoms.⁵ Moreover, the experience of SPT often carries psychological problems such as shame, feelings of isolation and of disconnection with their “new” body, making the issue of the structural normalization of birthing injuries even more relevant (Priddis, Schmied et al., 2014).

The process of childbirth has in previous research, such as the work by DiMatteo in 1993 and Salmon in 1997, been described as a source of anxiety based on the women’s feeling of loss of autonomy, lacking information and/or emotional reactions (DiMatteo, 1993; Salmon, 1997). In 1997, based on these descriptions, Glazener conducted a study about persistent morbidity after childbirth and the lack

³ The trauma can occur spontaneously or as a result of an obstetric intervention called episiotomy, a surgical incision of the perineum and the posterior vaginal wall generally done by a midwife or an obstetrician (Dahlen et al., 2007, Fernando et al., 2010). Perineal tears are classified into four categories: first-, second-, third- and fourth-degree tears. While first- and second-degree tears are superficial lacerations to the perineal skin, vaginal mucosa or perineal muscles, third- and fourth-degree tears include different degrees of violation of the anal sphincter and require medical attention to prevent lasting damage, pain and incontinence. Third- and fourth-degree perineal tears are defined as severe perineal trauma (SPT).

⁴ SPT reportedly affects a relatively small percentage of the childbearing population in international measurements, but as the impact of SPT can result in “extensive and complex long-term physical and psychological morbidities” (Priddis, Schmied et al., 2012 in *Journal of Advanced Nursing*, January 2013, p. 749), it is still highly relevant to discuss the treatment of those who do suffer from SPT.

⁵ Stress and/or urge urinary incontinence, flatus and fecal incontinence, hemorrhoids, dyspareunia and risks of the development of additional morbidities such as vaginal fistulas and pelvic organ prolapse (Wall, 1999; Pauls et al., 2007; Bagade & Mackenzie 2010; Rathfisch et al., 2010; Tin et al., 2010; Priddis, Schmied et al., 2012).

of professional recognition, finding that a high percentage of women who experienced SPT reported problems due to perineal pain long after giving birth. Glazener elaborated that the participating women themselves perceived their sexual morbidity and pain as “only to be expected”, based on the handling they had received from healthcare-professionals. Some women even described healthcare-professionals as unwilling or unable to help with issues related to SPT, lending weight to the suggestion that professional reluctance to discuss sensitive issues hampers their effective management, which reflects embarrassment or lack of interest (Glazener, 1997).

Similar results were identified by Priddis, Schmied et al. (2012) in a meta-ethnographic study examining the experiences of women who had suffered postpartum morbidities, including SPT. Priddis, Schmied et al. (2012) found that most studies showed that women experienced inadequate and dismissive treatment. For instance, this manifests in the experience that suggested treatment options were inadequate, which, to them, indicated that their experience of postpartum morbidity was perceived as trivial (Salmon, 1999; O’reilly et al., 2009). As a consequence of having their concerns repeatedly dismissed, women described that healthcare-professionals coerced them to accept that their postpartum morbidity was insignificant and an acceptable consequence of childbirth (Salmon, 1999; Herron-Marx et al., 2007).

The normalization of both physical and psychological symptoms lies in stark contrast to the medicalization of pregnancy and childbirth described in the previous chapter. Where the pregnant and laboring body is seen as in a constant state of sickness and in need of medical care and intervention, the female body suffering the consequences of SPT with symptoms that have a direct effect on the women’s day-to-day life is denied treatment. Even when actively seeking medical help for their issues, women's conditions are trivialized to a degree that they experience as coercion. This is reinforced by the power structures in the relationship between healthcare-professionals and, in particular, female patients.

According to Priddis, Schmied et al. (2012) this dismissive attitude towards postpartum morbidities ties into a shared cultural perspective where women experience a lack of support not only from doctors, but also from partners, friends and relatives. The importance of the way healthcare-professionals interact with women that have suffered SPT can, according to the previous research, not be stressed enough. Williams et al., (2005) identified similar patterns as Priddis, Schmied et al. (2012), stressing the lack of information and poor communication as the most crucial components of the structural normalization of birthing injuries.

Priddis, Schmied et al.'s (2014) second study identified new themes, including another crucial aspect. "The abandoned mother" reflects the mothers' experience of being vulnerable and exposed during and after the birthing process as a direct result of the actions of healthcare-professionals. This shift of focus towards the newborn will henceforth be referred to as the "empty vessel syndrome". This experience is described as a form of "loss of self" which occurs during the birthing process: the women lose themselves when undergoing the change from woman to mother. This feeling is magnified when women suffer SPT, as they are in need of medical attention after the delivery (Priddis, Schmied et al., 2014). The second theme, the "fractured fairytale", reflects the breach between the women's expectations of birth giving and their real birth experience and intermediate postpartum period, and how this influences the women's ability to take care of their newborns. Priddis, Schmied et al. (2014) stress that the concept of motherhood is shaped upon social and cultural expectations, which are challenged by the reality of the symptoms of SPT (Boon, 2012).

2.3 Feminist Theory: Quality of Care From a Gendered Perspective

Due to the level of dissatisfaction with Swedish obstetric care and the recent movement fighting for a more patient-centered approach to reproductive healthcare, this thesis is based on the assumption that the current assessment does not catch all factors relevant to evaluating the quality of Swedish obstetric care. However, in order to be able to discuss this, we need to outline the vague concept of quality of care from a gendered perspective. The differences between male and female

healthcare needs in general and reproductive care needs in particular have always been a central consideration in healthcare (Doyal, 2001). Today, we see a growing national and international recognition of gender as a central indicator of health differences (O'Brien et al., 2003). However, despite recent progress when it comes to both accessibility and quality of care, major inequalities can still be identified both in the western world and in developing countries (van Wijk et al., 1996). Among many others, van Wijk et al. (1996) have therefore identified the need for the establishment of gender sensitive healthcare.

2.3.1 Gender Sensitive Healthcare

The impact of sex and gender in healthcare has been discussed and demonstrated by a vast amount of research (UN, Platform for Action, 1995; Verdonk et al., 2009; Doyal, 2003; Klinge, 2007; Largo-Janssen, 2007; Celik et al., 2008). Accordingly, this topic features in the most prominent agenda for social change on a world scale, the United Nations' Millennium Development Goals (Harcourt, 2009). Celik et al., (2008) state that, if not systematically taken into account by health professionals, sex and gender differences may lead to further inequality. Though a lot of attention has been given to insufficient reproductive and obstetric healthcare in developing countries, shortcomings in developed countries' reproductive healthcare have not received the same amount of attention (van Wijk et al., 1996; Celik et al., 2011).

In research and policy practices, sex, gender and health are often conflated with women and women's health (Richardson & Carroll, 2009; Smith & Robertson, 2008; Wilkins & Savoye, 2009). As Turshen (2007), for instance, correctly observed, "studies with gender in the title still too often mistakenly use the word as a synonym for women, or open with a nod to gender and then glide on to women" (p. 320). Despite the fact that this thesis emphasizes women's reproductive health, it is important to stress that GSH is not synonymous with women's health. Instead, a very elementary definition of GSH entails that healthcare-professionals are given the competency and the tools to perceive existing gender differences and incorporate those into their actions (Celik et al., 2011).

In the words of van Wijk et al., (1996), women's health is primarily affected by the environmental, social, political and economic factors that determine their material circumstances. In the same spirit, Kuhlmann (2002) has argued that an explicit engagement with gender theory is needed in health sciences (Teunissen et al., 2016). Nevertheless, women's health is also greatly influenced by the extent and quality of healthcare available to them (Clark, 1983; van Wijk et al., 1996). As stated by van Wijk et al., as a general consensus between women's rights organizations, gender sensitive healthcare should be **available, accessible, affordable, appropriate and acceptable**, where the first three aim at the provision of services by the healthcare system and the latter reflect the intrinsic quality of healthcare provided from the point of view of female clients (NGO Forum Vienna, 1994 in van Wijk et al., 1996). Van Wijk et al. (1996) also suggest adding "**adequate**" to this general consensus, as healthcare that is primarily based on male models of pathology and treatment often is inadequate in addressing health problems experienced by women. This indicates that the quality of care is not simply ensured through quantity (van Wijk et al., 1996). In other words: "(...) more healthcare is not always better healthcare, especially from the viewpoint of women" (van Wijk et al., 1996, p. 708).

In the context of GSH, Andrist (1997) stresses five aspects as crucial for conducting what she calls "feminist practice in healthcare". Firstly, inquiry and practice need to be based on the assumption that women are the actors and definers of their own experience. Therefore, healthcare-professionals need to take women's experiences into account. Secondly, existing power relations need to be changed as the medical care system is currently based on hierarchical and patriarchal models. Thirdly, Andrist stresses that the so-called "new psychologies of women" indicate that women are relational beings, which is why healthcare providers need to regard women's decisions about healthcare as possibly affected by other responsibilities. Andrist's fourth point involves that some women reportedly have "objectified" their own bodies, which manifests in a split between mind and body, where women view their body as "the other". Lastly, she stresses that the goal of feminist practice is to change healthcare both for the individual woman as well as for all women. This incorporates the concept "the personal is political" into the concept of healthcare

practice, where the intended outcome is a change of consciousness. This is seen to lead to new values, which, in turn, bring on social transformation.

3. Theoretical Framework for the Analysis of Swedish Obstetric Care

In the previous sections, I have presented a rather extensive theoretical literature background consisting of critical feminist theory on the marginalization of women in obstetric care through medicalization and normalization, and on gender sensitive healthcare. This section aims to summarize and clarify the three concepts that will be used in the analysis of the case of Swedish obstetric care, and to demonstrate their connection. Firstly, I will concentrate on the medicalization of childbirth based on a shift of focus from soft to hard parameters in Swedish obstetric care. Secondly, I will apply the concept of the structural normalization of perineal injuries to the case of Swedish obstetric care, trying to identify possible patterns or aspects that contribute to or counteract it. Lastly, the concept of empowerment in the context of healthcare will be applied, as I will discuss possible solutions based on GSH.

As previously discussed, power structures play an immense role in any doctor-patient interaction but are amplified by gender roles. In line with Johannisson (1994), van Wijk et al. (1996) point out that gender differences in the way symptoms are presented to healthcare-professionals play a crucial role in manifesting these traditional power structures between patients and doctors (Meeuwesem, 1988; Davis, 1988). Thus, physicians might take symptoms of people with “traditionally female” behavior less seriously and are more likely to attribute them to an emotional rather than a physical cause (Birdwell et al., 1991; van Wijk et al., 1996). Moreover, Johannisson (1994) also describes that women generally are seen as “better” patients as they are taught to obey authority figures.

As medicalization of pregnancy and childbirth can be defined as a shift from incorporating both soft, thus traditionally female, and hard, patriarchal parameters towards a sole focus on the latter, medicalization and power structures in healthcare

are closely intertwined. Keeping in mind Parry's (2008) definition of medicalization as the biomedical tendency to pathologize normal bodily processes and states, the process has severe consequences in the context of obstetric care. While pregnancy and childbirth are normal physical processes, they represent a stark contrast to almost all other aspects the biomedical model generally is associated with, which is why the medicalization of female reproductive processes is highly problematic. As presented in section 2.2.2, the feminist critique of the structural medicalization of female reproductive processes is based on the argument that freedom of choice is not possible within the confines of medicalization as it is based on the patriarchal control of women's bodies (Bergeron, 2007; Parry, 2008). Subsequently, when medical interventions become routine, the concept of what constitutes a normal birth shifts, thus creating a sense of insecurity for women, as birth becomes an event to be medically managed (Lothian, 2006; Munro et al., 2009; Parry, 2008). This in turn creates a situation where a woman cannot make a free choice about her own birthing experience, which Lowe (2004) and Lothian (2006) interpret as a form of disempowerment.

While the connections between power structures, medicalization and (dis-)empowerment are obvious, the connection to the normalization of perineal injuries is at first glance not as clear. Specifically the medicalization of childbirth, a normal bodily process, and the structural normalization of perineal injuries, an actual state of pathology, might be viewed as contradictory. However, as de Beauvoir (1949) and Johannisson (1997) point out, both are mere symptoms of the structural marginalization of women in healthcare. As pointed out in section 2.3, I will focus on two aspects of the structural normalization of perineal injuries, namely the trivialization of women's symptoms and morbidities in relation to the norm of motherhood and the "empty vessel syndrome". Both are crucial components of normalization and usually reinforce each other. As elaborated upon in section 2.2.3, the trivialization of perineal injuries refers to the dismissive attitude towards postpartum morbidities, which is reinforced by the existing power structures and the ideal of motherhood. There is an apparent taboo surrounding any negative emotions towards the transition from women to mother, manifested in trivialization and

neglect by healthcare-professionals. Empty vessel syndrome relates to the shift of focus from mother to newborn after the delivery. When a mother has suffered perineal injuries, this experience is further magnified (Schmied et al., 2014). In order to ensure patients' empowerment van Wijk et al. (1996) suggest that care should be gender sensitive to the standard of being **available, accessible, affordable, appropriate, acceptable** and **adequate**.

4. Methodology & Empirical Material

Based on the theoretical framework outlined in the previous section, this study has been conducted through a qualitative methodological approach. A set of qualitative methods and techniques were applied in order to answer the research questions on how the quality of Swedish obstetric care can be determined and measured, based on the assumptions that (A) the current assessment does not include all relevant factors and (B) patriarchal societal structures have a direct or indirect impact on how quality of care is defined. This section will outline the chosen methods, display the selection of material and present the epistemological assumptions along with limitations and possibilities of this methodological approach.

4.1 Feminist Methodological Approach

Feminist theory is closely interconnected with power relations and male dominance (Ramazanoğlu & Holland, 2002). Subsequently, the concepts of gendered power and the assumption that our society is patriarchal come with certain connotations for the methods applied to conduct feminist research. Although there are no distinct feminist research techniques or ontological or epistemological positions, Ramazanoğlu and Holland (2002) do stress that feminist researchers have developed qualitative, politically sensitive research styles and fieldwork relationships, as this suits their purpose of making diverse women's voices and experiences heard. In other words: qualitative research methods are not distinctively feminist, nor does feminist research necessarily require qualitative techniques. Moreover, as feminist methodology typically is shaped by feminist theory, politics and ethics, one can argue that it cannot be independent of the ontology, epistemology, subjectivity,

politics, ethics and social situation of the researcher (Ramazanoğlu & Holland, 2002). Feminist research, merely by situating itself as such, is politically charged and actively opposes patriarchal “truths” such as female inferiority and the denial of societal structures of male dominance (Ramazanoğlu & Holland, 2002).

Partly due to this reason, feminist research has historically been scrutinized and the generalizability of qualitative research results in comparison to quantitative studies has been questioned (Ramazanoğlu & Holland, 2002). Quantitative research is, as opposed to qualitative research, generally portrayed as scientific, generalizable, and most important, objective. This claim of scientific objectivity has been questioned and criticized by many researchers on the grounds that science itself is a social product and scientists are socially situated beings. Therefore, “(...) no scientific method ensures access to some incontrovertible “truth”” (Chalmers 1982; Haraway 1989; Kuhn 1970; Latour 1993; Woolgar 1988: from Ramazanoğlu & Holland, 2002, p.45). The feminist critique of the domination of scientific research methods challenges the patriarchal consciousness that only permits certain questions to be asked, in certain ways, within male-centered frameworks of explanation (Comer 1974; Dinny 1981; Morgan 1978; Women and Science Group 1981).

4.2 Research Design

The above-mentioned, “scientific”, male-centered approach based on hard parameters is currently used to measure the quality of Swedish healthcare in general and of obstetric care in particular. Quality is measured by the extent or lack of physical injuries, death rates, and other factors limited to the scientifically measurable. While these aspects undeniably are crucial elements of the quality of healthcare, I argue that other factors relevant to the determination of quality of care are excluded by merely applying said scientific measures. Once a certain standard of healthcare is reached, quality assessments should be expected to include the patients’ experience of the care they are given. Based on the fact that Sweden is ranked as one of the countries with the highest quality of healthcare, I argue that this standard has been reached and surpassed.

Undoubtedly, quantitative research has had important consequences in terms of measuring and developing the concept of quality of care. However, this positivist tradition that has dominated medical research has offered a rather narrow perspective by rendering patients experiences as invisible, thus perceiving them as an unreliable source of legitimate knowledge (Salmon, 1999). Hence, women's voices are not included in the current quality assessment of obstetric care. I have therefore chosen to incorporate an interpretive feminist perspective into this study, which allows for the exploration of gender related oppression and marginalization by valuing the voice of the lived experience of women (Ackerly & True, 2010). Thus, I am placing my focus on soft rather than hard parameters. Feminist research methods assimilate a critical approach that aims to grasp and challenge individuals' experience of the world (Ackerly & True, 2010; Shapiro et al., 2003; from Priddis, Schmied et al., 2014). Understanding *how* something is experienced can in itself facilitate opportunities to bring about change for members of marginalized groups (Ackerly & True, 2010).

4.2.1 Data Collection & Selection

This research is primarily based on semi-structured expert interviews and the textual content analysis of reports on obstetric care. Respondents for said interviews were chosen based on their profession and/or their involvement in political activism related to Swedish obstetric care. In addition, snowball sampling was used as participants were asked to suggest other experts in relevant fields who may also be suitable to participate in the research (Priddis Schmied et al., 2014). The texts included in the textual analysis were selected based on their content. Therefore, I have chosen to include reports published by the NBHW in order to balance the information gained by the interviews conducted in this study.

One could ask why this research does not include interviews with women on the topic of their experience with Swedish obstetric care. The answer is simple: I do not aim to determine *whether* Swedish obstetric care is lacking despite the positive quality measurements. Instead, I assume that Swedish obstetric care *is indeed* lacking. Therefore, my method of choice is expert interviews. Experts have specialized knowledge due to their profession, based on both their technical

knowledge by education and their process-related knowledge by experience. Expert knowledge includes expertise as well as tacit knowledge about maxims of action, rules of decision-making, collective orientations and social patterns of interpretation (Bogner et al., 2009). Thus allowing me to gather information about the interviewees' specialized knowledge without denying the importance of individual experiences, especially in the field of reproductive health.

Six semi-structured interviews were conducted, using open questions to enable the respondent to disclose their experience in their field of expertise (see table 2). To ensure informed consent from all participants, the respondents were asked to read and sign a consent form prior to the interview. The recordings were transcribed verbatim and analyzed using open coding and thematic analysis. Statements and patterns were identified and placed in broad categories and analyzed in order to identify subthemes, which represent the patterns within the categories (Braun & Clarke, 2006; Liamputtong, 2009). All quotes used in the thesis were translated from Swedish to English by the researcher.

Qualitative content analysis is an appropriate method for this study as it is an unobtrusive technique based on the texts published by the NBHW, SKL and SWL on the topic of Swedish obstetric care, as the information in the text is what the institutions deem central from their perspective on quality of care. I regard this in combination with the interview to be an adequate balance. As I am working with feminist methodology, the units I am most interested in are significance and thematic units. After identifying those, content categories and subcategories are developed and the relevant units are placed in them. Finally the data is analyzed, yielding qualitative data on what is being communicated in the chosen texts.

Since I am combining semi-structured interviews with textual content analysis, interviewees and texts were selected with the goal of creating an as thorough and saturated as possible basis for the analysis, aiming to complement the information gained through one source with information from the other. As the interviews allowed for a deeper insight to both midwives' and women's perspectives, texts were primarily selected from sources that represent a different perspective and could

reveal new, relevant information. A table of the analyzed texts and interviewed experts can be found in appendix 3.

4.2.3 Limitations

The limitations of this study include the relatively small number of interviews conducted in combination with the fact that many of the interviewees work within the same field. Also, the use of snowball sampling may have resulted in the recruitment of experts with similar experiences. Therefore, methods of participant recruitment should be considered for future studies.

4.2.4 Validity

The use of qualitative methods has in recent years become increasingly accepted in healthcare. However, the quality of results thus obtained is still regarded an enigma by many healthcare researchers. The debate on this is centered on the generalizability of the knowledge produced by qualitative methods (Mays, 2000). There are, however, steps a researcher can take to improve the validity of the results. The methods of triangulation and reflexivity have been used in this study to ensure authenticity throughout the research process. While triangulation is controversial as a test of validity, as it assumes that one methods' potential weakness is compensated by the strength of the other, it is a fruitful way of ensuring comprehensiveness and encouraging a reflexive analysis of the data (Mays, 2000). In this study, triangulation can be found in the choice of interviewees and reports. As for reflexivity, I, the researcher, have made my political standpoint clear by choosing feminist critical theory and methodology. This thesis is based on the assumptions that we exist in a society that is created within patriarchal structures, which influence women's role not only in healthcare but also in almost every aspect of our lives. The mere fact that I have chosen said theory and methodology makes this study politically charged. Furthermore, the fact that I am female and white may have an influence on the way I interpret feminism and choose the aspects I focus on.

4.2.5 Ethical Considerations

When conducting qualitative research, a few crucial ethical concerns should be taken into account, namely anonymity, confidentiality and informed consent. In order to ensure informed consent, each participant was presented with a consent form explaining the overall plan for the research, its purpose, methods and potential consequences. While the experts were presented with the explicit option of anonymity, all participants consented to the use of their name and title. For further information, the consent form can be found in Appendix 2.

5. Results & Analysis

In the following section, the results of my research are presented and analyzed. The main focus lies on the concept of quality of obstetric care, where a gender sensitive healthcare perspective is applied to identify potential deficiencies not included in the current quality assessment.

5.1 Medicalization in Swedish Obstetric Care

A central aspect of the medicalization of childbirth is the balance between soft and hard parameters in obstetric care, as presented in section 2.2.2. Hard parameters are generally described as medical and measurable, such as medical outcomes, interventions, procedures and treatments. Soft parameters within healthcare, however, include vaguer concepts such as the perception of safety or respect in a healthcare encounter, the feeling of being listened to, reassured and involved in the decisions regarding one's care. The process of medicalization often entails a shift to a sole focus on hard, medical outcomes. In this section, I set out to detangle the seemingly contradictory elements of medicalization within Swedish obstetric care.

5.1.1 The Swedish Model of Obstetric Care

Like most countries of the western world, Sweden has over the past centuries experienced a successive shift of childbirth from the home, a historically predominantly female area, to the hospital, a historically male-dominated area. Moreover, the primary responsibility for obstetric care was simultaneously transferred from midwives to obstetricians, further reinforcing a structural medicalization. The Swedish obstetric care model, however, does differ from many other western countries in the role of the midwife. For approximately 300 years, well-educated midwives, not obstetricians, have been the main distributor of care throughout normal pregnancy, birth and aftercare within Swedish obstetric care. Hence, despite the shift from the home to the hospital, the Swedish obstetric care model still deems midwifery, a mainly female profession, crucial for obstetric care.

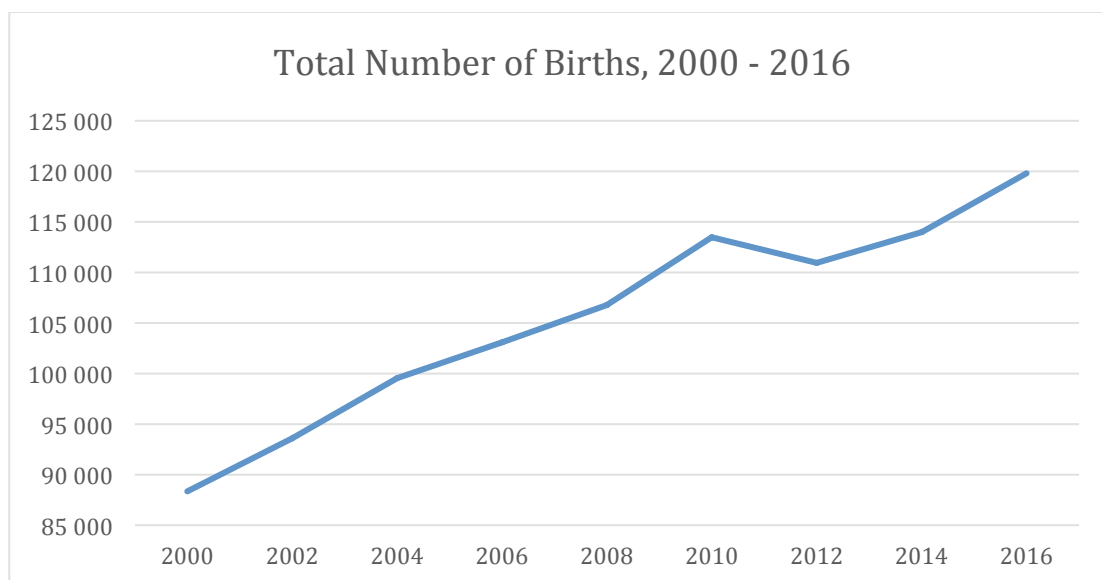
According to Ahlberg, midwife, doctorate and president of the Swedish midwives association, this is one of the principal strengths of Swedish obstetric care: *“One of the main reasons that Swedish obstetric care is so successful and good, is that we have highly educated midwives that are in charge of care during pregnancy and birth”*. Ahlberg further elaborates that Swedish midwives can be described as a crucial balancing force in obstetric care when it comes to the medicalization of normal pregnancy and childbirth. *“Studies show that when doctors are in charge of women’s healthcare during pregnancy and birth, obstetric care becomes predominantly medical and the rate of medical interventions rises, for instance in terms of more examinations and interventions. (...) [I]t is crucial to include midwives, as there are so many aspects of pregnancy and birth that are normal and need to be protected from unnecessary intervention”* (Ahlberg, Stockholm, 20.03.2018).

According to the experts interviewed for this thesis, the profession of midwifery can be described as the connecting element between hard and soft parameters of obstetric care, as it emphasizes their connection. While midwifery’s medical area of expertise specializes in normal pregnancy and birth, it places an equal emphasis on the importance of soft parameters such as support, communication, the feeling of safety, and respectful treatment of patients. As opposed to for instance obstetric nurses, midwives are trained in both the medical aspects of obstetric care and what is often referred to as the “art of midwifery”, the focus on supporting and including the woman in the birthing process. Thus, midwives are crucial as they ensure women’s right to make empowered choices about their health, birth experience and bodies in line with Andrist (1997). Ahlberg describes this interaction of soft and hard parameters as a healthy tension between relevant factors, stressing yet again *“(...) the rate of medical interventions generally increases when other personnel, not educated in the field of midwifery, are in charge of obstetric care”* (Ahlberg, Stockholm, 20.03.2018).

5.1.2 Medicalization in Swedish Obstetric Care

During the past decades, Swedish midwives have tried to alert the public and government to the lacking working conditions, often stressing that the current working conditions risk affecting the quality of the care they are able to provide for their patients. However, according to the quality measurements of the NBHW, birth outcomes in Sweden are better than ever. This raises the question: what has changed in Swedish obstetric care that affects its quality without affecting the quality measurements?

One of the key changes is that the number of babies being born in Sweden has increased drastically in recent years, rising from 88 326 in 2000 to 119 794 in 2016, as illustrated in the graph below.

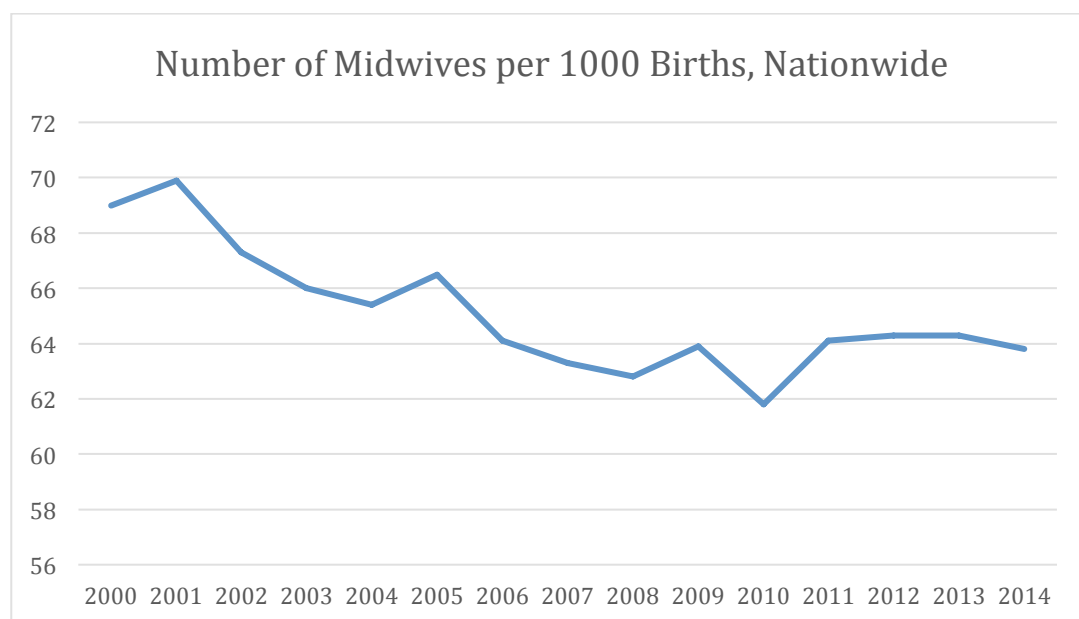


Graph 1: Total Number of Births in Sweden 2000-2016.

Source: SCB, 2018

Statistics Sweden (SCB) estimates that this trend will keep rising during the years to come, thus creating an increased need for midwives. Yet, 15 out of 21 Swedish councils report on an insufficient supply of midwives according to SCB (SWL, 2017). Furthermore, 7 out of 10 employers report on a shortage of midwives and that their need will presumably increase over the next three years (SWL, 2017). This alarming trend becomes even clearer when comparing the increasing rate of birth per 1000 women to the rate of active midwives per 1000 births. In 2000, Sweden had 69

midwives per 1000 births, a number that had decreased to 64 midwives per 1000 births in 2014.



Graph 2: Number of Midwives per 1000 Births, Nationwide

Source: SWL, 2017

Based on the SCB's prognosis on birthrates, it can be considered likely that the relationship of midwives per 1000 births will continue to drop (SWL, 2017, NBHW, 2016). Moreover, there is a risk that this trend will be further magnified by midwives leaving the sector of obstetric care, a trend that has been palpable during the past decade, partly due to the lacking working conditions. Thus, we can conclude that midwives are responsible for the care of more births, which implies a higher workload. This development is predicted to be amplified within the coming years, as approximately 50% of Sweden's midwives are older than 50 years and are expected to retire until 2030 (SWL, 2017). According to predictions of the NBHW, the number of midwives is expected to increase by 16% until the year 2030, while the percentage of decrease due to retirement is expected to amount to approximately 30% before 2024.

The government is trying to counteract this development by increasing the number of newly educated midwives. However, according to Ahlberg, this does little to help the issue: *"Midwifery can be described as a form of craftsmanship; experience is*

crucial. (...) It is not possible to run a maternity ward with only newly educated midwives, the quality of care is not nearly as good as with experienced midwives. We need to focus on keeping experienced midwives in the field, as it does not help to just fill up with newly educated” ”(Ahlberg, Stockholm, 20.03.2018). This is corroborated by reports from SWL, who point out that Swedish maternity wards do not have the time or resources to guide midwifery-students due to the strained work environment (NBHW, 2017; SWL, 2017). Universities in turn report that they would be able to increase the number of students for the theoretic part of the education, but are restricted from doing so as long as maternity wards cannot offer slots for internships. Therefore, the workload for midwives will increase further. The growing number of births also places an increased demand on the capacity of maternity wards, but current developments point in the opposite direction. According to SWL, the number of deliveries per bed has increased from 104,5 in 2006 to 123 in 2016 (SWL, 2017). One factor that has had an immense effect on this development is the closing of 13 Swedish maternity wards since 2000.

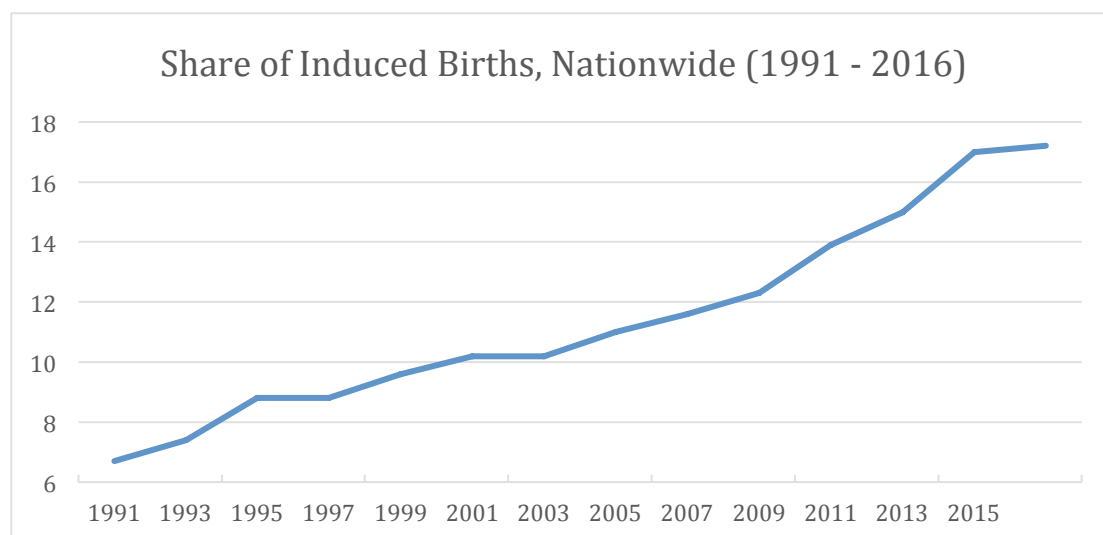
Hence, the medicalization of Swedish obstetric care appears to be occurring on two levels that are closely interconnected. Firstly, the previously outlined lack of midwives at Swedish maternity wards has created a shift from traditional midwifery to predominantly medical treatment of pregnant or birth-giving women. Secondly, there appears to be a normative shift in how society views the concept of childbirth, which further reinforces the process of medicalization. This becomes clear when speaking to Ahlberg, president of the SMA. She describes working as a midwife in Stockholm as follows. *“Nowadays, it is quite normal to be responsible for caring for two women who are in labor simultaneously, while in addition also needing to take care of someone who has already given birth or has come to the maternity ward because of some pregnancy-related issue. (...) So you have three rooms with three different women in different stages of labor for which you are responsible. And as a midwife you know that you should not leave any of these women alone because they need your support, but you still have to leave them to take care of the others. And this might not be medically dangerous but it forces midwives to make priorities that you know are not ideal in any way!”* ”(Ahlberg, Stockholm, 20.03.2018). Midwives

are put in a position where they constantly need to prioritize the medical treatment of women in labor, having not enough time or personnel to offer anything beyond. While the provision of medical supervision and treatment during labor has increased, other factors had to be limited or completely neglected. These factors are predominantly “soft” parameters, including “(...) *feeling safe, listened to, receiving the support from a midwife not only when it is medically relevant but also when the woman just needs mental support*” (Ahlberg, Stockholm, 20.03.2018).

This development and the relationship between soft and hard parameters in obstetric care becomes clear when looking at the development of four medical interventions commonly used in Swedish obstetric care, the induction of labor by intervention, speeding labor along by the use of contraction stimulants, pain medication such as spinal anesthesia and C-sections.

Induction of Labor

Since the 1990’s, the share of induced births in Sweden has drastically increased, from approximately 6.6% in 1991 to almost 17% in 2016 (SWL, 2017), as visualized in the graph below.



Graph 3: Percentage Induced Births, Nationwide

Source: SWL, 2017, NBHW, 2018

While most inductions are based on medical factors, other factors have contributed to this drastic increase (SWL, 2017; NBHW, 2016). Hagen-Andersson describes that

the strained working conditions of midwives and the lack of available maternity ward beds play a crucial role when deciding whether to induce labor. She elaborates that when midwives know that the following weeks will have a high number of expected deliveries, induction can be used as a tool to prevent having to turn women in labor away later: *“When we know that we have several pregnant women about to go into labor in the following days or weeks and a woman comes in who is maybe not fully in labor yet, but has started to experience some light contractions, we do have to consider inducing labor. (...) So even though there are technically no medical reasons for the intervention, we have to do it because we don’t want to have to turn women away later on.”* (Hagen-Andersson, Malmö 21.03.2018).

This demonstrates the connection between midwives’ workload and medicalization: interventions are not based on medical needs but to ensure that the mother will have a bed in a maternity ward. While inducing labor based on medical needs does not necessarily contribute to medicalization, routinely using interventions due to other factors can be a step towards pathologizing birth. By normalizing the use of medical interventions, the line for what is acceptable and appropriate in obstetric care gets blurred, resulting in a shift of norms. Inducing labor without medical reasons is a manifestation of what Bergeron (2007), Johansson et al. (2002) and Munro et al. (2009) have identified in their theory of medicalization: pregnant women’s bodies are portrayed as in need of medical assistance.

Additionally, the 2017 report by the SWL points out that there seems to be a connection between the rising fear of childbirth among women and the increased rate of induction. Inducing labor allows women to plan when their labor starts, which might entail a certain feeling of safety and limit the fear of giving birth (SWL, 2017). Also, many women are uncomfortable in the final weeks of pregnancy and might be inclined to allow medical professionals to induce them just to escape their discomfort. Of course, offering a “quick fix” without elaborating on potential risks or even basing the decision on medical reasons lies in contrast to allowing women to make educated and empowered choices about their care.

Hagen-Andersson's testimony of her experience as a midwife in Swedish obstetric care corroborates this: *"(...) I do think our concept of how a normal childbirth should proceed is too narrow. I strongly think that we need to update our version of normal, because that is what is causing us to use too many medical interventions."* (Hagen-Andersson, Malmö 21.03.2018).

Contraction Stimulators

Hagen-Andersson's statement takes us to the second of the common medical intervention within Swedish obstetric care, contraction stimulation. Interestingly, this topic was not brought in any of the reports analyzed in this study. All respondents however pointed to the increased use of contraction stimulants in Swedish obstetric care. As Hagen-Andersson describes, the concept of normal birth is expected to follow a certain model at a certain speed. This is partly due to the strained situation in obstetric care and partly to the shift towards framing the process of birth in hard parameters. Philipsson points out how the combination of these two factors influences the care women receive: *"Generally, I am critical towards forcing women to stay home as long as we do in Sweden. If you come to the hospital and [the cervix] has not opened enough, they have to send you home, whether you want to or not"*. Thus, regardless of the woman's need of support, she will be sent home while in labor, unless she fulfills the medical requirements to stay. In combination with the severe lack of beds, this can create an anxiety for the mother-to-be: if she is sent home, can she be sure that there will be a bed available when she is ready to return? Measuring every step of childbirth with generalizable categories manifests the process of medicalization, as women's wishes and needs are secondary to this.

Philipsson criticizes this development by pointing out that childbirth and women's bodies are individual, stressing that women who are offered contraction stimulators to speed along the process of their labor generally do not decline, as they trust the healthcare-professional. *"The concept of having to open up one centimeter per hour [referring to the cervix] does not take any individuality into consideration. (...) Any variation in this does not fit the mold and even though patients have the right to say*

no to contraction stimulators, who are they to say no to an expert?" (Philipsson, Lund, 26.04.2018).

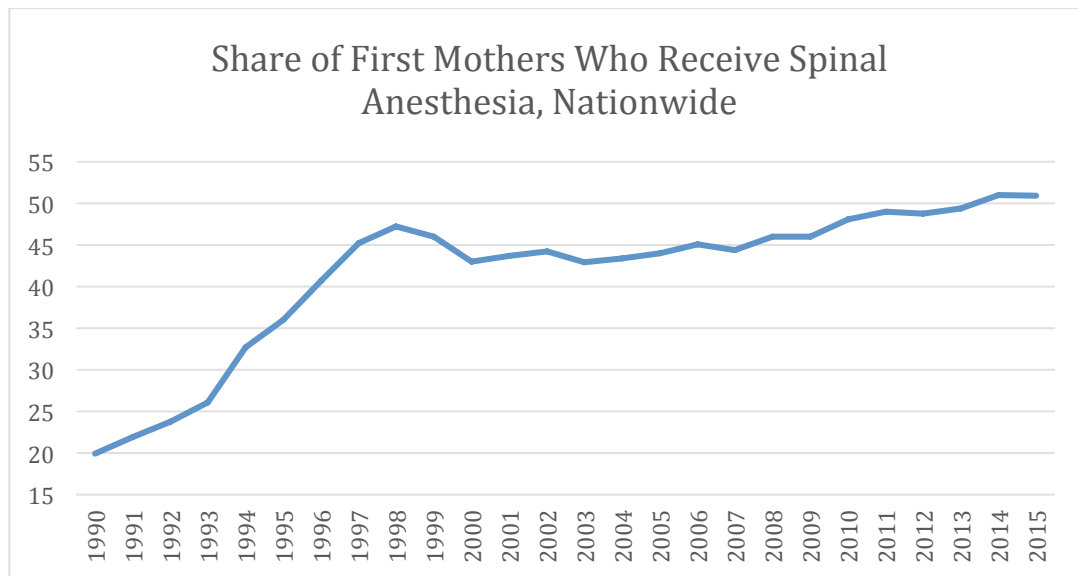
The use of contraction stimulators has increased in recent years, according to Hagen-Andersson (2018). Unfortunately, as this topic was missing in all reports analyzed, I am unable to present any statistics on the matter. Midwife-doula Cullhed-Engblom however states that in her experience, contraction stimulators are used in almost 70% of all first labors. She stresses the connection between speeding along labor and the occurrence of perineal injuries, which will be discussed in section 4.2.1: *"I think that the high use of contraction stimulators for first mothers might be contributing to the fact that first mothers in Sweden have such a high rate of perineal injuries"*. This is in line with Hagen-Andersson's perception of the use of contraction stimulators in Swedish obstetric care: *"(...) We are speeding up deliveries in Sweden. According to our guidelines, it is important that the process of childbirth does not take longer than a certain amount of time, but questions are being raised as to whether these guidelines are appropriate."* Hagen-Andersson stresses that medical intervention during childbirth in many cases generates the need for further intervention. In line with Cohain (2007) and Lothian (2006), she points out that there are always risks with inducing labor for other reasons than medical ones (and even when there are medical reasons). *"Once we have started to medically intervene, there is a greater risk that you have to continue. And everything we do can influence the outcome. Both when it comes to perineal trauma but also when it comes to the health of the child"*(Hagen-Andersson, Malmö, 20.03.2018). She also raises another important aspect that applies to both the induction and the process of medically speeding it along: *"(...) the earlier in the birthing process we use contraction stimulator, the more it can affect the woman's mentality to think that she can't do it on her own"*(Hagen-Andersson, Malmö, 20.03.2018).

This point ties perfectly into Bergeron (2007) and Johanson et al. (2002), who in their theories stress that medicalization of normal bodily processes leads to labeling them as states of sickness. By routinely inducing labor and using contraction stimulators when it is not medically necessary, obstetric care is reinforcing this

image, thus decreasing women's autonomy to make decisions related to their birth (Shaw, 2013). Here, we can also draw a connection to Andrist's (1997) theory on gender roles and power structures in women's healthcare. According to this theoretical approach, women have not only internalized their lesser social status manifested in the female gender role, but have a "othering" relationship to their bodies, i.e. seeing one's body as separate from the "self". In the context of healthcare this entails seeing your body as weak and not capable, which might lead women to ask for contraction stimulators even when they are not medically needed. If Swedish obstetric care was not in such a strained spot, Hagen-Andersson points out that midwives could support and reassure women, only using medical assistance when it is needed. As childbirth is a vulnerable state for many women, midwives "protecting" women from medicalization are especially needed.

Spinal Anesthesia

The use of pain medication during childbirth, in particular the use of spinal anesthesia has also increased in recent years (SWL, 2017). In 2015, on average every second woman giving birth for the first time received spinal anesthesia (NBHW, 2016). According to the NBHW (2016), this might partly be due to an increase in the number of complicated births or to the fact that babies are generally getting bigger. Furthermore, there are indicators suggesting that hospitals' routines concerning pain medication during childbirth have changed in recent years, as well as attitudes towards the use of pain medication (NBHW, 2016). However, the use of spinal anesthesia varies largely between Swedish counties, ranging from 37% to 63% in 2015 (SWL, 2017). Norrbotten County, which next to Stockholm ranked the highest in 2015, has increased its use of pain medication by 34% since 2002 (NBHW, 2016).



Graph 4: Share of First Mothers Who Receive Spinal Anesthesia, Nationwide

Source: SWL, 2017

According to the county’s council and the SMA, this drastic increase should be seen as an indicator that midwives are not able to offer sufficient support (SWL, 2017). SWL stresses the connection between this and an increased use of pain medication in general. When midwives are forced to take care of several women simultaneously, their attendance in each room, and therefore the support they are able to offer each individual woman, decreases.

Moreover, Cullhed-Engblom points out that even the attendance women do receive is influenced by the fact that the midwife might be taking care of several other women: *““Presence” is a difficult factor to measure because we need to distinguish between being physically present in the room and being unconditionally present, which is what we would need to measure. Today in Swedish obstetric care, the midwife’s presence is, more often than not, highly conditional. She might be physically present in one room, but as she is simultaneously responsible for two other births, she might have to leave the room when something more important happens there. So she can only stay in the room on the condition that nothing else happens somewhere else. (...) Hence, she always has to prioritize where her medical knowledge and her hands are needed the most. (...) But that has nothing to do with supporting the woman in labor mentally! She might need the most support*

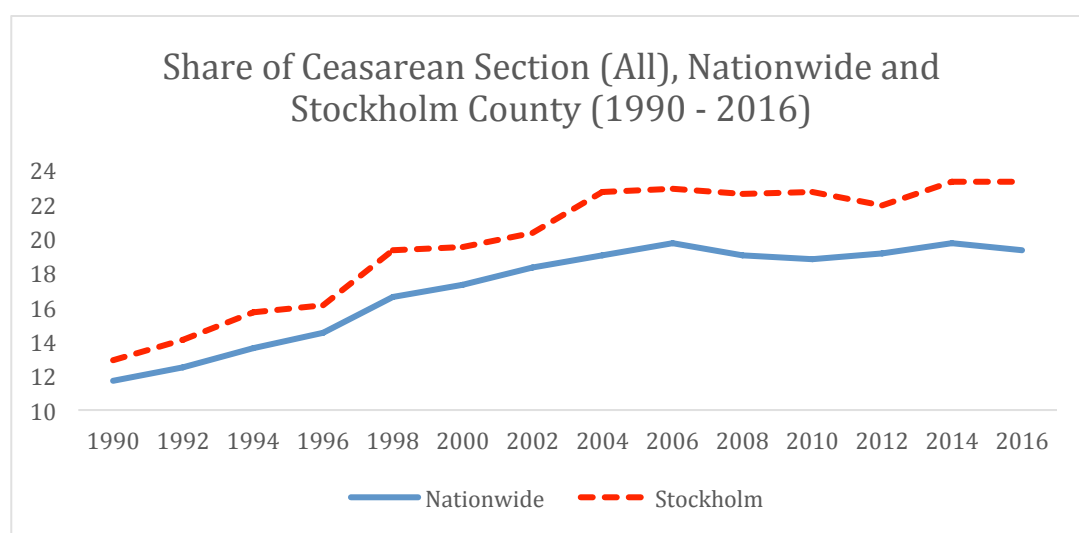
when she does not need medical assistance, but then the midwife cannot be in the room!”(Cullhed-Engblom, Lund, 02.05.2018). The connection between the perceived need of spinal anesthesia and lacking support from midwives would make for an interesting research topic in itself. However, recent studies do indicate that the use of anesthesia in general during labor decreases during births with a high support of midwives such as homebirths: “It is well-known from international research in the field of midwifery that a sense of safety and together-ness will result in positive outcomes for the women. We have even seen documented effects on the hard parameters as a result of good midwifery care throughout both pregnancy and birth! It results in fewer early labors, a lower rate of spinal anesthesia, and less cuts. (...) Overall there are more spontaneous, vaginal, normal births.” (Ahlberg, Stockholm, 20.03.2018).

Today, Sweden does neither have any national policies for the use of pain medication, including spinal anesthesia, during childbirth, nor are there guidelines to the fact as to what constitutes the optimal level for the use of spinal anesthesia (SWL, 2017; NBHW, 2016). Instead, it is up to each hospital to decide on a case-by-case basis. Furthermore, there is no research that indicates whether the use of spinal anesthesia contributes to a positive birthing experience (SWL, 2017). The lack of guidelines and routines surrounding pain medication during childbirth must be seen as a contributing factor to the large regional variances between Swedish counties and hospitals (SWL, 2017).

Cesarean Sections

According to the WHO’s recommendations, C-sections should only be performed when they cannot be avoided or prevented. According to the NBHW (2016), though the Swedish obstetric profession agrees that vaginal delivery is best for both mother and child, the C-section rate has increased drastically since the early 1990s. In general, this rate in a country should not be seen as a perfect quality measure within obstetric care. But when, as it has in Sweden, the rate of planned C-sections increases during a relatively short period of time, it does make sense to investigate whether the trend is due to medicalization or if other factors might be influencing it.

Approximately 19% of first mothers and 17% of all women gave birth via C-section in 2015 (NBHW, 2016). This constitutes an increase of 6% for all women since 1990. Most of the C-sections conducted are acute, which means that they are not planned in advance but are conducted due to complications during birth (NBHW, 2016). The number of both planned and acute C-sections has increased, with large variation between counties and hospitals. As with inductions and spinal anesthesia, Stockholm County has the highest rate with 23% and Norrbotten County the lowest with 16.5%. (SKL, 2018; SWL, 2017). Again, the large variation between counties indicates the differences in routines and guidelines throughout the country.



Graph 5: Share of C-sections Nationwide and in Stockholm.

Source: NBHW, 2018

In addition to the overall rate being highest in Stockholm, the county also has the highest number of planned C-sections, with 9% of first mothers and 15% of mothers who have previously given birth (SWL, 2017). According to the NBHW (2016), this might partially be due to the fact that women there are generally older and have higher BMI's. Moreover, most pregnancies with multiple babies and babies that are in the breach position are delivered via C-sections today. However, the increase in planned C-sections might also have to do with the fact that more women experience anxiety prior to childbirth. The fear of childbirth has increased drastically in recent years (SWL, 2017). This is, according to SWL, largely attributed to the strained situation within obstetric care. As many women are worried by the lack of maternity

beds and fear being turned away once labor has started, planned C-sections seem to have become a form of guarantee to a bed in the maternity ward. The fact that Stockholm has the highest rate of planned C-sections corroborates this theory, as Stockholm has the biggest issue when it comes to the lack of maternity beds. According to SKL (2018), it is crucial to identify the women that have negative birthing experiences in order to prevent them from developing fear of childbirth, which would make them inclined to choose planned C-section in case of another pregnancy. Ahlberg summarizes: *“We see an increased number of cases of secondary fear of giving birth, which means that you are afraid of giving birth when you get pregnant the second time. And we think if women have a midwife to support them throughout the entire birthing process and feel safe, calm and that the midwife can do all the things that we know lead to a safe delivery, we will decrease the incidents of secondary fear of childbirth. (...) And we know that this will influence both the soft and the hard parameters”*(Ahlberg, Stockholm, 20.03.2018).

According to the report by SWL (2017), more women want to deliver via planned C-section in order to avoid the risk of preventable perineal injuries, as the topic has gained medial attention. I will discuss the topic of perineal injuries in section 4.2, but I do want to stress the connection between the structural normalization of perineal injuries (including the allowing working conditions for midwives that contribute to a higher rate of occurrence of preventable SPT) and medicalization of obstetric care. Women are presented with a choice between two imperfect alternatives: if they choose to give birth vaginally, which is considered the healthier option for both woman and baby, they risk a high percentage of perineal trauma and a traumatizing birthing experience. Additionally, this option comes with the anxiety of not knowing whether they will be sent to another hospital, town or county due to the lack of maternity ward beds. Plus, depending on where the mother-to-be lives, she may have to deal with worrying about giving birth on the way to the maternity ward, due to the closing of maternity units in rural Sweden. The second option, giving birth via planned C-section, has its distinct downsides, too. While the mother-to-be avoids the uncertainty of a vaginal birth, C-sections are associated with other health risks, especially if she plans to have more children later on. According to

Bergeron (2007) and Scamell et al. (2017), these options cannot be seen as empowered ones, as they are based on flawed options born out of a patriarchal system. If women are forced to choose between two imperfect options due to the lacking obstetric care, how can their choices be considered empowered?

Another aspect that might be contributing to this is the fact that Sweden is considered to be a gender-equal country. The government has proclaimed itself feminist and stresses the importance of feminist healthcare.⁶ Therefore, women, their partners and midwives could be led to believe that the care they receive or respectively provide should be considered feminist or gender equal. Cullhed-Engblom points out the importance of expectations within healthcare: *“If you have not seen your options, then you don’t know what they are. One can be very happy with the care they receive in Sweden because “that is how it’s done” [airquotes]. You give birth at the hospital, you don’t know who will be taking care of you and you go home after two days with nowhere to turn. You have not experienced anything else. (...) That’s why it’s difficult to measure birthing experiences, it depends immensely on the woman’s expectations, and if the woman does not expect much, it will be reflected in her experience. Then you might be very happy if you and your baby manage to survive. It’s a little bit like Stockholm’s syndrome; you don’t know how bad it is because you don’t know anything else.”*(Cullhed-Engblom, Lund, 02.05.2018).

In this quote, Cullhed-Engblom touches upon two crucial points. Firstly, in order for a choice to be truly empowered, one must not only know the options available within the constraints of that particular system, in this case the Swedish obstetric model, but should be aware of all relevant options. For instance, while 19 out of the 21 Swedish counties do not financially subsidize midwives for women who choose a planned homebirth, Stockholm and Umeå County have chosen to do so under certain conditions. Thus, at least two Swedish counties deem homebirths to be a safe alternative to hospitalized birth, further contributing to the national differences.

⁶ According to the Swedish government’s homepage (regeringen.se), Sweden has the world’s first feminist government. Equality is listed as one of the government’s main goals on all societal levels. Moreover, six goals for equality are listed, including equal rights, opportunities and conditions to adequate healthcare.

Moreover, Cullhed-Engblom points out that during a homebirth, the woman is guaranteed the constant support of two midwives; something that is currently not possible for in-hospital labor. Yet, this option is not presented to all Swedish residents, limiting women's choices to "what is on the menu". Contrarily, homebirths could also be compared to planned C-sections in the way that women might choose this option because of the risk to receive insufficient support in a maternity hospital. And if something should go wrong during a homebirth, the risk of serious consequences for mother and child are higher, being further from emergency medical support. While international studies show that the risk of this is very low, it might still be a source of anxiety for women who choose homebirth due to the lacking conditions of obstetric care.

In summary, medicalization in Swedish obstetric care occurs on many levels and is often clearly linked to the lacking working conditions of midwives, not allowing them to practice in the way they have been educated in. This is manifested in a general shift from soft parameters to medical interventions and further magnified by women's gender role and power structures in healthcare. In line with Benyamini's (2017) theoretical concept of medicalization as part of patriarchal societal structures, the shift from a traditionally "female" approach to childbirth to a medical approach implies deeming hard parameters as more important than soft ones. Hence, as lacking working conditions prevent midwives from offering women the care they are educated to give, they are also forced to prioritize hard factors. What is considered a successful birth is therefore limited to the physical health of mother and child, measurable according to the patriarchal concept of quality of care. Thus, while the quality of obstetric care might be deteriorating from a female perspective, the hard quality measurements of the NBHW do not show this trend. These prioritizations further entail that negative experiences due to lacking support during labor, or negative consequences to the mother's mental health are deemed less important. Thus, a positive birthing experience and the lack of trauma becomes a bonus rather than the standard of a successful delivery

5.1.3 Medicalization and the Creation of a New “Normal”

As previously touched upon, the medicalization of Swedish obstetric care does not only affect individuals, but also creates a shift in what is perceived as a normal birth and how women view their ability to give birth (Parry, 2008). This affects both midwives and women alike.

For women, the shift towards the pathologization of their bodies is merely a confirmation of their socially constructed gender role. Based on this, women tend to see their “self” as separate from their bodies. Women have historically been portrayed as the “weaker sex” by associating patriarchal values such as physical strength and authority with the male gender role. Hence, traits associated with the female gender stereotype are valued less in society (Andrist, 1997). That in itself is interesting in the context of obstetric care, as midwifery in Sweden stresses the importance of incorporating said traditionally female parameters, at the same time being limited due to external factors. Scaling back aspects of care that are considered unnecessary according to the patriarchal model of healthcare could be interpreted as a delayed effect of the shift from home to hospital, and is a core aspect in the process of medicalization. In addition, a woman’s relationship to her body is generally affected by other societal norms, which from a young age implement the thought that female bodies need to be changed to be acceptable. Andrist (1997) stresses that girls are taught from a young age that their bodies are incapable and in constant need of alteration, thus leading to a process of “othering”. The medicalization of obstetric care confirms this previously internalized process. The more unnecessary interventions are used, the more the view that the female body, despite being able to give birth, needs medical assistance to do so, is cemented and reproduced.

Going back to a point from the previous section, medicalization can be considered as norm-changing. Women’s expectations are shaped by the way birth is presented to them, and their experiences are shaped by their expectations. Thus, the process of medicalization shifts women’s expectations in the direction that hard parameters of

outcome are most important, while soft parameters are unnecessary and can be carried out by their partner.

For Swedish midwives, the shift of medicalization manifests on three levels. Firstly, as the current working conditions do not allow them to work supporting one woman in labor, midwives are constantly dealing with a phenomenon referred to as “conscience stress”. Secondly, as the inductions rate and the use of pain medication or contraction stimulators increases, these processes become normalized, shifting the line of when to conduct medical interventions. Thus, medicalization does not only affect the women’s perspective of a normal birth, but also the midwives’. Lastly, as childbirth is becoming more medicalized, midwives are losing aspects of their practical knowledge as midwifery can be described as a practice-makes-perfect craft.

Ahlberg describes the concept of “conscience stress” the following way: *“Conscious stress occurs when you have an education and you have the practical knowledge and you know what women and their partners need in order to feel good and safe, but you don’t have the time to do these things. You are forced to prioritize things away. And then, of course, you have to prioritize the “hard” aspects to ensure that you don’t get any severe medical outcomes. And that does not feel right, you are not happy when you go home”*. This quote illustrates the interplay between midwives’ work conditions and the medicalization of obstetric care. Constantly being forced to prioritize the hard parameters seems to be one of the main causes for medicalization. Apart from the negative effects on women and the quality of their care, this further contributes to the lacking working conditions of midwives, creating a vicious cycle. Ahlberg elaborates that many midwives choose not to work under such stressful circumstances. Instead, they go back to working as nurses or in different fields altogether. This is corroborated by the 2017 report by the SWL, which points out that many midwives leave the sector of obstetric care due to the intense workload and the related emotional stress. After the closing of BB Sophia and Södra BB, experienced midwives that had worked there were so disappointed in the Swedish

obstetric care system, that they left the field altogether, which Ahlberg describes as an enormous loss.

The normalization of the use of medical intervention in childbirth is hard to notice while it is happening: *“We do so many unnecessary things and interventions and you can often justify them in the moment. But then when you step away from the situation and analyze it, you see how many cuts we do, how many times we use forceps, how much we use the drip [contraction stimulators]... it’s almost an exception to see a normal birth! So we are constantly creating risks, because unnecessary interventions mean risk.”* (Cullhed-Engblom, Lund, 02.05.2018). Even if the routine use of induction or contraction stimulators is born out of the need for quick deliveries due to the lack of maternity ward beds, when done long enough, it becomes routine. New midwives are being taught that this is how labor proceeds, possibly without being told the reasons that have created the need for the procedure in the first place. Without midwives necessarily realizing it, the concept of a normal birth has changed and the norm as to when medical interventions are appropriate has shifted.

Cullhed-Engblom describes how this process is self-reinforcing by being taught from one midwife to another: *“I know that we have to speed along labor for that reason [the lack of maternity ward beds] and you aren’t even always aware of it at that moment. But this is the reason that we are losing the concept of normal birth and the knowledge of how to work with normal births! And that is a knowledge we desperately need to maintain. You can’t just tell new midwives “this is how we work with normal births”, because they have never even seen it. Instead, they have only seen births with drop [contraction stimulants], so they only know how to work with births with drop. It becomes like a self-turning wheel! The knowledge of midwives is completely watered down, it’s disappearing”* (Cullhed-Engblom, Lund, 02.05.2018).

I find the image of a self-turning wheel fitting in this context. The wheel is brought into motion by external factors but keeps turning because there is nothing to stop it. Instead, as the process of medicalization gets reinforced from two levels, the wheel

is picking up speed. If midwives are gatekeepers of medicalization, and midwifery is a craft that needs to be taught through practice, how are midwives going to learn the things they never get to practice? Therefore, when the large retirement retrenchment will occur in the years to come, obstetric care will not only lose midwives but their knowledge as well. This ties into Scamell et al. (2017), who stress the connection between the development of medical technologies in the field of obstetric care and medicalization. Monitoring the baby's heartbeat during labor might for instance lead to unnecessarily speeding along births (Wiklund, New York City, 04.04.2018). Before, midwives would instead rely on their clinical experience as to what a baby can handle. Thus, in line with Scamell et al. (2017), medical advancements might lead to increased medical interventions.

Philipsson has identified similar trends: *“Midwives are experts on normal birth, but they are losing it more and more. Only a very limited number of midwives know how to deliver a baby that is in breech anymore, they have lost that knowledge because they don't do it anymore. And that's the way it is: the more we use medical interventions, the more we lose the... incredible flair of midwives! (...) There is an incredible well of knowledge and we are losing it”* (Philipsson, Lund, 26.04.2018).

As Ahlberg elaborated upon, there is evidence that shows that medical interventions increase drastically when doctors are in charge of childbirth. Hence, if Cullhed-Engblom is correct in her anticipation, the development of Swedish obstetric care is leading to further medicalization. Recently, the use of doulas during childbirth increased drastically. According to Ahlberg, Hagen-Andersson and Cullhed-Engblom, this is a clear indicator that midwives are not able to provide the care that women need. *“I see it as an answer to women's awareness of their need for support and safety and that we are not able to provide that in Swedish obstetric care. Because midwives are educated on the same things a doula does in addition to our medical skills. But as long as we are not allowed to provide that care, women are forced to find something else”* (Ahlberg, Stockholm, 20.03.2018). While this development sounds positive, it comes with a bitter aftertaste. Doulas are not free, which means that adequate obstetric care that suits the women's needs will only be

available for those who can afford it. Allowing a new profession to take over the aspects of care midwives are not able to perform also means reinforcing the process of medicalization. Doulas will become experts in the soft parameters, while midwives focus on the hard parameters. This takes us back to Cullhed-Engbloms point of midwives' duties shifting into those of obstetric nurses. When doulas take over the soft parameters, the gap between the soft and hard parameters becomes deeper and the patriarchal perspective of what is deemed important in healthcare becomes reinforced.

I would like to end this section with a quote of Cullhed-Engblom, who after years of working as a midwife has left maternity care: *“Because I want to work according to my moral and ethical compass, it has become very difficult to work in obstetrics as a midwife. I am not allowed to work the way I know is best for the women in my care. And I do not want to abuse women by leaving them in vulnerable situations. (...) Rather than the norm, normal birth without intervention has become the exception in today’s obstetric care. (...) Even in births where we do not need to, we are increasingly using intervention after intervention. I think it is safe to say that the art of midwifery is getting lost”* (Cullhed-Engblom, Lund, 02.05.2018).

5.2 Normalization of Perineal Injuries in Swedish Obstetric Care

It does seem contradictory: the process of childbirth in Swedish obstetric care is getting increasingly medicalized, while perineal injuries that are sustained during the process of delivery are normalized and often not treated sufficiently. Instead, a structural process or normalization of birthing injuries seems to be in place, based on the idea that birthing injuries are an acceptable consequence of giving birth that women need to learn to live with. Thus, while normal births are pathologized to the degree that the concept of normal birth shifts, actual injuries are trivialized to the degree that women suffer symptoms from injuries that are, to a certain degree, preventable. However, as both medicalization and the normalization of perineal injuries in Swedish obstetric care can be traced back to a lacking focus towards women's experiences, they may not be so contradictory after all. This section will outline how the process of medicalization and the current maternity care system

contribute to the normalization of perineal injuries and a shift of focus from mother to baby.

5.2.1 Normalization of Perineal Injuries in Swedish Obstetric Care

According to the reports analyzed in this study, almost 50% of women suffer some kind of injury as a result of vaginal birth, ranging from urinary incontinence, negatively affected sex life to severe perineal trauma (SPT) (SWL, 2017; NBHW, 2016; SKL, 2016). That is however not to say that 50% of Swedish women suffer SPT. In 2016, 6.2% of women that gave birth for the first time in Sweden suffered SPT according to the NBHW (2017). It is important to point out that the statistics collected by the NBHW are limited to SPT, and thus do not include PT. Furthermore, for some reason only the cases of SPT affecting first mothers are statistically recorded. Thus, we do not have access to an accurate number covering the rate of all SPT occurring.

Despite the rate of SPT being higher than desired, it has been relatively stable since the early 2000s. As the Swedish Municipality and County Council points out, Sweden ranks higher in the occurrence of SPT than other Nordic countries and is among the highest ranking in OECD's international comparison (SKL, 2016). Wiklund points out that Swedish obstetric care has improved severely in the last decade when it comes to diagnosis and documentation of perineal injuries. While Sweden's high ranking in OECD's comparison might be due to the fact that Swedish obstetric care in recent years has placed an emphasis on perineal injuries, thus detecting previously undiagnosed SPT, the comparison to other Nordic countries indicates that there is room for improvement.

This is corroborated by the results of national comparisons presented in the reports analyzed, as they account for a large variation between Swedish counties and hospitals when it comes to the occurrence of SPT (SKL, 2016; NBHW, 2016, SWL, 2017). Even after accounting for several factors that might influence its outcome, such as the mother's age or the baby's weight, these differences prevail. In 2014, Halland had the lowest rate of SPT for first mothers with 2.4%, while Stockholm

ranked the highest with 7.8% (SKL, 2016). This variance could be interpreted as a strong indicator that SPT is currently not prevented in the best possible way. SKL (2016) estimate that one third of all obstetric injuries occurring, including SPT, could be prevented by the proper care or treatment. Let that sink in for one second: more than 30% of all obstetric injuries currently occurring are deemed preventable. As presented in section 2.2.3, SPT can lead to severe physical symptoms as well as psychological symptoms such as shame or feelings of isolation. If SKL's estimate is correct, Swedish obstetric care represents a clear case of marginalization of women through inadequate healthcare. This begs the question: what factors influence the rate of perineal trauma and what is being done (or not done) to prevent the avoidable share of SPT?

According to Ahlberg, the answer to this question is not as easy as one would wish: *“What I can say now is that many Swedish hospitals have succeeded in keeping the number of perineal trauma low, sometimes as low as our neighbors [Norway and Finland]. And there are a variety of things that have been done, so there is not one explanation for it. Take Stockholm for example, the rate of perineal injuries is so high! I would say that the reason for this is that we have not placed enough emphasis on the issue in general”*(Ahlberg, Stockholm, 20.03.2018). However, this trend is starting to change as women and midwives speak more openly about perineal injuries. Ahlberg points out that this is generally a good thing when trying to break a negative pattern: *“(…) As soon as you start to talk about a topic, it will get better. (...) So since women have started to speak about perineal injuries, the pressure on obstetric caregivers has grown. Women are demanding better care; and the pressure is on us to provide it. And all of the sudden, research is emerging and we are learning about how to prevent perineal trauma”*(Ahlberg, Stockholm, 20.03.2018). This statement raises an interesting point: despite the fact that the normalization of perineal injuries is closely connected to the norm of motherhood and the shame associated with the symptoms of SPT, the responsibility to shift focus upon the issue in obstetric care seems to rest on women themselves. This is problematic, as Priddis, Schmied et al. (2012) stress that said shame often prevents women from doing just that.

Taking a step back to the prevention of avoidable perineal injuries, Ahlberg points out the importance of qualitative midwifery. *“It is well-known from international research in the field of midwifery that a sense of safety and together-ness will result in positive outcomes for the women. We have even seen documented effects on the hard parameters as a result of good midwifery care throughout both pregnancy and birth! It results in fewer early labors, a lower rate of spinal anesthesia, and less cuts [episiotomies]”* (Ahlberg, Stockholm, 20.03.2018). However, as was presented in section 4.1.2, Swedish obstetric care is lacking when it comes to providing enough midwives to ensure adequate support during labor. There is yet no policy in place ensuring that every woman in labor is guaranteed the support of one midwife during her entire birthing process. The SMA has therefore demanded a national policy establishing the rule *“One midwife per woman in labor”*, as has been implemented in for instance Norway and Finland. Ahlberg, who is the organization’s president, explains why this is important: *“It’s important from the woman’s perspective, because we think that it will give better results when it comes to the soft variables. (...) We think if you have a midwife and feel calm and she can do all we know for a safe delivery, we will reduce the occurrence of secondary fear of childbirth”* (Ahlberg, Stockholm, 20.03.2018).

Wiklund corroborates this by stressing that midwives know how to avoid preventable SPT, but are often not able to do so due to the strained situation. *“Today, we speak very clearly about the importance of a slow birth in order to prevent [SPT]. Instead of telling mothers to push forcefully, we make sure that the baby is delivered slowly. And we can see that this leads to an immense decrease in injuries”*(Wiklund, New York City, 04.04.2018). Here, we can see a clear connection between medicalization of childbirth and the normalization of perineal injuries; the common denominator between the two being midwifery, or rather the lack thereof. When midwives are forced to speed labor along, they are simultaneously unable to prevent preventable SPT. Thus, by medicalizing childbirth, perineal injuries are simultaneously normalized.

The diagnosis and treatment of SPT is a reoccurring theme in all reports analyzed in this thesis, which might have a connection to the recent emphasis on the consequences of perineal injuries discussed in the media coverage on the topic of Swedish obstetric care. However, after comparing said reports, a difference in emphasis emerges. For instance, the NBHW stresses the need for further education in the areas of diagnosis, treatment and follow-up of perineal injuries. The report emphasizes that the majority of Swedish maternity hospitals do have policies in place for the follow up of SPT, yet not for PT (NBHW, 2017). Interestingly enough, the report by the NBHW lifts this as a positive aspect in the treatment of SPT, while SWL places their emphasis on the fact that these policies vary drastically from hospital to hospital, as there are no national guidelines. Here, the emphasis is placed on the lack of policies and the fact that Sweden still has one maternity hospital that does not have relevant policies in place.

Still, Sweden seems to be making progress when it comes to the diagnosis and the treatment of perineal injuries. Hagen-Andersson stresses that in her experience “(...) *Sweden is very good at diagnosing [SPT]. We always make sure to check, bring in colleagues when we are unsure and we have excellent physicians that are skilled in suturing the injuries.*” (Hagen-Andersson, Malmö, 21.03.2018). However, as there are no national guidelines and recommendations for SPT, I have to assume that this lack could have a severe effect on what is diagnosed and how it is treated, leaving the statistics less reliable. In a nationwide attempt to counteract this by measuring the degree of occurrence of perineal injuries, to identify women who suffer from symptoms after sustaining SPT, the National Registry of Perineal Injuries (“Bristningsregistret”) was started in 2014. It also serves the purpose of providing feedback on their treatment for doctors and midwives and gives hospitals the possibility to improve their policies (NBHW, 2017). So far, the rate of SPT for first mothers has increased instead of decreasing since the registry’s introduction. However, as the registry has been active for less than four years, it is of course too soon to interpret its potential impact. Rather, the introduction of the registry itself can be interpreted as a step in the right direction. As described by Ahlberg: by merely placing an emphasis on the subject of perineal injuries and discussing their

occurrence and consequences openly, the associated taboo could be minimized and unnecessary shame might be lifted from the shoulders of the affected women. This could lead to a better dialogue between healthcare-professional and patient, ultimately resulting in better quality of care. Secondly, the identification of women who suffer SPT on a national level might lead to comparable statistics and hopefully national guidelines for the diagnosis and treatment of SPT, which according to the researched materials is currently lacking in obstetric care.

The argument related to the current taboo surrounding SPT becomes clear when looking into the aspect of treatment and follow-up of SPT in Swedish obstetric care. As Glazener's study (1997) shows, doctors are generally not prone to ask patients about issues related to SPT, especially in the context of intercourse. Thus, the taboo itself becomes reinforced by healthcare-professionals' disinclination to discuss and treat women's symptoms. In the context of obstetric care, the structural normalization of perineal injuries (apart from the previously mentioned non-prevention of preventable trauma) is deeply based on this taboo. Despite a series of successful efforts to increase healthcare-professionals' knowledge of how to prevent, identify and treat said injuries, there are still severe shortcomings to be found (SKL, 2018). Many patients indicate that they were indeed not asked about perineal injuries during their follow-up appointment at MVC, according to SKL (2018). The report further stresses that women generally do not bring up any issues related to perineal injuries due to the taboo surrounding the topic. This is line with Salmon (1999) and Priddis, Schmied et al. (2012), who in their respective studies stress the psychological impact of SPT. Thus, when healthcare-professional disregard asking about it, there is a high probability that women will not bring up the issue themselves. However, those who do bring up their issues with their doctors or midwives, risk being met with a trivializing attitude.

Ahlberg describes: *“We need to look even more at how to follow-up perineal injuries properly and make sure the care holds the same standard nationwide. (...) As long as women tell us about their experiences of not being taken seriously when describing issues that are related to perineal trauma, but have been treated in terms*

of “That’s normal” or “Well, you’ve given birth” when they actually have an injury, we have failed!” (Ahlberg, Stockholm, 20.03.2018). The attitude towards the symptoms of SPT is, according to Salmon (1999) and Priddis, Schmied et al. (2012) crucial to counteract the structural normalization of preventable injuries. A dismissive attitude towards these injuries is closely connected to the norm of motherhood, which expects women to disregard their own needs. Moreover, as discussed in section 2.4, according to Birdwell et al. (1991), physicians are likely to take women less seriously if they describe their symptoms in a traditionally female matter, i.e. in a narrative style. If this is the case for women in obstetric care, possible psychological symptoms of SPT might not be seen as such but associated with an emotional, rather than a physical cause. This, in combination with the female gender role, which according to Johannisson (1994) makes women “better” patients, can lead to a misdiagnosis or mistreatment of a female patient’s symptoms.

In line with Woods (1995), the normalization of SPT also serves as a way of shifting the focus from potential problems within the obstetric care model. When women are repeatedly told that the symptoms of perineal injuries are normal, the problem is located in the women’s bodies, thus deflecting attention from external factors that influence women’s health. In the case of obstetric care, the strained working conditions of midwives and the lack of policies to change these conditions can be seen as such sociopolitical factors. Thus, when no policies are put in place to counteract the development, the problem is placed with the women who have suffered preventable SPT, not with the structural reasons that brought it about.

The dismissive attitude towards SPT in Swedish obstetric care is manifested in a quote from Masoumeh Rezapour, the head of the department of women’s health at the Akademiska Sjukhuset in Uppsala, which came up in one of the interviews conducted for this study.⁷ In an interview with SVT, the Swedish state television in March 2017, Rezapour was asked about women reporting on lacking and dismissive treatment after suffering SPT by healthcare-professionals working at her hospital. Her answer is a display of what normalization of perineal injuries can look like: “Of

⁷ The interviewee asked not to be mentioned by name in connection to this particular quote.

course it is negative if patients feel that they have not been treated well here, but at the same time I have to say that it is a question of expectations. Do you expect to look the same way you did before giving birth? That is not always the case, you might look a little bit different after childbirth”. To contextualize, her interview was a response to an article describing the experience of a woman who gave birth at the hospital. When she experienced severe pain after giving birth, she repeatedly sought out the hospital for treatment, but was told by numerous doctors that this was normal and that she should enjoy being a mother. The woman was later diagnosed with SPT at a different hospital and needed to undergo surgery. While this treatment in itself is a manifestation of the normalization and trivialization of childbirth, it is of course the experience of one woman, which I am not focusing on in this thesis.

However, the reaction of Rezapour, given her knowledge of the case, is a more obvious and also more devastating display of the normalization of perineal injuries. In her statement to SVT she is not only defending the dismissive attitude of the healthcare-professionals, but she is belittling the issue of SPT in general by suggesting that patients wish to “look the same after childbirth”. Expecting treatment for the symptoms of SPT has nothing to do with looks but mere function. Trivializing the symptoms of SPT to sheer vanity is the embodiment of a dismissive attitude towards the physical and psychological pain that comes with the injuries. This becomes even more problematic when it is uttered from a person of power in a public forum, such as SVT.

5.2.2 Continuity of Care in Swedish Obstetrics – Mothers as “Empty Vessels”

As previously touched upon, the Swedish obstetric care model consists of several institutions that aim to fill different aspects in the care for women and newborns. Due to the centralized healthcare system, obstetric care follows the same model nationwide. In order to detangle the postnatal care system and its effect on the treatment of SPT, I think it is important to briefly outline the model. From the early stages of pregnancy, midwives at the “mödravårdcentralen” or “MVC” (healthcare for mothers) carry the main responsibility for the care of women with normal, low-risk pregnancies. Upon the start of labor, the responsibility shifts from MVC to

“förlossningsavdelning” (maternity ward), when women in labor come to the local maternity ward and are cared for by midwives throughout the entire delivery. After a normal delivery, mother and baby are either moved to “Barnbördshus” (“BB”; maternity hospital), or allowed to stay in their delivery room until being discharged, depending on the policies of the hospital. Until this point, all hospitals seem to follow the same chain of care. After a successful delivery however, it becomes more complicated and the variance from county to county and even hospital to hospital becomes greater. Below you will find a figure of the chain of care after a delivery according to the Swedish NBHW (NBHW, 2017).

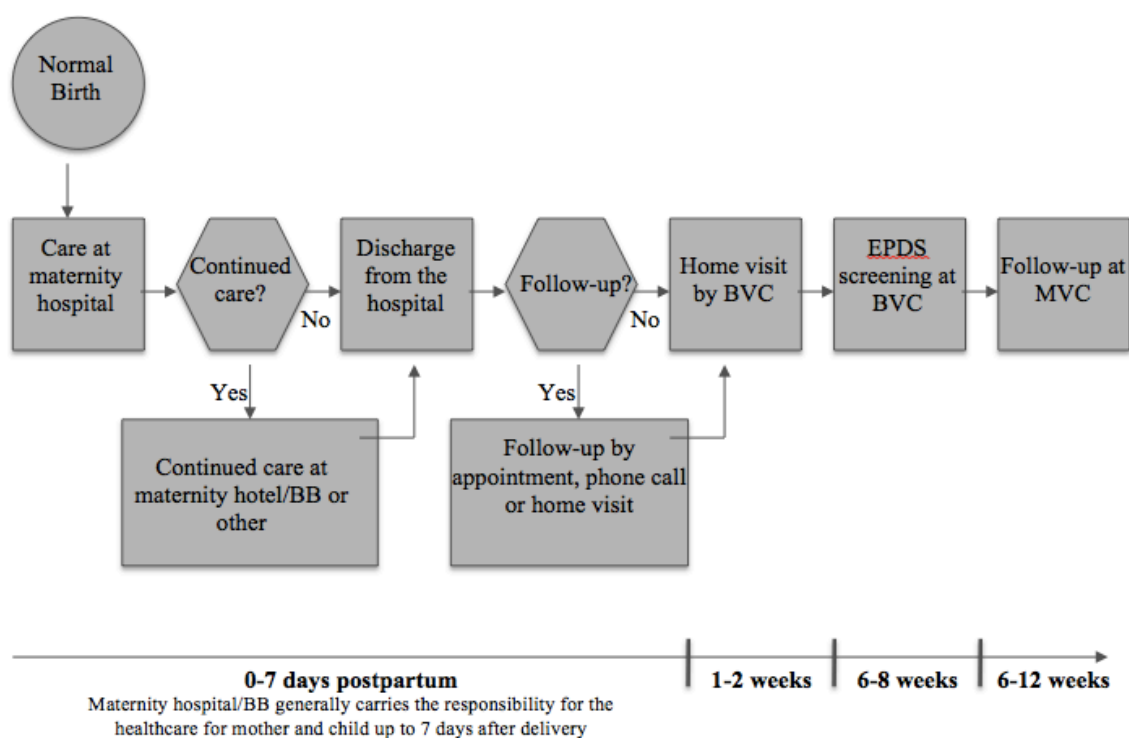
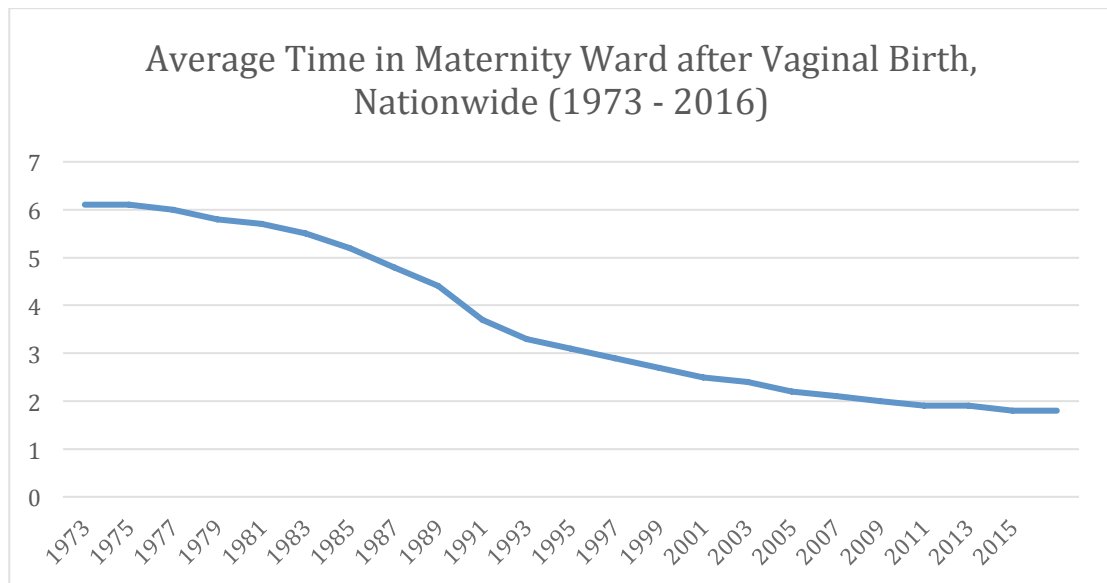


Figure 1: Swedish Postpartum Care (NBHW, 2017)

As illustrated in Figure 1, the maternity wards or BB are responsible for the care of mother and child up to seven days postpartum. However, this only applies to approximately 70% of Swedish counties, as some counties carry the responsibility for mother and newborn up to 14 respectively 42 days after delivery (NBHW, 2017). This means that the maternity ward/BB is the woman’s first-hand contact for questions about her recovery or potential follow-up. Whether the hospital offers any

follow-up to the mother after leaving the maternity ward/BB depends on the respective hospital's policies. However, according to the NBHW (2017), only about one third of Swedish hospitals conduct follow-ups routinely, while 56% only do them in certain cases. Additionally, according to the same report, in approximately 90% of the Swedish counties and municipalities, there is no active communication between the maternity ward/BB and the MVC or "barnvårdscentral", children's care, (BVC), who will be responsible for the care of mother and child following the 7-day-period after delivery. While midwives at MVC can access both the mother's and the newborn's medical records of delivery, midwives at BVC can normally only access the newborn's record. BVC, carrying the responsibility for the care of the newborn and partly for the aftercare of the mother, conducts a home visit approximately 1-2 weeks after the birth of the baby, which also constitutes the first contact between parents, newborn and the institution. BVC's main focus is the health of the baby but they are also required to support mothers in breastfeeding, monitor their mental health and support the parents in their new role. After 6-8 weeks postpartum, BVC is required to offer all new mothers a screening for symptoms of postpartum-depression based on the Edinburgh postnatal depressive scale (EPDS). In practice, however, there is great variation between counties in the implementation of this requirement, ranging from 50% to 90% of mothers being approached (NBHW, 2017). Generally, the NBHW concludes that the monitoring of the mother's postpartum health is limited to one follow-up appointment at MVC in the vast majority of Swedish regions and counties. According to the NBHW, only 76% of women that gave birth in 2015 attended their follow-up at MVC. As this chain of care through different institutions may seem confusing at first glance, I will now dissect it step by step based on the theoretical framework of this thesis, namely the normalization of perineal injuries and the empty vessel syndrome, identifying and analyzing potential risks and benefits.



Graph 6: Average Length of Stay in Maternity Ward after Vaginal Birth Nationwide
NBHW, 2018

Source:

As demonstrated in the graph above, the average length of hospitalization after birth has decreased immensely from the national average of 7 days in 1973 to 2 days in 2015, with variance from 6-12 hours after delivery up to 4 days. According to Ahlberg, this development is partly due to the fact that healthcare-professionals have learned that mother and infant do not suffer any severe health risks upon being discharged after a normal birth (Ahlberg, Stockholm, 20.03.2018). However, she also stresses that this is not the only relevant factor: *“When working at a [BB], we have to prioritize discharging healthy mothers quickly, because the maternity hotel works almost as a stopper for the delivery ward. So in order for the chain of care to work, we need mothers to go home”*(Ahlberg, Stockholm, 20.03.2018). This is corroborated by the 2016 report by SKL, which stresses that the decreasing trend in the length of hospital stay seems to be closely connected to the current lack of maternity ward slots in Swedish obstetric care (SKL, 2016). While the short postpartum hospitalization does not have to be a problem, it does raise the question whether women are receiving adequate care if they are asked to leave the hospital before feeling ready to do so.

Hagen-Andersson gives a similar description of the situation as Ahlberg: *“(…) having worked at a BB-unit for the past six months, I have become painfully aware*

that there are many cases where we have to push families to go home because we have other patients that need to come in” (Hagen-Andersson, Malmö, 21.03.2018). According to this, the postpartum care is not dictated by the needs of the mother, but highly influenced by the lack of maternity ward beds. Thus, the lacking working conditions of midwives and the limited supply of hospital beds have a direct negative impact on the quality of obstetric care. The needs of women after delivery come second to the needs of women currently in labor, as there are more direct threats to the health of mother and child during labor if they do not receive medical attention. Hence, the lack of hospital beds in both Swedish maternity wards and maternity hospitals leads to the need to prioritize one woman’s need for medical support over another woman’s need for support postpartum. This becomes clear in the 2016 report by SKL, which states that one of the main risks with early discharge after delivery is that postpartum depression or SPT are less likely to be discovered and treated. Additionally, if shorter hospitalization presents a risk factor when it comes to the treatment of postpartum symptoms of perineal injuries, one must conclude that this risk is further magnified in combination with midwives’ high workload and their lacking working conditions. If working conditions entail that a midwife needs to shift her focus from the patient’s health to ensuring that the chain of care is not disrupted, one can assume negative effects on her performance when it comes to diagnosis and treatment.

According to the NBHW, the acute re-hospitalization after birth has risen in recent years, from 1.3% in 2005 to 1,7% in 2016. While this might not seem a drastic increase, the nationwide variation is reported to range from 0.6% to 3.3%, indicating that a large percentage may have been preventable (SLK, 2016; NBHW, 2016). While the NBHW interestingly do not place much emphasis on this fact in their reports on Swedish obstetric care, the SWL stresses the connection between this development and the decreased average length of stay.

While a short postpartum length of stay does not necessarily present a problem when it is based on the patient’s empowered decision to go home, it does raise the demand for a functional aftercare system with clear directions as to where mothers can turn if

they are in need of healthcare after delivery. However, in the obstetric care system, this does not seem to be the case. This takes us to the second step in the postpartum care chain, which according to Ahlberg is “(...) *basically non-existent compared to other countries*”. The NBHW assesses that it is unclear where women should turn for medical and mental support once a week has passed since the birth and the maternity ward/BB is no longer responsible for their care. This uncertainty is described as a gap in the care chain after mother and child have been discharged from the hospital (NBHW, 2017). “*The first week after giving birth, mothers can just pick up the phone and call us at the maternity ward, and we have access to their birth journal, so it's pretty simple. But problems can occur so much later than that! And they don't know where to turn*” (Hagen-Andersson, Lund, 21.03.2018).

The SWL stresses that “(...) the aftercare system largely relies on new mothers getting in touch with healthcare-professionals themselves. The elevated rate of acute re-hospitalization indicates that women are discharged before they are ready and that the aftercare is lacking” (SWL, 2017). While women are under medical supervision during pregnancy, they seem to be left to their own devices after giving birth. As previously outlined, only one third of maternity hospitals conduct follow-ups after every birth. In the majority of counties, the aftercare is limited to the BVC, an institution dedicated to the care for the health of babies and children. Ahlberg points out: “*It's not midwives working at BVC but nurses specialized in children's care, their area of expertise is the newborn. We [the SMA] are convinced that we could provide better aftercare for women if we had a chain of care centered around the midwife that was responsible for the woman throughout her pregnancy, in order to be able to conduct a proper postpartum follow-up*” (Ahlberg, Stockholm, 20.03.2018).

In a similar tone, the NBHW indicates that while BVC is expected to provide support for new parents, BVC nurses generally lack adequate education, which would enable them to do so (NBHW, 2017). Instead, the report identifies severe deficiencies when it comes to supporting mothers in questions regarding perineal injuries, breastfeeding issues or other postpartum complications. This pinpoints the

absurdity of the current postpartum care system: while the aftercare technically requires BVC nurses to not only focus on the health and development of the newborn, it also requires the nurses to support mothers, a field in which they are not educated (NBHW, 2017). Creating a postpartum care system that does not include women's care manifests the shift of focus from mother to child in an almost preposterous way.

The is a structural shift of focus from woman to newborn after birth is closely interconnected to societal values concerning the change from "woman" to "mother" (Priddis, Schmied et al.,2014). During her pregnancy, the woman's body, a vessel for the health of her unborn child, is central in her care. During birth, a shift towards the health of the baby occurs. After a successful delivery, the now empty vessel becomes a mother, with all the societal norms and values that come with it. A mother is expected to put her child first and her own needs second. The aftercare system seems to be a manifestation of this process. "Women are generally presented with much information surrounding the health and care for the newborn but little on her own health. There is little to no information regarding possible depression, anxiety, worry and mental illness that often affect new mothers, and in that way also the babies' wellbeing" (SKL, 2018). I find it important to point out that SKL emphasize the mother's wellbeing as a relevant factor for the wellbeing of the baby. One could interpret this as a potential indication towards the shift from woman to mother: her wellbeing is no longer reason enough to provide adequate care. Instead, her health as being linked to the health of the baby is seen as the crucial reason to provide care for her. On the other hand, SKL does go on to criticize the fact that the Swedish aftercare system does not seem to put any emphasis on women's non-medical postpartum needs (SKL, 2018). According to their report, "(...) there seems to be a distinct need for mothers to talk to someone that completely focuses on her" (SKL, 2018). Ahlberg stresses the need of the obstetric care system to compensate for this, pointing out that new mothers are in a particularly vulnerable position because of the physical and mental implications of labor. *"There is a certain taboo surrounding expressing negative emotions for new mothers because they are expected to be happy. Therefore it is crucial to ask direct questions and open up for*

the conversation” (Ahlberg, Stockholm, 20.03.2018). The socially constructed idea of motherhood in combination with the empty vessel syndrome is manifested in the postpartum system’s shift of focus towards the baby.

5.3 Quality of Care in Swedish Obstetric Care

As mentioned throughout this thesis, the quality of Swedish obstetric care is almost exclusively measured in hard parameters. While these indicate that the birth outcomes in Sweden are better than ever, reports from midwives and new mothers demonstrate that these measurements do not correspond with their experience. The closing of birthing clinics leading to a severe lack of available maternity ward beds, the lack of midwives and the high prevalence of preventable perineal trauma are only some of the aspects criticized by those affected most by obstetric care: women. However, women’s experiences and midwives reports on their strained working condition are constantly met with skepticism, because of Sweden’s excellent results in international comparisons. In this section, I will critically analyze the current quality measurements within obstetric care, focusing on the lack of soft parameters.

5.3.1 Reconsidering the Concept of Quality

As outlined in section 2.2, the medical model of obstetric care lies in stark contrast to the midwifery approach. Despite the fact that midwives almost exclusively conduct obstetric care of normal pregnancies, the quality measurements of the NBHW are mainly based upon the medical model. This focus on hard medical outcomes has had a severe effect on the medicalization of childbirth, as the medical model suggests that in order to guarantee safe births and positive outcomes, birth needs to be controlled and medically supervised, thus pathologizing the process. What is not included in these measurements are the experiences of those most affected. Ahlberg points out the irony in this: *“(...) When looking at this retrospectively, this system is classically patriarchal. We are looking down on obstetric care from above according to the parameters that we [the medical community] have determined are important. However, we forgot to ask women what matters to them, and have not measured it. And therefore we haven’t seen what is not working either. So quality*

needs to be measured in more ways than we do today” (Ahlberg, Stockholm, 20.03.2018).

The NBHW currently measures the quality of Swedish obstetric care in hard parameters including: share of first mothers that suffer SPT during labor; share of newborns that suffer care-related infections in neonatal care; share of life-threatening heart disease (newborns) discovered in birthing clinics; share of newborns with low Apgar-points; share of acute re-hospitalization after childbirth (mothers); share of newborns that suffer injuries during childbirth (NBHW, 2016).⁸ The NBHW has since 1973 collected relevant data concerning pregnancy, birth and newborns in the medical birth registry (Medicinska födelseregistret, MFR), through the years adding variables that are deemed relevant. However, as the register’s name indicates, all included indicators are exclusively medical and based on hard parameters. In general, the NBHW has set a number of criteria that aim to identify and develop indicators of quality of care by distinguishing key ratios and background variables. According to these criteria, an indicator of quality needs to be measurable and accessible, established and valid, relevant, interpretable and affectable (NBHW, 2016). This in itself presents a problem when researching quality from a GSH perspective, as most of these criteria are based on the biomedical model, thus applicable to hard parameters. While it is possible to frame soft parameters to be both measurable and accessible, these are not yet established and thus not relevant according to the NBHW. And while soft parameters are valid, they are not as easily interpretable as e.g. the share of newborns with low Apgar points.

Nevertheless, in an attempt to include women’s experiences, women are asked to assess their birth experience in conjunction with their release from the maternity hospital/BB after delivery. This assessment is based on a VAS-scale (Visual Analog Scale), from zero to ten, zero being the worst possible and ten the best possible experience. What is included in the assessment of her experience of giving birth is up to each woman to decide, as healthcare-professionals acknowledge that the

⁸ Based on the 2016 NBHW indicator-based report on healthcare from a patient safety perspective.

factors of what constitutes a good experience are individual and may vary drastically. However, women are leaving the hospital earlier, with some women being released hours after giving birth. Thus, women are asked to assess the quality of their experience very shortly after it has occurred, presenting a problem for the reliability of the assessment: *“Today, the only factor we measure is a woman’s birth experience, by using a VAS-scale. (...) We do it pretty soon after the delivery. And in my opinion this gives up unreliable measurements because we measure it before the woman has had a chance to process and deal with what happened. So you get the measurement directly after delivery but you would get a completely different number two or three weeks later! So we have good VAS numbers and obstetricians say that that means that women have good experiences. I don’t agree with this, because the measurement is flawed to begin with”* (Cullhed-Engblom, Lund, 02.05.2018). Thus, a measurement that fulfills all criteria of an indicator of quality, but is conducted in a way that delivers flawed results, does little to incorporate women’s voices in the assessment of their care.

Apart from this self-assessment of women’s experiences, soft parameters are completely excluded from quality measurements of Swedish obstetric care. Hagen-Andersson elaborates which factors are, according to her experience, relevant and should therefore be included: *“[Soft values] are crucial for the quality of care. They affect the outcome because there is such a close connection between soft and hard parameters. Yet, they are not included at all. I am referring to women’s experiences. For instance, if you look at fear of giving birth, it has a huge impact on the hard parameters and values. It even affects the baby’s well being in the end, because it affects how the parents can take care of it. So it would be so important to include these things”* (Hagen-Andersson, Malmö, 21.03.2018). Wiklund points out that even a birth that looks perfect on paper might have severe consequences if the woman’s experiences are not taken into consideration: *“It can be a completely normal birth on paper but the mother still feels that she wasn’t looked after and did not receive the care she needed. And this is related to a lack of support during childbirth, but invisible on paper”* (Wiklund, New York City, 04.04.2018).

Hence, Sweden is creating a picture of obstetric care that does not correspond entirely with reality, as the current quality assessments do not include all relevant factors. As I have argued throughout this thesis, Sweden's healthcare has reached a standard where it can be expected to include patient's experiences. However, as long as these issues are invisible in quality measurements, it is difficult to implement concrete policies and remedies.

Another crucial aspect is that excluding the voices of those affected shapes the tone of the debate surrounding obstetric care. When midwives and women report on the insufficient care they give, respectively receive, they are often met with doubt based on the positive quality measurements, reinforcing the female patient role. As discussed in section 2.4, healthcare professionals are more likely to attribute women's symptoms to psychological than physical reasons. If the quality assessments show that obstetric care holds a high standard, this might further reinforce these power structures. Cullhed-Engblom stresses a similar point: *“Who is entitled to define what entails good care? (...) They [NBHW] sit there with these numbers, the medical outcomes, the VAS-measurements. Of course, if you only look at those you come to the conclusion that there is no problem. (...) This is where the power structures come in. Because both the women's and the midwives' experiences show the opposite, but that is not deemed as important. Why are we not listening to that instead?”* (Cullhed-Engblom, Lund, 02.05.2018).

According to Wiklund, one reason for the lack of soft parameters in Sweden's quality assessment is the fact that soft parameters are more difficult to measure statistically: *“It [soft parameters] is difficult to define and measure. (...) They [NBHW] release information on things that people can grasp easily, like perineal injuries and number of C-sections”* (Wiklund, New York City, 04.04.2018). However, I disagree with this analysis. While Wiklund raises a valid point by stressing that the current way of measuring quality is based on hard parameters, this does not necessarily have to imply that soft parameters cannot be measured that way. The current assessment of women's experiences by a one-question VAS-scale measurement is both insufficient and poorly conducted, but the approach of rating

one's experience on a VAS-scale allows for soft parameters to be statistically measurable and comparable. Thus, women's voices could be incorporated in the current quality assessments without having to drastically change the NBHW's view on valid indicators, even though a change in the perspective of what constitutes good healthcare is needed in line with Celik et al. (2011).

As the results of my research show, Sweden seems to be on the brink of taking a crucial step in the direction towards displaying the real quality of care as its recipients experience it, as the so-called Pregnancy-Survey will be launched in the fall of 2018⁹. All women will be asked to answer questionnaires during pregnancy, birth and aftercare. The aim of this is to raise women's participation on the topics of obstetric care and provide support for learning and improvement for Swedish county councils and regions. With questions developed by midwives and obstetricians, the Pregnancy-Survey should be answered in the middle of pregnancy, after childbirth and about one year postpartum. Moreover, all results will be presented online. While the results will not be included in the official quality measurements of the NBHW, the launch of this survey is an immense development and a step towards including women's voices.

Ahlberg, who has taken part in developing the Pregnancy-Survey, elaborates on what kind of questions will be included: *"They are called PROM [Patient Reported Outcome Measures] and PREM [Patient Reported Experience Measures] questions. They are centered on how the patient experiences their health and experience. Possible questions are "Did I get answers to the questions I had?", "Do I feel safe?". These are examples on soft questions that we will use, experiences, outcomes, accessibility and other soft parameters"* (Ahlberg, Stockholm, 20.03.2018).

In summary, there seems to be a shift in the way the concept of quality is framed in Swedish obstetric care. Allowing women to partake in assessing the quality of the

⁹ In a cooperation of SKL, the Swedish Midwives' Association, the National Patient's Questionnaire (Nationell Patientenkät), the National Registry of Perineal Injuries, The National Pregnancy Register and the Swedish Association for Obstetrics and Gynecology (SFOG)

care they receive is a crucial step towards patient participation but also towards portraying a more accurate picture of obstetric care, thus possibly allowing currently invisible issues to become visible. Of course, as the Pregnancy-Survey has yet to be launched, it is too soon to say what effects it will have on the quality of care provided and the policies implemented to counteract the medicalization of childbirth and the structural normalization of SPT. Moreover, as the results of the Pregnancy-Survey are not included in the quality assessment of the NBHW, one could raise the question if the division might contribute to keeping soft parameters separate from the biomedical model. Nevertheless, this development can be interpreted as a crucial step towards a more gendered approach to the concept of quality of care.

6. Conclusions & Final Discussion

In this section, I outline the conclusions of this research, presenting my thoughts on Swedish obstetric care from a Gender Sensitive Healthcare perspective and discuss possible policy implications.

6.1 Swedish Obstetric Care = Gender Sensitive Obstetric Care?

Having defined the processes of medicalization and normalization of SPT, in this section I will discuss Swedish obstetric care from a gender sensitive healthcare (GSH) perspective. As GSH is defined as available, accessible, affordable, appropriate, acceptable and adequate according to van Wijk et al. (1996), I set out to analyze the case of Swedish obstetric care through the lens of those factors. Furthermore, I will discuss the concept of quality of Swedish obstetric care based on the hard and soft parameters I have elaborated on throughout this thesis.

6.1.1 Availability

While one of the main strengths of the Swedish model of obstetric care is its ability to provide the same level of care for everyone, there are some crucial issues regarding the availability of said care (Ahlberg, see section 4.1.3). As discussed in 4.1.2, Swedish obstetric care is becoming increasingly centralized. Maternity clinics in rural areas are closing and hospitals close their maternity units during the summer

due to insufficient funds or personnel. As van Wijk et al. (1996) state, women's health is largely affected by social and economic factors, which in turn also affect the availability of healthcare. External factors, such as the lack of midwives (which in turn is due to the apparent inferiority of predominantly female jobs), therefore have a direct affect on the availability of Swedish obstetric care.

Moreover, due to the severe lack of available maternity beds, mothers-to-be are regularly sent to other hospitals, counties or even neighboring countries to give birth. While the number of hospital referrals for women in labor has declined in the past few years, this trend does not necessarily indicate a positive development. According to Cullhed-Engblom, one central factor is the recent closing of two maternity wards in Stockholm, which has the highest number of referrals. She stresses that it is impossible to refer a patient when there is nowhere to refer her to. Therefore, midwives are put in a situation where they have to make do with the beds they have, tying back into my point of how medicalization is used to speed up labor. Ahlberg further elaborates that the referral of a woman in labor is a last resort, and that even a low rate hides the crisis that is actually occurring in Swedish obstetrics: *“There needs to be almost chaos at a maternity ward before we start referring because we know how important it is for women to come to a hospital when they are in labor and not be sent to a different county or even country! So hiding behind these numbers, there is so much you cannot see”*.

Ahlberg's point ties perfectly into one of the core points of this thesis. The rate of referrals, which is one indicator often used to measure and describe the quality of Swedish obstetric care, is based on hard parameters both measurable and comparable. This does, however, in no way make the rate a reliable indicator of quality, since it hides a level of stress, unavailable care and negative consequences for both mothers and midwives. But since the rate of referrals is seen as an indicator for the availability of obstetric care, at first glance Sweden seems to be doing a good job. As Clark (1983) and van Wijk et al. (1996) argue, women's health is greatly influenced by the extent and quality of healthcare available to them. However,

according to the results of this study I have to conclude that Sweden is obviously lacking when it comes to the availability of obstetric care.

6.1.2 Accessibility

The accessibility of Swedish obstetric care varies immensely throughout the country. As discussed in section 4.1.2, eleven maternity wards have closed in recent years, most of which were located in rural areas of the country. As a consequence of this, in six of Sweden's 21 counties, women have to travel up to 300 kilometers to the closest maternity ward (SWL, 2017). These six counties combined make up more than two thirds of the entire extent of Sweden. It is important to point out that all affected counties are situated in the north of Sweden where it can get very cold, icy and snowy in the winter months. Having to travel up to 300 kilometers, possibly in rough weather conditions, while in labor cannot be considered as accessible healthcare. However, Sweden does not keep any statistics of for instance car-births, which makes it impossible to know for sure how many women have had to deliver on their way to the maternity ward. The fact that, as long as the placenta is delivered in the hospital, the birth is considered a in hospital birth makes this development even more absurd. SWL stresses that the risks for mother and baby during a delivery on the way to the maternity ward are considerably higher and that there have been reports of cases where the baby did not survive (SWL, 2017). Regardless of how many women have given birth in their cars so far, Swedish obstetric care cannot be considered accessible according to GSH.

6.1.3 Affordability

As healthcare is free for all residents of the country, at first glance, Swedish obstetric care seems to be fulfilling the third aspect of GHS. However, women are increasingly employing doulas as support during childbirth. This is, as previously elaborated, mainly due to the fact that midwives are in many parts of the country currently not able to provide care that takes the soft parameters into account. Instead, women are often left alone during labor, as midwives have to look after other patients simultaneously. Therefore, the care women receive cannot be described as unconditional, as Cullhed-Engblom described in section 4.1.2. Soft

values such as a basis of trust, the feeling of safety and support are often not being offered to the women, leading to a demand for doulas to fill that void. Doulas are, however, not a service that is provided by the healthcare system, leaving women and their potential partners responsible for their fee. Thus, while obstetric care is free and therefore affordable in general, it is arguable if the care provided is sufficient. The possibility of having to buy services to improve the healthcare provided by the state lies in stark contrast to the Swedish model. Cullhed-Engblom describes the development the following way: *“In Sweden, we have the consistency and consensus that healthcare is the same for everyone. And if it is bad, it will be as bad for everyone, so at least it will be “fair” [airquotes in interview]. But that is not the case, because those who have money and contacts can buy themselves a good delivery. So that is what we are creating at the moment”* (Cullhed-Engblom, Lund, 02.05.2018).

In summary, I consider Swedish obstetric care to be affordable according to GSH. However, there are some worrying trends related to the external factors that need to be kept in mind. Creating a class-system of birth, where soft parameters are a luxury that only those with means are entitled to is so far from both the Swedish obstetric model and GSH as we can get.

6.1.4 Appropriateness

Throughout this thesis, one of the main emphases was placed on the medicalization of childbirth. Thus, it should come as no surprise that Swedish obstetric care cannot be deemed appropriate in the context of GSH as long as women suffer the consequences of the medicalization of their bodies during childbirth. According to van Wijk et al. (1996), more healthcare is not always better healthcare, especially from a woman’s perspective. Using unnecessary medical interventions because of external factors such as an insufficient number of maternity ward beds and, in the process, risking women suffering a negative birthing experience or even obstetric injuries, cannot be deemed appropriate. Furthermore, within the constraints of medicalization, women’s choices cannot be considered empowered, educated choices while midwives simultaneously are pushed to giving up their role as

gatekeepers. This, in combination with the changing picture of childbirth, reinforces the process of medicalization, thus creating a vicious cycle. Hence, while the Swedish model in theory must be seen as appropriate from a GSH perspective, the current situation of obstetric care does not live up to this criterion.

6.1.5 Acceptability

Van Wijk et al. (1996) stress the importance of viewing health and illness within their social context, as the concepts are closely intertwined with social factors on both the individual and the collective level. However, in the case of Swedish obstetric care, the structural normalization of perineal injuries indicates that this is not the case. As long as the Swedish system allows the current incidence of preventable perineal injuries without implementing policies to stop this development, and as long as the follow-up of SPT is normalizing and trivializing their symptoms, Swedish obstetric care cannot be deemed acceptable according to GSH.

6.1.6 Adequacy

By including adequacy to the general consensus of GSH, van Wijk et al. (1996) address the fact that healthcare is primarily based on male models of pathology and treatment and therefore often lacking in addressing women's health problems. As the Swedish aftercare discussed in section 4.2.2 shows, the focus is shifted from mother to child. Women's postnatal health problems, e.g. SPT and postnatal depression, are hardly addressed in this system.

Moreover, according to Andrist (1997) and van Wijk et al. (1996), one crucial aspect of GSH is ensuring women's right to a central place within the country's healthcare system, including the right to determine the significance of health and wellbeing and the means to achieve these on an individual level. In the Swedish obstetric care system, however, women's voices are systematically excluded from determining the quality of the care they receive. Instead of measuring women's birth experiences, the level of support they received or the quality of the aftercare, the NBHW focuses merely on patriarchally determined measurements. However, as discussed in section

4.2.2, recent developments show that Sweden seems to have taken notice of this. Generally, if women's voices are to be stronger included in the quality measuring of obstetric care, Sweden will have taken a big step towards adequate healthcare according to GSH.

6.2 Concluding Remarks & Policy Suggestions

Throughout this thesis, I have discussed the lack of nationwide policies, guidelines and recommendations. Thus, I will give five policy recommendations for Swedish obstetric care based on the concept of GSH.

1. While it can be acceptable for midwives to be responsible for two women at the same time under exceptional circumstances, this currently seems to be rule rather than exception in Swedish maternity wards. This contributes to the structural medicalization of childbirth, a high prevalence of avoidable perineal injuries as well as a shift in what constitutes a normal birth. Thus, Swedish maternity wards need to be organized according to the rule "one midwife per woman in labor". To achieve this, national policies need to be launched and funds need to be allocated for this specific purpose. As a positive side effect of this, the strained working conditions would be eased, allowing midwives to take on students, thus sustaining a new generation of midwives.
2. As discussed in section 4.2.2, the model for aftercare is severely lacking. A nationwide investigation regarding the shift of focus from mother to child and the lacking follow-up for women with postnatal depression or perineal injuries is required. Furthermore, the chain of care needs to be evaluated, in particular the continuity of care.
3. National guidelines concerning medical interventions need to be devised. These interventions should only be used with the patients' best interests in mind. National variances need to be evaluated, allowing counties to learn from each other's mistakes and successes. A possible channel for this is the national registry of perineal injuries. However, as SPT are not the only

aspects with high national variance, the application of this concept to different aspects of obstetric care should be evaluated.

4. Obstetric care needs to become patient-centered. Women should be viewed as experts on their own bodies and healthcare-professionals need to be educated in the provision of GSH. E.g. dismissive attitudes towards SPT stress the need of education in this field.
5. Lastly, the accessibility and availability of obstetric care throughout the country needs to be reviewed. National guidelines concerning the invariable quality of care need to be formulated. Women residing in rural areas need to be presented with concrete solutions to the issue of long distances to maternity wards, as for instance safe transportation or patient hotels during the final weeks of pregnancy.

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Appendix 1 – Key Concepts of Feminist Theory

Patriarchy	A hierarchical, societal structure with direct and indirect effects on politics, economics and social norms in all current societies, which entails that men are more privileged than women.
Sex	Currently assigned at birth on the basis of someone's reproductive organs and structures as either female or male, as the traditional definition refers to merely two sexes. However, not everyone falls into these categories. Thus, there are more than two sexes.
Gender	Socially constructed behavioral, cultural, or psychological traits typically associated with one sex.
Gender sensitive healthcare	Healthcare with a focus on gender specific issues: i.e. when healthcare-professionals are given the competency and the tools to perceive existing gender differences and incorporate those into their actions.
Empowerment	There are various definitions of empowerment. This thesis uses the definition that empowerment refers to the process in which those who have been denied the ability to make choices acquire that ability (Kabeer, 2005).

Power Structure	Hierarchical interrelationships existing within a group, society or between two people. Influenced by social norms and societal structures.
Intersectionality	The complex, cumulative way in which the effects of multiple forms of discrimination (e.g. racism, sexism, and classism) combine, overlap, or intersect, especially in the experiences of marginalized individuals or groups (Merriam-Webster dictionary, 2018).
Hard and soft parameters	Hard parameters are generally associated with measurable, generalizable and statistical data that is predominantly used in natural sciences. Soft parameters are generally associated with individual experiences, perspectives and knowledge that are mostly used in qualitative research in, but not limited to, social sciences.
Patriarchal/ “male” values	Values rooted in patriarchal, societal structures, generally associated with a “male” perspective on the world, knowledge and facts. Patriarchal/male values are however not limited to men, instead they are tied to the typical socially constructed male gender role. Often based on hard facts as explained above.

Appendix 2 – Consent Form

Samtyckesblankett intervju

– Enligt etikprövningslagen 13- 22 §§



LUNDS
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Bakgrund och syfte

Med bakgrund till den kontinuerliga rapporteringen om brister i den svenska förlossningsvården genomför denna studie en kritisk granskning av Socialstyrelsens vårdkvalitetsmätning. Syftet med detta är att komma fram till huruvida kvalitetsmätningen fångar upp samtliga faktorer som är relevanta för vårdkvaliteten just när det kommer till förlossningsvård samt formulera ett ramverk som inkluderar de faktorer som eventuellt inte tas i beaktan i dagsläget.

Metod

Studien är baserat på såväl kvantitativa och kvalitativa metoder där de kvalitativa utgörs utav textanalys av Socialstyrelsens rapporter och granskningar samt semistrukturerade expertintervjuer.

Hantering av data och sekretess

Samtliga respondenter har rätt att vara anonyma om så önskas. Informationen som framkommer under intervjun kommer vid önskemål av anonymitet behandlas på ett sådant sätt att respondentens identitet inte röjs. Samtliga intervjuer spelas in med syfte att transkriberas. Inspelningar och transkriberingar hanteras enbart av forskaren.

Samtycke

Jag samtycker härmed att medverka i studien. Jag har tagit del av information om studiens syfte och metod samt vilken roll informationen som tillkommer vid denna intervju spelar. Jag har informerats om att mitt deltagande i studien är frivilligt och att jag har rätt när som helst och med omedelbar verkan återta mitt samtycke utan att behöver ange något skäl. Jag är medveten om att intervjun spelas in och kommer att transkriberas av forskaren. Den information jag lämnar kommer endast att användas till denna studie men jag är medveten om att slutversionen är offentlig.

Respondentens Namnteckning
namnteckning

Forskarens

Ort och datum

Jag vill vara anonym:

JA

NEJ

Appendix 3 – Material Textual Analysis & Expert Interviews

Table 1: Textual Analysis

Institution	Report	Year
National Board of Health and Welfare, NBHW (Socialstyrelsen)	Postnatal Care – A National Overview of Care for Women After Childbirth	2017
National Board of Health and Welfare, NBHW (Socialstyrelsen)	Safe Care – An Indicator- based Follow-up	2016
National Board of Health and Welfare, NBHW (Socialstyrelsen)	Open Comparison: Equal Care 2016 – Women’s Healthcare – An In-depth Report	2016
National Board of Health and Welfare, NBHW (Socialstyrelsen)	The Impact of Socioeconomic Factors on Postnatal Health After Childbirth	2016
Sweden’s Municipality and County Council, SKL (Sveriges kommuner och landsting)	Focus on Obstetric Care and Women’s Health – Overview and Areas of Improvement	2016
Sweden’s Municipality and County Council, SKL (Sveriges kommuner och landsting)	Safe All the Way – Overview of Care Before, During and After Pregnancy	2018
Sweden’s Women’s Lobby, SWL (Sveriges kvinnolobby)	With the Right to Give Birth – A Review of Obstetric Care Interventions in the Budget Bill 2018	2017

Table 2: Expert Interviews

Name	Position	Date of the interview
Mia Ahlberg	Midwife, chairwoman of the Swedish Midwife Association (SMA), care supervisor at Karolinska Institutet, leader of research group in the field of midwifery and obstetric care	20.03.2018
Ingela Wiklund	Midwife, former chairwoman of the Swedish Midwife Association (SMA), CEO for BB Stockholm (Maternal – and Infant-care, maternity ward), researcher at HI, working internationally for the “International Confederation of Midwives”	04.04.2018
Märta Cullhed Engblom	Midwife at Akademiska sjukhuset in Uppsala (maternity ward, obstetrics and aftercare), previously at BB Stockholm and Södra BB, home-delivery midwife and midwife-doula at “Märta’s birth support”, expert in midwifery care and feminist activist for obstetric care	02.05.2018
Anneli Hagen Andersson	Midwife at KK in Lund, Sweden (specialized in obstetrics, maternity care, prenatal care)	21.03.2018
Emma Philipsson	Doula, feminist activist in obstetric care, founder of the feminist podcast “Förlossningspodden” (“The Birth Podcast”) where women are invited to share their experience of pregnancy, birth and aftercare, which at the moment of writing has 116 released episodes.	26.04.2018
Gubb-Marit Stigsson	Activist in the case of BB Sollefåe and author of debate articles on the topic of Swedish obstetric care, member of the	21.03.2018

	municipality council (Fi), Spokesperson for environmental issues on the national level, parliamentary candidate for Fi (Feminist Party)	
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Appendix 4 – Interview Guide

Interview guide

Interview topics:

1. Media reports on closing birthing clinics
 - Interviewees opinion on whether they paint an accurate picture of the situation of obstetric care
2. Quality of healthcare
 - How does the interviewee define quality in healthcare
3. Measurements of NBHW
 - What does the interviewee think about the current way to measure quality
4. Midwifery as a tool to support & empower women
 - In what ways does the interviewee think that midwifery is used to support and empower women in labor?

Possible Questions:

Role of the interviewee

- Can you state your name and your position
- How long have you worked as ...?
- What did you do prior to that?

If interviewee works/ has worked as a midwife

- Please tell me why you chose to become a midwife.
- When did you start getting involved with the Swedish midwives association?
- Why?

“Crisis” in obstetric care

- Do you think that the media coverage of the “crisis” in obstetric care paints a fair picture of what is actually happening?
- Why/ why not?

- How would you describe the situation of obstetric care?
- How would you describe the current working conditions in obstetric care?
- If the interviewee finds anything to be lacking: How should the working conditions in obstetric care be approved in your opinion?
- What do you think about the “Norwegian Model”?
- Do you think the “Norwegian Model” is applicable in Swedish obstetric care? Why/ why not?

Quality of Swedish obstetric care

- How would you define quality of care in general?
- Does obstetric care, in your opinion, require any specific aspects to be measured to ensure good quality of care? Why/ why not?
- How would you describe good obstetric care in a birthing clinic?
- What do you think about the quality of Swedish obstetric care based on your definition of good quality of care?
- In day do day working life; do you think the clinic you have worked at provides good care for women in labor? Why/ why not?
- What issues, if any, do you as a midwife face in your day to day working environment that influence the quality of care you are able to provide for you patients?
- Do you know how the National Board of Health and Welfare measures quality of care?
- What do you think about that way of measuring quality?
- If you could change the way NBHW measured quality, what (if anything) would you change?
- Do you think that the measurement of the NBHW is affected by the lacking working conditions for midwives that you described before? If so, how?
- The NBHW wrote a report on the issues within Swedish obstetric care in 2015. Among other things, they pointed out that there is a lack of continuity in the way obstetric care is organized. Do you agree with this? Why/ why not?
- What, if any, are the issues with having lacking continuity in care?

Politics

- The government has recently increased the budget for obstetric care by 1 billion SEK/ year between 2018 and 2022. This is not the first time the budget for obstetric care has been increased in recent years (2017: 500 million SEK). What do you think about this increased budget?
- In their proposition, the government stated that the money should be used for increasing the number of midwives in order to improve the working environment, improve the neonatal care. What aspects within obstetric care do you think should be prioritized budgetwise? Why?