UMEÅ UNIVERSITY

DEFICIENT BODIES AND DIVINE INTERVENTIONS

Women, midwives, and the medicalisation of childbirth – A gender perspective

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Responsible publisher under Swedish law: The Dean of the Medical Faculty

Dissertation for PhD
ISBN: 978-91-7855-564-2 (print)
ISBN: 978-91-7855-565-9 (pdf)
ISSN: 0346-6612
New Series Number: 2140
Cover design by Bodil Frey, ‘The Creation of Woman’
Sketches by Agneta Westergren
Electronic version available at: http://umu.diva-portal.org/
Printed by: Cityprint i Norr AB, Umeå
Umeå, Sweden 2021

Someone clever once said
Women were not allowed pockets
In case they carried leaflets
To spread sedition
Which means unrest
To you & me
A grandiose word
For common sense
Fairness
Kindness
Equality
So ladies, start sewing
Dangerous coats
Made of pockets & sedition

~ Sharon Owens ~

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Abstract

Background In Sweden, one of the safest countries to give birth and to be born in, there is a trend towards increasing interventions during childbirth, and fewer women than ever give birth without having their labours induced or augmented, epidural analgesia, or caesarean section. While interventions at times are vital for a safe birth, there is a growing body of evidence demonstrating that an overuse of medical and technological interventions may have adverse effects on woman and child. Furthermore, intervention rates vary widely between different hospitals, suggesting varying local practices and in some places, poor adherence to national recommendations. In addition, the 'Swedish maternity care crisis' continues to attract media attention, with recurrent reports of overcrowded labour wards, overworked midwives, and of women feeling mistreated during labour and birth.

Aim The overall aim of this research project was to explore the implications of a medicalised birth culture for birthing women and midwives in a Swedish context. Through a mixed-methods approach, combining qualitative and quantitative methods, focus was placed on women's expectations before birth; their preferences for and actual use of pain relief; rates of intrapartum interventions; women's level of satisfaction with the birth experience; their written evaluations of the birth experience; and interactions between women and midwives in the birth room. The project was informed by a gender perspective, aiming to illuminate the impact of gender on childbirth experiences and practices.

Methods The thesis is based on four papers. Data collection for Papers I, II, and III consisted of birth plans, data from medical records, and written birth evaluations. Four hundred women were invited to participate, of which 259 consented. Out of these, participants were selected according to the specific aims of each study. Thus, Study I included women with birth plans (n=132), and data was analysed through qualitative content analysis. Study II was a cross-sectional study analysed by means of descriptive statistics and logistic regression, and included women with a birth plan (n=129) and without a birth plan (n=110). Study III included women with written birth evaluations (n=190), and the analysis consisted of word frequency and thematic analysis. Finally, Study IV was a focused ethnography, gathering data through participant observation during eight births, as well as interviews with the women who gave birth and with the midwives who assisted them (n=16). Data was analysed by thematic analysis.

Results Women and midwives alike had similar ideals of childbirth, many valorising natural childbirth and a woman-centred, relational care, based on trust and reciprocity. When comparing women's expectations and wishes for pain relief as expressed in their birth plans, with actual pain relief used, first-time

mothers with birth plans used more pharmacological pain relief than intended, and 93.6% of them had some form of intrapartum intervention, such as induction or augmentation of labour, internal foetal monitoring, or urinary catheterisation. Regardless of having a birth plan or not, primiparas used more pain relief, had more interventions, and were slightly less satisfied with their birth experiences than multiparas: VAS 7.4 vs 8.4 respectively. In their written birth evaluations, written within 48 h of birth, women were mostly satisfied with the support they had from the midwife. In a manner that is suggested to affect their birth experiences, women displayed examples of a gender-normative behaviour, being thankful, sympathetic, and belittling of their own feelings or requests, despite the fact that some women felt that they had not had the support or overall birth experience they had hoped for. In the interaction between women and midwives in the birth room, the midwives continuously bridged the gap between the medical and the social models of care, integrating medicalised practices into midwifery care. Although very passionate about their work, low staffing, hospital hierarchies, and working against their ideological convictions came with a price, at times leaving midwives with feelings of inadequacy and a bad conscience, when trying to meet the needs of the birthing women and colleagues, as well as the demands of the work place.

Conclusion Women's birth choices and experiences and midwives' working conditions are closely intertwined, and mirror contemporary discourses not only on childbirth, but also on women's rights and position in society. The present work illustrates that women's and midwives' birth ideals, i.e. relational, one-to-one care, incidentally supported by a growing body of evidence, is in conflict with a medicalised and efficiency-driven labour care organisation, leading to job strain for midwives, and a fragmented and interventionist birth care for women. More attention needs to be drawn to the impact of societal and cultural gender norms on contemporary birth practices. There is also the need to recognise birth as existential, emotional, and potentially empowering experiences for women. To achieve this, women need to be informed of, and offered, choices in the way they give birth. At the same time, midwives must be given the time and the support of the organisation to be able to practice 'watchful attendance', acknowledging the values of relational care and emotional support.

Keywords Birth experiences, birth plan, birth setting, childbirth, cross-sectional study, femininity, feminism, focused ethnography, gender perspective, intrapartum interventions, medicalisation, midwifery, qualitative methods, women

Sammanfattning på svenska

Ur ett globalt perspektiv är Sverige ett av världens säkraste länder att föda och att födas i. Svenska barnmorskor arbetar självständigt med högkvalitativ vård både under graviditet och förlossning och läkare tillkallas när något avviker från det normala. I likhet med andra höginkomstländer finns en medikaliseringstrend av svensk förlossningsvård där interventioner som igångsättning av förlossning, värkstimulerande medel, ryggbedövning och kejsarsnitt ökar. Dessa ingrepp är ibland nödvändiga för en säker förlossning, men stora variationer mellan olika sjukhus och regioner tyder på att handläggandet av en förlossning är lokalt betingad och i en del fall beror på bristande följsamhet till nationella riktlinjer. De goda utfallen till trots synes återkommande rapporter i media om överfulla förlossningsavdelningar, kvinnor som i värkarbete hänvisas till andra sjukhus, kvinnor med traumatiska förlossningsupplevelser, samt om stressade och utarbetade barnmorskor.

I den här avhandlingen utforskas konsekvenserna av en ökad medikalisering av förlossningsvården för de födande kvinnorna och för barnmorskorna. Detta har gjorts genom fyra delarbeten där första studien handlade om att med kvalitativ innehållsanalys analysera kvinnors förlossningsplaner med önskemål inför förlossningen. Den andra studien är en tvärsnittsstudie där kvinnornas önskemål vad gäller smärtlindring enligt förlossningsplanen jämfördes med faktisk användning av smärtlindring enligt kvinnornas journaler. Där gjordes även en jämförelse mellan kvinnor med och utan förlossningsplan gällande smärtlindring, interventioner under förlossningen samt hur nöjda kvinnorna var enligt en skattning på en skala mellan 0-10 (VAS). I den tredje studien analyserades med tematisk analys kvinnors skriftliga utvärderingar av förlossningen genom att undersöka vilka ord de använde mest frekvent. Den fjärde studien undersökte samspelet mellan kvinna och barnmorska under förlossningen genom deltagande observation. Kvinnornas och barnmorskornas upplevelser följdes upp med intervjuer efteråt och materialet analyserades med tematisk analys. Ett genusperspektiv genomsyrar avhandlingen där kvinnors förväntningar och upplevelser samt barnmorskors erfarenheter och handläggande av förlossningen, analyserats med avseende på genus-konstruktioner och maktförhållanden.

Datainsamlingen för Studier I, II och III bestod av förlossningsplaner, journaldata och skriftliga förlossningsutvärderingar. Fyrahundra kvinnor tillfrågades om deltagande i studien varav 259 tackade ja. Av dessa inkluderades i Studie I 132 kvinnor som skrivit en förlossningsplan. I Studie II inkluderades 239 kvinnor: 129 kvinnor med förlossningsplan och 110 kvinnor utan. I Studie III inkluderades 190 kvinnor som skrivit en utvärdering av sin förlossning inom 48

timmar efter förlossningen. I Studie IV observerades åtta kvinnor och åtta barnmorskor i samband med förlossningen och uppföljande intervjuer genomfördes med samtliga inom två dagar efter förlossningen.

Studierna visade att kvinnor med förlossningsplaner i första hand önskade en naturlig förlossning med främst icke-medicinsk smärtlindring, men att särskilt förstföderskor använde mer medicinsk smärtlindring än de tänkt. Det visade sig också att 93,6% av förstföderskor med förlossningsplan hade någon form av intervention under sin förlossning, till exempel igångsättning, värkstimulerande dropp, eller inre fosterövervakning. Det var ingen större skillnad på användandet av smärtlindring, antal interventioner eller nöjdhet beroende på om kvinnan hade skrivit en förlossningsplan eller inte. Förstföderskor överlag använde mer smärtlindring, hade fler interventioner och var något mindre nöjda jämfört med omföderskor: VAS 7,4 jämfört med VAS 8,4. De skriftliga utvärderingarna visade att det kvinnorna var mest nöjda med var stödet från barnmorskan. Med en genusteoretisk förståelse gjordes tolkningen att föreställningar om genus och egenskaper kopplade till femininitet påverkade utvärderingarna, där kvinnor var tacksamma och förstående och förminskade sina egna känslor och behov, trots att många inte fått den förlossningsupplevelse de förväntat sig. Observations- och intervjustudien visade att barnmorskornas ideal om födandet som en naturlig och normal process och om hur de ville stötta de födande kvinnorna påverkades av låg bemanning och ett effektivitetstänk i organisationen. För barnmorskornas del kunde det leda till frustration, stress och dåligt samvete när de försökte tillgodose både de födande kvinnornas och organisationens behov, samt stötta sina kollegor.

Avhandlingen kan med sitt genuskritiska perspektiv bidra till att tydliggöra hur födande kvinnor och barnmorskor anpassar sig till en medikaliserad förlossningsvård som inte alltid gynnar dem. För en förlossningsvård på kvinnors villkor bör kvinnocentrerad vård eftersträvas, där kvinnor kan göra informerade val och barnmorskor får utrymme att praktisera one-to-one care.

Sökord Barnmorska, feminism, förlossning, förlossningsplan, förlossningsupplevelse, förlossningsvård, genuskonstruktion, genusperspektiv, intervention, kvalitativ metod, kvinna, medikalisering, observation, tvärsnittsstudie

Definitions

Midwife – In line with the International Confederation of Midwives (2017), Swedish midwives are trained to work independently to give the necessary support, care, and advice during pregnancy, labour, and the postpartum period; to attend births on the midwife's own responsibility; and to care for the newborn. Moreover, their field of work also includes counselling and giving advice on contraception; testing for and treating certain sexually transmitted infections; promoting sexual health; performing cervical screening tests; carrying out abortions; providing antenatal education; and counselling women during menopause, to name a few (The Swedish Association of Midwives, 2018). In this thesis, when referring to midwives or midwifery, I am primarily referring to those working within labour care, while nonetheless recognising and appreciating the many different competencies of the midwife and the various branches of midwifery.

Woman – Among the central assumptions of this thesis is that patriarchal values and biomedicine, through the process of medicalisation, promote the view of the birthing woman's body as deficient and in need of surveillance and management, thus giving rise to an interventionist labour care, precisely because birthing persons most often are women, or at least conform to the gendered notion of what it entails to be a woman. In *Women Confined*, Ann Oakley (1980, p. 5) writes that 'The trouble with childbirth (sociologically speaking) is that it only happens to women', and that 'The trouble with women is that they are also people'. While I welcome the day when gender does not negatively affect equality between women and men, we are not there yet. Thus, recognising the importance of inclusion, and also acknowledging that not all of those born biologically female identify as women, labelling a birthing woman a birthing person could risk concealing oppressive gender structures towards women on the basis that they are women. When referring to 'a woman' in this text, I use the biological definition and mean a person equipped with a uterus.

Although most births in Sweden take place in hospitals, assigning birthing women a patient role forwards a medicalised view of birth, making a predominantly normal life event into a medical event, with connotations of illness and disease, and to a certain extent, of compliance and subordination. I have thus made the conscious choice to avoid the word 'patient' for a pregnant or birthing woman.

With 99.7% of Swedish midwives being women, and since all midwives who participated or were mentioned in the studies were women, I have consistently used the pronouns 'she/her' when referring to a midwife.

Original papers

This thesis is based on the following papers:

Paper I. Westergren, A., Edin, K., Walsh, D., Christianson, M. (2019). Autonomous and dependent – The dichotomy of birth: A feminist analysis of birth plans in Sweden. *Midwifery*, 68, 56–64. https://doi.org/10.1016/j.midw.2018.10.008

Paper II. Westergren, A., Edin, K., Lindkvist, M., Christianson, M. (2020). Exploring the medicalisation of childbirth through women's preferences for and use of pain relief. *Women and Birth: Journal of the Australian College of Midwives,* 34 (2), e118-e127. https://doi.org/10.1016/j.wombi.2020.02.009

Paper III. Westergren, A., Edin, K., Christianson, M. (2021). Reproducing normative femininity: Women's evaluations of their birth experiences analysed by means of word frequency and thematic analysis. *BMC Pregnancy and Childbirth*, 21:300. https://doi.org/10.1186/s12884-021-03758-w

Paper IV. Westergren, A., Edin, K., Nilsson, B., Christianson, M. The manifestation of medicalisation – A focused ethnography on woman-midwife interaction and birth practices in two Swedish hospital labour wards. (In manuscript).

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Preface

I would like to share the story behind my choosing of the poem about dangerous coats above. In Swedish, the framework, or cover story, of the academic thesis is called a 'kappa', meaning 'coat', metaphorically signifying the protective covering that encloses the years of scholarly work done by the doctoral student. During one of many seminars with the Graduate School of Gender Studies, to which I have been affiliated during my doctoral studies, Professor Annelie Bränström Öhman gave us the enticing assignment to design our own actual coats, symbolising our cover stories. I instantly saw before me a red, sleek, but sharp-looking coat, tailor-made, classy, and elegant. I saw the colour red representing rage and indignation, but also symbolising an all-encompassing love: a love comprising passion and compassion for our fellow human beings, for all creatures, for nature; a love with the power to heal; a love bringing forth new life. I also saw red as the colour of blood, in my midwife's mind representing fertility, life, and power. Furthermore, my coat was made of wool – warm and a little rough and itchy on the outside, but on closer scrutiny, it had a soft lining on the inside, facilitating a perfect fit. My coat also had pockets, lots of them, discreetly sewn in so as not to overpower its smart design, but nevertheless with room for seditious messages.

Seditious or not, the first message of this thesis is on the front page in the shape of a painting by my dear friend Bodil Frey, 'The Creation of Woman'. In her version of Michelangelo's 'The Creation of Adam', she has replaced the original characters with women. Leaving religion aside and not necessarily placing matriarchy over patriarchy, the painting (apart from being wonderful) serves to show how certain ideas or beliefs become so deeply ingrained that they are taken as objective truths, and only a complete change of perspective, however far-fetched or seemingly absurd at first glance, may open up for alternative ways of looking at and interpreting the world.

One such belief is that childbirth is inevitably painful, dangerous, and in need of various interventions in order to keep it safe. While there are times when this description of birth is accurate, it is not always so. Paradoxically, in our privileged part of the world, where the risk of being seriously injured or dying in childbirth is extremely low, birth is still treated as one of the riskiest things a woman can do. One could argue that it is precisely this risk rhetoric that makes birth safe, but as will be discussed in this thesis, this is not entirely true. I do not wish to belittle or disqualify the highly proficient obstetrical care in this country, which has greatly improved birth outcomes. On a personal note, I am well aware of the privilege of having immediate access to advanced medical care, and I am forever grateful to modern medicine and skilled surgeons, without which my youngest child and I would not be here today. But we need to talk about birth from other perspectives than risk alone. We need to talk about birth as potentially sensual, existential, and empowering, and recognise it as the life-altering event that it is, changing the birthing woman to the core, and also deeply affecting those around her. But mostly, we need to talk about birth as

something that does not just happen to women, but something that women actively do.

Among other things, this thesis aims to do that, and it would never have seen the light of day had it not been for my insatiable fascination with pregnancy and birth. In a way that probably affected me more than I realised, my late mother always spoke warmly of her own births, despite them involving mandatory enemas, shaving, episiotomies, giving birth on her back with her legs in stirrups, and sometimes being shouted at by harsh midwives. In spite of this, she still conveyed something of the magic, beauty, and sanctity of childbirth.

Having the good fortune of being the mother of six wonderful children myself, I have spent 15 years of my life either pregnant or breastfeeding. Through my pregnancies and births, and certainly through motherhood, I have encountered and explored parts of myself that I did not know existed. Focusing for a moment on the births themselves, I would be remiss not to recognise the immense impact they have had on me. This is not to say that my births have been particularly easy – I have been through hours of excruciating pain; I have been neglected and not cared for when I needed it the most; I have been subjected to various interventions, poked, prodded, and penetrated, at times without my informed choice; I have been withheld information concerning my own body; I have been 'put in my place' by arrogant midwives and doctors, leaving me feeling treated like something less than human, or should I say like a woman?

Needless to say, my view of childbirth would have been rather dismal based on those experiences alone. Fortunately, two of my births have been extremely empowering experiences that I will cherish and draw strength from for the rest of my life. The key to these experiences had nothing to do with how prepared I was before birth, the amount of physical pain, or even the place of birth, but all to do with feelings of trust, mutuality, control, and respect. I am eternally grateful to the midwives who assisted me during those births.

Having experienced positive and powerful births, I wanted to convey this to other parents to be. Thus, I first became a doula and a childbirth educator, and then a midwife. My passion for childbirth, in combination with my love of writing and critically analysing just about everything from various perspectives, then brought me into academia. Becoming an 'academidwife' has presented me with the amazing opportunity to fully immerse myself in two of my favourite topics: childbirth and women's/human rights.

With the disclaimer that one size does not fit all, I hereby invite you to try on my coat, dangerous if you will, with pockets full of, if not seditious messages, at least some nibbles for thought.

Umeå, June 2021

Agneta Westergren

It is a stretch, but like your perineum,
your mind can be huge and fit almost any idea or thought.
If you have not been told otherwise.
~Unknown~

Introduction

The room is gradually filled with the distinct sweet scent of amniotic fluid, slowly dripping down from a pool between the woman's legs onto the floor. The midwife, who has just performed the amniotomy (or 'broken the waters'), tells the woman that she can use the nitrous oxide if she wants to, switches it on, and asks me to keep an eye on her as she leaves the room to check on another woman in labour she is also assisting. My intention to shadow the midwife and stay with her at all times during my ethnographic field work has just presented me with a delicate dilemma. Should I follow the midwife as planned and leave the woman with her waters now forming a substantial puddle on the floor, or should I stay put? In a split second I choose the latter, and as I fetch the woman a pad, mop up the fluid, and instruct her on how to inhale the nitrous oxide, thoughts about interactions, interventions, power, and ethics in the labour room, as well as ethical principles in research, run through my head.

~Field note from a labour ward, AW~

The paragraph above is an excerpt from the field notes I wrote while conducting a focused ethnography in a labour ward, observing woman-midwife interactions and birth practices (further described in Paper IV). In a way, this reflection captures the essence of my thesis: what happens to childbirth as a transformative, existential, and potentially empowering event for women, when midwifery, for various reasons, becomes task-oriented, a 'doing to' over a 'being with' the woman, placing focus mainly on a healthy mother and baby as a goal, and not always considering the journey to get there?

The observation above is not to pass judgement on the individual midwife concerned. She was just doing her job, performing a task ordered by the obstetrician, making sure labour was progressing according to plan. The woman who had had her waters broken was coping well, and the midwife had another woman, who was terrified of birth, to tend to in the room next door. Viewing me as a colleague, although I was on site as a researcher, the natural thing to do in this situation was to ask me to briefly take over the woman's care.

But midwives do not always have an extra pair of hands, and interventions during childbirth are increasing, despite midwives' struggle for one-to-one care, focusing on one birthing woman at a time, which is known to lower the rate of intervention and increase women's satisfaction with the experience. Routinely interfering in the physiological process of birth, which means doing something to, on, or in the

woman's body, has become the norm rather than the exception, paradoxically at times increasing the risks rather than reducing them. This needs to be discussed in terms of what it entails for the women who give birth, as well as for the midwives who, in the Swedish setting, are primary caregivers in a birthing culture where routine intervention is the norm.

It is my understanding that practices and attitudes around childbirth are socially produced and culturally constructed, dependent on several factors such as history, culture, place, and time. As women's bodies host the biological processes of pregnancy and birth, the societal understanding of reproduction is closely linked to prevailing ideas about women's position in that society. Thus, this project is informed by a gender perspective along with the concept of medicalisation as a theoretical framework, which is further described in that section.

Although the medicalisation and hospitalisation of birth was a trend in most Western countries from the beginning of the 20th century onwards, and entailed major changes for the concept and management of birth, it is important to keep in mind that there are differences between countries. Lena Milton, a Swedish historian researching the hospitalisation of birth in the Swedish context, likens labour care in the USA to 'something of a laboratory for obstetricians and researchers' (Milton, 2001, p. 16). She further argues that even though childbirth was also medicalised in Sweden, it was not pathologised as it was in the USA (Ibid.). Therefore, the American feminist critique of the medicalisation of childbirth and of women's bodies is substantial, but perhaps not entirely applicable to the Swedish setting. Nevertheless, as childbirth in Sweden becomes increasingly medicalised, the American feminist critique can provide a useful tool for the analysis of Swedish labour care.

To set the scene for the reader and to describe the research problem more thoroughly, the background section provides information on historical events and developments that have influenced views of women's bodies and childbirth practices, predominantly in Western countries. The Swedish labour care setting is described from both a historical and a contemporary perspective. The next section presents the theoretical framework, where feminism, gender constructions, and medicalisation are discussed. Subsequently, the different methodological approaches for each paper are described, followed by a discussion of the main findings.

Background

In the beginning there was birth

Historically and across countries and cultures, visual representations of birth, such as drawings, paintings, sculptures, and textiles, have depicted birth as a woman-centred event. Typically, the birthing woman is placed in the centre, surrounded and supported by a number of other women. Commonly seen in these representations is the woman giving birth in an upright position – standing, squatting, sitting, or kneeling. Often, the birthing woman is supported from behind by one person, and there is another person in front of her, catching the baby (Carty, 2017).

It has been argued that evolution has conditioned women to seek assistance during childbirth, unlike non-human primates, who seek solitude (Rosenberg & Trevathan, 2002). The hypothesis of the obstetrical dilemma, coined by Washburn (1960), posits that when early humans started walking upright, the pelvis became narrower, and as their brains and skulls became larger, babies had to be born earlier in order to fit through the birth canal (Washburn, 1960), resulting in newborns that are less developed than the young of other animals. The potential risk for a more difficult, painful, and dangerous birth because of the mismatch between the width of the woman's pelvis and the size of the baby's head is thus suggested as the motivation for birthing women to surround themselves with people, with natural selection leading to reduced mortality if the birthing woman has access to assistance (Rosenberg & Trevathan, 2002).

However, the hypothesis of the obstetrical dilemma has been challenged by more recent research. Dunsworth (2018) claims that the hypothesis overestimates risk and underestimates women's bodies, and suggests that gestational length, or the period of time between conception and birth, has more to do with maternal metabolism than with the size of her hips. When the foetus' energetic needs exceed what the mother can provide, pregnancy ends. Rather than contending that women's bodies are compromised and birth dangerous, the perils and difficulties of childbirth may instead be linked to cultural conditions, such as the effects of malnutrition on pelvic development or the effects of diabetes and preeclampsia on foetal growth (Dunsworth, 2018). According to this line of thinking, the tendency for birthing women to seek companionship may instead be attributed to the emotional and social benefits of continuous support during labour and birth (Bohren, Hofmeyr, Sakala, Fukuzawa, & Cuthbert, 2017).

While both theories will have their supporters, it is interesting to note that the hypothesis of the obstetrical dilemma is based on the belief that women's bodies

are flawed by design, and have been so for some six million years or more. But where did this notion come from? Part of the answer may be found in the development of Western thought and medicine, and in the idea of the body as a machine.

And then there was science

The Scientific Revolution marked the emergence of modern science in Western Europe in the 16th and 17th centuries. Advances in the natural sciences such as astronomy, mathematics, physics, chemistry, and biology brought about fundamental changes in views of nature, body, and society (Brookes Spencer, Brush, & Osler, 2019). At that time, society was dominated by religious ideas, and the general belief was that God was the source of knowledge, which could only be acquired through priests. To tamper with nature was to go against the will of God, and those who did so were labelled immoral and enemies of God (Russell, 2013).

René Descartes (1596-1650), a French philosopher, mathematician, and scientist, managed to lift the religious embargo on knowledge by introducing the theory of mind-body separation. The mind-body problem, addressing the interaction between the two entities, had been in existence for several thousand years, and is found in Ancient Egyptian, Buddhist, and Ancient Greek philosophy (Taylor, 2010). Descartes argued that the mind and body are connected but separate (dualism), the mind representing thinking and the spiritual world, and the body representing the physical world, a machine consisting of separate, non-interrelated parts and governed entirely by natural laws (Cahill, 2001; Taylor, 2010). The philosophical separation of mind and body was fundamental for studying illness and disease in that it allowed for locating ailments in the physical body, thus avoiding interference with the superior cultural and spiritual essence of the mind (Russell, 2013).

The separation of mind and body facilitated the emergence of modern medicine, as it made possible the meticulous study of the human body. With greater knowledge of human anatomy and physiology came the formation of discrete groups of medical practitioners: physicians, surgeons, and apothecaries. As they organised themselves into one occupational group – doctors – the medical profession gradually gained social and political power, marginalising other practitioners and healers, traditional midwives included (Cahill, 2001; Reiger, 2008).

A gendered and hierarchical dualistic thinking can be traced back to the Greeks, but it has been argued that the Cartesian dualism has reinforced the effects of the symbolic opposition between male and female (Prokhovnik, 1999). The advancement of modern medicine was thus facilitated by an already prevailing

dichotomous thinking, where men were associated with the higher values of the social/culture, mind, reason, and action, while women were assigned the less valued attributes of biology/nature, body, emotion, and passivity (Annandale, 2009). With the new manufacturing processes that precipitated the Industrial Revolution in the late 18th century, the idea of the body as a machine was further reinforced. The following excerpt from a 17th-century text shows the imagery of machines applied to the human body (Synnott, 1993, in Russell, 2013, p. 9):

> 'Whoever examines the bodily organism with attention will certainly not fail to discern pincers in the jaws and teeth; a container in the stomach; water-mains in the veins, the arteries and other ducts; a piston in the heart; sieves or filters in the bowels; in the lungs, bellows; in the muscles, the force of the lever; in the corner of the eye, a pulley, and so on.'

Thus, medicine, including the speciality of obstetrics, became male-dominated and based on a scientific and mechanistic approach, underpinned by the metaphor of body as machine, and valuing an objective, distanced approach to knowledge (Russell, 2013). This is known as the rise of biomedicine, further described below, which came to be the dominant discourse of Western health care practice over the course of the 19th century. Robbie Davis-Floyd (2001), an American anthropologist specialising in childbirth, midwifery, and obstetrics, argues that the male body came to be viewed as the prototype of the properly functioning body-machine, and the female body, deviating from the male standard, came to be regarded as defective and in need of manipulation in order to function. Like other bodily processes, childbirth came to be viewed as mechanical. Davis-Floyd (2001, p. S6) writes:

> 'The hospital became the factory, the mother's body became the machine, and the baby became the product of an industrial manufacturing process.'

Martin (2001) adds that in this process, the doctor is seen as the manager. And as childbirth was during the 20th century increasingly re-sited from the private, female world of women's homes to the public, male world of the hospitals, the 'management' and social experience of birth changed dramatically for both birthing women and midwives (Hunt & Symonds, 1995).

The hospitalisation and medicalisation of childbirth

From women's homes to hospitals

Through a series of complex socio-political processes in the Western countries, involving the discrediting of midwives, medical discourses on risk, and women's demands for safe and pain-free births, a rather rapid change of setting for childbirth took place over the course of less than 100 years. Today, almost all European women give birth in hospitals (Sandall, 2015). Below is a short account of this transition.

The woman-centredness of birth and birth support is visible in the meaning of the word for 'midwife' in different languages. In early English it means 'with woman'; the French term for midwife is 'sage femme', meaning 'wise woman', and the Danish and the Norwegian midwife is called 'jordmor', or 'earth mother' (Wagner, 1998). In many cultures, the woman's body has been or is still considered unclean through menstruation and the 'messiness' of childbirth (Filby, McConville, & Portela, 2016). Because midwives were/are mainly women caring for other women, and through birth exposed to bodily fluids like blood, sweat, tears, and other secretions, midwifery has historically been considered low status, carried out in the hidden and private world of women's homes (Filby et al., 2016; Hunt & Symonds, 1995; Öberg, 1996).

In the 17th century, a time of wars on the European continent, crop failure, starvation, and disease, there was an increased need for state control over reproduction, with the cynical aim of meeting the demands for new soldiers for the war machine (Höjeberg, 1991). The Industrial Revolution in the UK in the 18th century also contributed to maternal and child welfare becoming of interest for the State, as it was connected to the value of a healthy and numerous population as a national resource to meet demands for factory workers and also human military material for the maintenance of the empire (Davin, 1978).

Through the legacy of Cartesian dichotomies and patriarchal hierarchies, doctors, who were most often men, managed to gradually position themselves as the scientific, prestigious, and legitimate alternative to midwives, who were made out to be ignorant and dangerous old women (Reiger, 2008). The danger of these wise women/midwives had presumably to do with the fact that they were knowledgeable not only about childbirth, but also about contraception and abortion. This control over reproduction made them powerful and feared by the Christian Church, and they were liable to charges of witchcraft in the Middle Ages (Cahill, 2001; Hunt & Symonds, 1995). Through compulsory schooling and licensing, midwives were placed under formal control by the State in an effort to limit unskilled practice and to prevent the use of 'sorcery' and 'witchcraft' in

medicine. While these measures raised the status of midwifery and increased midwives' medical competence, they were also restrictive on midwives' independence (Donnison, 2011).

In the beginning of the 20th century, midwife-assisted home births had lower mortality rates than hospital births assisted by doctors, mainly due to puerperal sepsis, which spread more easily in institutions (Hunt & Symonds, 1995). However, births deviating from the norm were more often referred to a doctor and admitted to hospitals, which may also explain the higher rates of death in hospital deliveries (Ibid.). In the UK, socioeconomically privileged women still pursued hospital births, which may be explained partly by the equation of medicine and obstetrics with superior male scientific knowledge, and with modernity, progress, and development (Hunt & Symonds, 1995; Reiger, 2008; Wagner, 2001). Also, doctors possessed instruments and surgical techniques which were beneficial in the event of complications; and with the discovery of sulphonamides and antibiotics in the 1930s, maternal mortality decreased even further, and hospitals became a more appealing option for birthing women.

Another reason for women to choose a hospital birth had to do with access to pain relief and a desire to control their birth process in the context of 'the oppressive circumstances of women's lives', with the norm being one pregnancy every other year, with uncertain outcomes for both woman and baby (Riessman, 1983, p. 52). With time, women of lower socioeconomic status also started giving birth in hospitals, as they offered an 'escape from the responsibilities and pressures of domestic life', making access to a hospital birth an issue of social equality (Hunt & Symonds, 1995, p. 12).

By the prerogative of science, medicine, race, class, and gender, white, male obstetricians became in charge of the 'management' of birth in the hospital setting in Western countries. In some countries, such as the USA, midwifery was almost completely abolished through the hospitalisation and medicalisation of childbirth, and midwives became obstetric nurses and obstetrician's assistants (Riessman, 1983; Wagner, 1998). In other, mainly Western European countries, midwifery prevailed, but under the new conditions, the profession inevitably had to change. Instead of assisting women in their homes, midwives started practising in hospitals.

Due to the presumed uncleanliness of childbirth in combination with traditional gender stereotypes, midwives, who were mainly women, were considered naturally apt for emotional care work, with their connection to the corporeal and their inherent qualities of empathy and patience (Hunt & Symonds, 1995). Thus, in hospitalised birth, midwives were still the primary caregivers for women having normal births, but now under the close scrutiny of doctors, who delineated

and demarcated the working practices of midwifery (Hunt & Symonds, 1995; Öberg, 1996).

Medicalisation and intervention

The medicalisation of childbirth is a double-edged sword. On the one hand, there were the doctors using their growing political and cultural authority to redefine birth as a dangerous and pathological event, who helped shape popular perceptions of childbirth, associating doctors and hospitals with safety (Beckett, 2005). Some of the innovations that have arisen in relation to childbirth may be seen as a reflection of a biomedical and mechanical view of women's bodies and of labour and birth, and the efforts of some physicians to control it. On the other hand, there were first-wave feminists who saw the right to pain relief as a political issue, arguing for women's right to relieve their suffering, and gain control over their own bodies and reproductive rights (Riessman, 1983).

Along with the hospitalisation of birth, experienced obstetricians' 'watchful expectancy', i.e. closely monitoring but only intervening when necessary, was replaced by an interventionist one-size-fits-all approach, and the increased use of pain-relieving drugs and various tools for the management of normal birth followed (Donnison, 2011). Examples of some of the most influential are presented below, and it is important to note that each has its benefits and disadvantages.

The forceps

The invention of the obstetric forceps in the 17th century preceded the hospitalisation of childbirth, but represents an important milestone in the management of birth. In cases of pelvic deformity due to starvation or rickets, leading to obstructed labour, the forceps enabled delivery in cases where both woman and child otherwise would have been lost (Dunn, 1999). Since custom discouraged the use of instruments by midwives, the forceps enhanced the position of medical men in the context of childbirth (Donnison, 2011). The French-English Chamberlen family is recognised as the inventor of the forceps, and for 150 years they kept the instrument a family secret, monopolising its use and carrying it to births in a lined box, allowing no one to see it so that it would not be replicated (Dunn, 1999). Showing a lack of concern for women's well-being, especially poor and working-class women, the Chamberlen family used the forceps selectively and for a high price (Belu, 2018).

The withholding of a device that had the potential to save the lives of many, from both midwives and birthing women, is misogynistic and demonstrates a lack of recognition of midwifery. In the history of childbirth, the forceps have become a symbol of the gendered and hierarchical power struggle between male doctors

and female midwives and their respective claims for authority (Öberg, 1996). Belu (2018) holds that the invention and later overuse of the forceps marks the beginning of modern Western childbirth, changing birth from a woman-centred process to a technology-centred one, and causing women to lose control over their birth experiences. Today, the forceps have in many settings been replaced by vacuum extraction, and in Sweden they are used mainly, though not exclusively, by obstetricians.

The partogram

In 1954, Emanuel A. Friedman, an American obstetrician, developed the partogram, a graphical record of labour progress where cervical dilation and is plotted against time. Basing his results on a study of 100 women, he defined normal labour progress as the dilation of the cervix at a rate of 1 cm/hour (Friedman, 1954). The partogram was further developed by Philpott and Castle (1972), who introduced alert and action lines in order to know when to initiate interventions in a prolonged and/or obstructed labour, and thus avoid complications. The partogram has given rise to the widely accepted notion that all birthing women dilate in the same manner and at the same rate, and that should they fail to meet this standard, they should have their labour augmented through the use of amniotomy (breaking of the waters) and/or an intravenous drip of synthetic oxytocin to enhance uterine contractions, or terminated by a cesarean section (Oladapo et al., 2017).

In response to increasing interventions in childbirth, there have been studies questioning the idea of the partogram's linear portrayal of labour, fearing that it has misclassified women who labour slowly but nevertheless progress normally, and as a result subjecting them to unnecessary labour interventions. These studies have reported findings that women dilate more slowly and in a more diverse manner than fits the model, and therefore do not recommend routine use of the partogram for the individual woman (Lavender, Cuthbert, & Smyth, 2018; Lundborg et al., 2020; Oladapo et al., 2017; Oladapo et al., 2018; Zhang et al., 2010).

Active management of labour

Another method still commonly used in labour care is the active management of labour. Developed in 1969 by Irish obstetrician Kieran O'Driscoll, its aim was to reduce prolonged labour in primiparas and to ensure that every woman was delivered within 24 hours (O'Driscoll, Jackson, & Gallagher, 1969). O'Driscoll proposed that prolonged labour gave women 'mental anguish' and involved a higher risk for caesarean section that may 'produce a permanent revulsion to childbirth', and that it also posed a risk for 'the survival and subsequent neurological development of the infant' (O'Driscoll et al., 1969, p. 477). While there is evidence to support this idea, it has also been claimed that the method

came about as a response to rising numbers of hospital deliveries and staff shortages, prompting a need to speed up labour (Thornton, 1997). As the method proved successful in shortening labour, in just a few years the timeframe for labour was reduced to 12 hours (O'Driscoll, Stronge, & Minogue, 1973).

Active management of labour entails a series of interventions. After establishing that the woman is in active labour, an amniotomy is performed, which means puncturing the amniotic sac with a crochet-like, long-handled hook during a vaginal examination. If cervical dilation does not progress according to the partogram's one centimetre per hour, oxytocin infusion is advocated to augment contractions. Taking a stand against colleagues who took a more expectant approach to childbirth, O'Driscoll and his co-authors (1969, p. 479) state their opinion on who is to be in charge in the delivery room, confirming the mechanistic approach to childbirth described above:

> 'The obstetrician assumes direct responsibility and forsakes the role of the passive observer for that of active director, controlling the course of labour instead of waiting in the hope that it may conclude within a reasonable period of time.'

With the promise of early delivery, pain relief was not deemed necessary, as imposing a timeframe on labour would help women cope better with pain (O'Driscoll et al., 1973). However, no woman was to be left unattended, and a personal nurse was therefore assigned for one-to-one continuous support until the baby was born. Today, there is evidence that women experience contractions augmented by administration of synthetic oxytocin as sharper and harder to handle than contractions initiated by endogenous oxytocin (Uvnäs-Moberg et al., 2019). There is also evidence that continuous support shortens labour and reduces the experience of pain (Bohren et al., 2017). Nowadays, in cases of augmentation of labour, epidural analgesia is frequently offered. Regrettably, continuous support is not.

Active management of labour has received heavy criticism, but in a slightly modified form is still used in contemporary labour care. While the method is associated with small reductions in the caesarean section rate, it is highly prescriptive, interventional, and leads to a medicalised birth in which women have less control and satisfaction (Brown, Paranjothy, Dowswell, & Thomas, 2013). In addition, the notion of a standard cervical dilation pattern of one centimetre per hour is non-applicable to most women (Oladapo et al., 2018). Routine amniotomy in labour with spontaneous onset carries a number of risks, and the evidence shows no shortening of the length of the first stage of labour, but a possible increase in caesarean section (Smyth, Alldred, & Markham, 2013). The administration of oxytocin is effective for enhancing contractions for women with slow progress in spontaneous labour, and has been found to shorten labour

by nearly two hours on average. Given the risk-benefit balance, the recommendation is to refrain from routine use of oxytocin during spontaneous labour (Bugg, Siddiqui, & Thornton, 2013).

Cardiotocography

Listening to the foetal heart rate as a way to assess foetal wellbeing has been a routine part of labour and birth care since at least the early 19th century (Alfirevic, Devane, Gyte, & Cuthbert, 2017). The heart rate can be monitored either intermittently or continuously using a foetal stethoscope (Pinard), a Doppler ultrasound device, or by a cardiotocograph (CTG). The first CTG was developed in 1968, using ultrasound to record changes in the foetal heart rate and their relation to the uterine contractions. This is facilitated by two transducers applied to the woman's abdomen and kept in place by two belts, and then connected to a machine, the CTG monitor. For continuous heart rate monitoring, an electrode is screwed into the foetal scalp, which requires a spontaneously or artificially ruptured amniotic sac. The foetal heart rate and the contractions can be viewed on a screen or on a printout.

CTG during labour is associated with reduced rates of neonatal seizures, but no clear differences in cerebral palsy, infant mortality, or other standard measures of neonatal wellbeing. CTG is however associated with an increase in caesarean section and instrumental vaginal birth (Alfirevic et al., 2017). In addition, continuous CTG may restrict the woman's mobility and make her for example unable to use a birthing pool, which in turn may impact on her coping strategies and choice of pain relief. It has also been argued that as CTG needs constant interpretation, caregivers (and partners) may focus more on the machine than on the needs of the birthing woman (Alfirevic et al., 2017).

Caesarean section

In 2015, an estimated 21.1% or 29.7 million births globally occurred through caesarean section (CS), almost doubling since 2000. When medically indicated, CS is a life-saving procedure for both women and babies (Boerma et al., 2018). However, rates above 10-15% are considered excessive with no evidence of improving mortality rates (World Health Organization, 2015). Although the reasons for increasing CS rates are complex and involve factors related to individual choice, attitudes, culture, economy, and practitioners' fear of litigation, the tendency towards women increasingly giving birth in health institutions is a key driver of the trend (Boerma et al., 2018). The highest rates were found in Latin America and the Caribbean: 44.3% (with the highest global rate of 58.0% in the Dominican Republic), and the lowest rates in West and Central Africa: 4.1%. These figures indicate that many women in the former two regions have unnecessary caesareans, and that women in the latter regions do not have

adequate access to life-saving surgery (Boerma et al., 2018). The obvious global disparities in access to health care are further discussed below.

Although there are limitations to CS studies due to study design and impact of study setting, there is evidence of both short- and long-term health consequences of CS compared to vaginal birth, including a higher prevalence of maternal mortality and morbidity, as well as a higher risk for adverse outcomes in subsequent pregnancy (Sandall et al., 2018). There is also emerging evidence of an altered neonatal physiology for babies born via CS, due to different hormonal, physical, bacterial, and medical exposures, as well as an altered immune development and increased likelihood of allergy, atopy, asthma, and reduced intestinal gut microbiome diversity (Ibid.). However, there is a need for larger-scale longitudinal studies to establish causality and effects later in life.

There is a fear that junior physicians have become experts in caesarean section but are losing the wider art of obstetrics and assisted vaginal birth (Boerma et al., 2018). However, there is also the matter of addressing women's sometimes iatrogenic fear of vaginal birth after a previous traumatic one, and that in some countries it has become fashionable and considered 'modern' or safer to deliver without labour (The Lancet, 2018).

Pharmacological pain relief

Before hospitalisation, opium and a variety of folk medicines and remedies were used for pain relief in childbirth, although there were objections on religious or quasi-religious grounds from clergy and medicine, since labour pain was viewed as punishment for Eve's surrender to temptation in the Bible (Skowronski, 2015). With time and encouraged by early first-wave feminists, who in the early 20th century demanded effective analgesia and improved maternity care in general, various pharmaceutical techniques for pain relief emerged, such as ether, chloroform, and the so called 'twilight sleep', a combination of morphine and scopolamine, which enabled women to have pain-free births, but with the downside of rendering them unconscious and unaware that they were giving birth (often by forceps), and waking up having no memory of birth at all (Belu, 2018). The twilight sleep was originally a German method but was mainly used in the USA. In 1915, one of its most prominent advocates died under its influence, after which it gradually fell out of use. It is worth noting that many American physicians were concerned regarding the safety of twilight sleep, not only for women but also for the newborns, who were often born drowsy and sometimes needing resuscitation, but continued its use under the demands from women (Skowronski, 2015).

Nitrous oxide, or 'laughing gas', became popular in the early 20th century along with epidural analgesia, a central nerve block technique, which was developed

and refined throughout the 20th century (Skowronski, 2015). Currently the most effective pharmacological method of labour pain relief available, the epidural does have its drawbacks in the form of various potential side-effects (Silva & Halpern, 2010). A Cochrane systematic review of epidural analgesia found that women having epidurals compared to women receiving opioids, although reporting lower pain scores, experienced more hypotension, motor blockade, fever, urinary retention, longer first- and second-stage labour, and labour augmentation through synthetic oxytocin (Anim-Somuah, Smyth, Cyna, & Cuthbert, 2018). In addition to this, a recent study found that women receiving epidural analgesia were more likely to have fever and to need antibiotics, and were half as likely to be breastfeeding at three months postpartum (Newnham, Moran, Begley, Carroll, & Daly, 2020).

Epidural analgesia has been found to have a positive impact on women's birth experiences, making birth manageable and enjoyable, and providing women with a sense of control over labour (Hidaka & Clark Callister, 2012; Jepsen & Keller, 2014; Thomson, Feeley, Moran, Downe, & Oladapo, 2019). However, there is also evidence that the quality of the birth experience is more dependent on the support received during labour than on pain relief, and that women requesting an epidural were less satisfied with their birth experience despite lower pain intensity (Hodnett, 2002; Kannan, Jamison, & Datta, 2001; Thomson et al., 2019). There are also women who do not consider labour pain an entirely negative experience, suggesting that coping with pain is a rewarding experience for some women (Waldenström, Bergman, & Vasell, 1996).

A cascade of interventions

Critics of the increasingly interventionist labour care have argued that interfering with the normal physiology of childbirth often gives rise to a chain of further interventions (Donnison, 2011; Lothian, 2019). Using the partogram as a starting point, Donnison (2011) demonstrates how one intervention is followed by many. Speeding up labour with synthetic oxytocin – if the partogram shows that cervical dilation is not progressing by 1 cm per hour – may produce more violent and more painful contractions than in normal birth (Uvnäs-Moberg et al., 2019). Increased pain may in turn require stronger pain relief, such as epidural analgesia. Epidurals diminish uterine activity, tending to hinder the natural rotation and descent of the baby, and to inhibit the urge to push, thus prolonging labour (Anim-Somuah et al., 2018). In augmenting labour there is also an increased need for continuous foetal monitoring, assessing foetal wellbeing, and avoiding the over-stimulation of contractions, thus increasing the risk for uterine rupture (Clark, Simpson, Knox, & Garite, 2009). Either the monitoring is external, which restricts the woman's movements, which are known to facilitate labour; or it is internal, through the foetal scalp, requiring the artificial rupture of membranes,

in turn affecting the internal rotation of the baby and increasing the risk for infection (Smyth et al., 2013; Walsh, 2012). With prolonged labour and difficulty pushing the baby out, there may be the need to assist the woman with forceps or vacuum extraction, increasing the likelihood of an episiotomy and of obstetric anal sphincter injuries (Wagner, 2001). Assisted vaginal birth in turn requires the woman to be in the supine position, which is known to be more painful for the woman and to reduce blood flow to the baby, due to compression of the inferior vena cava (Donnison, 2011). Moreover, the strict timetable of the partogram increases the risk for 'failure to progress' and caesarean section (Zhang et al., 2010). For newborns, the use of analgesic drugs may result in difficulties with breathing and suckling, delaying breastfeeding and/or necessitating time in the neonatal care unit (Donnison, 2011; Jonas et al., 2009).

Modern childbirth in an international context

In spite of overwhelming evidence of the physical, physiological, psychological, and economic benefits of keeping intrapartum interventions to a minimum, interventions are continuously increasing in high- and middle-income countries (Buckley, 2015; Miller et al., 2016; Peters et al., 2018; Tracy & Tracy, 2003; World Health Organization, 2018). When indicated, these procedures may be life-saving, but when overused, interventions that interfere with the normal process of labour and birth have been found to increase the risk of complications for mother and child (Jansen, Gibson, Bowles, & Leach, 2013; Miller et al., 2016; Romano & Lothian, 2008; World Health Organization, 2018).

In the Lancet series on Maternal Health from 2016, attention was drawn to the disparate conditions of maternal health care around the globe (Miller et al., 2016). Two extreme situations exist: too little, too late (TLTL) and too much, too soon (TMTS). TLTL is historically associated with low-income countries, where maternal morbidity and mortality are connected to inadequate access to services, resources, or evidence-based care (Miller et al., 2016). Every day, approximately 810 women die from preventable causes related to pregnancy and childbirth, such as post-partum haemorrhage, infections, preeclampsia, complications during birth, or unsafe abortions (World Health Organization, 2019).

On the other hand, there is TMTS, historically associated with high-income countries, describing an over-medicalisation of antenatal, intrapartum, and postnatal care. As more women give birth in hospitals or other medical facilities, there has been a rapid increase in practices to 'initiate, accelerate, terminate, regulate or monitor the physiological process of labour' (World Health Organization, 2018, p. 1). In the 20th century, along with advancements in medicine and the creation of a multi-billion dollar industry of technological innovations, normal birth has come to involve a number of interventions, such as

enemas, intravenous lines, repeated vaginal exams, electronic foetal monitoring, artificial rupture of membranes, induction and augmentation of labour, epidural analgesia, forced pushing, episiotomies, cord blood sampling, and caesarean section, to name a few (Miller et al., 2016; Romano & Lothian, 2008).

Regardless of whether maternity care is over- or under-interventionist, either way, women and children are the ones paying the price. Or as Mahmoud F. Fathalla (2012), former president of International Federation of Gynecology and Obstetrics, puts it:

> 'Mothers have often been seen as means and not ends. Health services have been targeted to mothers to help them to produce healthy babies, forgetting that there is a woman in the mother, who also has a right to health and survival. Society has an obligation to fulfil a woman's right to life and health, when she is risking death to give us life.'

Childbirth in the Swedish context

Then...

The history of childbirth in Sweden is somewhat different from that of other Western countries in terms of midwives' independent practice; but as in other countries, there are examples of obstetrician-midwife antagonism, rivalry, and inequality (Höjeberg, 1991). Johan von Hoorn (1662-1724) was a physician also known as 'the father of Swedish obstetrics'. He was a member of Collegium Medicum (The Swedish Board of Physicians) and initiated the first midwifery programme in Stockholm in 1708 in an effort to eliminate traditional midwives, whom he considered 'unscrupulous, drunken old women' (Höjeberg, 1991, p. 86). He also wrote the first Swedish textbook in obstetrics, published in 1697. In comparison, the Swedish midwife Helena Malhiem (1716-1795), certified by Collegium Medicum and the town midwife of Vänersborg, requested in 1758 to become a parish midwife, to train and examine new midwives, and to have her textbook published, the first ever in midwifery science written by a Swedish midwife (Höjeberg & Malhiem, 1995). She was granted permission to train local midwives, but after a few years this right was revoked, and her other requests were also turned down by Collegium Medicum. Helena Malhiem's experience, skills, knowledge in midwifery, and her ambition to improve birth care in Sweden were disregarded, and she died a destitute pauper. More than 200 years later, a copy of her textbook was found in the Swedish National Archives by Swedish midwife and author Pia Höjeberg, who was researching Malhiem's life and struggle for the recognition of the profession of midwifery, and had her textbook justly published (Höjeberg & Malhiem, 1995). The two textbooks are shown in Figure 1.

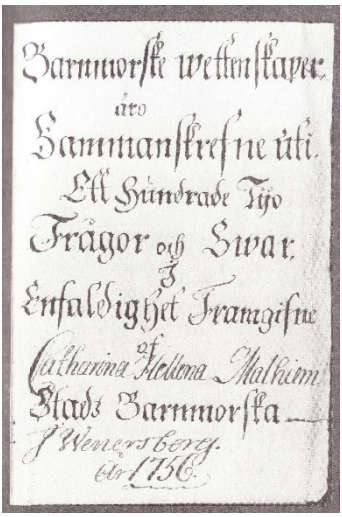


Figure 1 *Two Swedish textbooks on obstetrics/midwifery, the one on the left by obstetrician Johan von Hoorn, published in 1697, and the one on the right by midwife Helena Malhiem, written in 1756 but rejected for publication by Collegium Medicum (Höjeberg, 1991; Höjeberg & Malhiem, 1995; von Hoorn, 1697).* (The picture of Helena Malhiem's book is published with the kind permission of Pia Höjeberg.)

In an effort to lower the maternal mortality rate in Sweden, which in 1751 was 900 per 100,000 live births, Collegium Medicum proposed a national training programme for midwives, which was approved and initiated in 1757 (Högberg, 2004). As midwifery became regulated, traditional midwives were banned from practice and replaced by licensed midwives, who were installed in every parish, trained to handle various birth complications, and were the only midwives in the world to be certified to use forceps and other birth instruments (Ibid.). On the one hand, midwives thus gained a certain degree of freedom to practice independently; but on the other hand, their practice was closely supervised, and they were required to provide the county general practitioner with detailed reports of the women they had assisted in birth (Ibid.).

The installation of community midwives was successful in terms of decreasing maternal mortality rates. In combination with the use of antiseptic technique, home birth with a trained midwife proved safer than hospital birth in the end of the 19th century (Högberg, 2004). The decline in maternal mortality in Sweden thus began prior to the hospitalisation of birth, contradicting the common misconception of hospitals being the safest place for childbirth (Figure 2). Through the development of modern obstetrics, mortality rates continued to fall. At the same time, the emergence of the contemporary welfare state, which brought better living standards through access to clean water, better diet, and better housing conditions, improved public health in Sweden and in the rest of

the Western world during the 20th century, also having a positive effect on maternal mortality rates (Högberg, 2004; Russell, 2013).

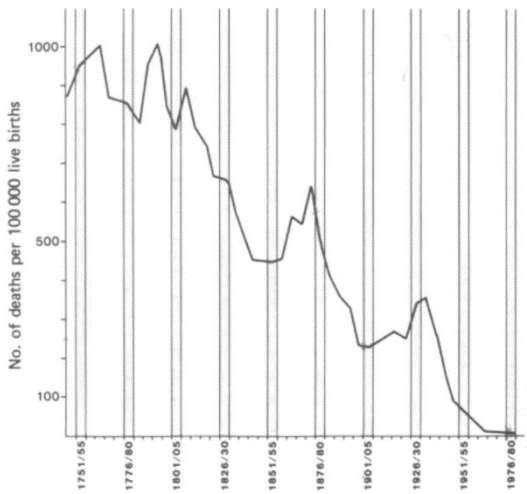


Figure 2 *Maternal mortality rate per 100,000 live births in Sweden for the years 1751-1980* (Högberg & Wall, 1986)

...and now

As in other Western countries, the childbirth setting in Sweden underwent a profound change between the end of the 19th century, when almost 90% of women gave birth at home, and the 1950s, when most women gave birth in hospitals (Thomas & Hildingsson, 2015). Today, 99.9% of women give birth in hospital labour wards. Home births are rare and there are no midwife-led units, like in the UK (Thomas & Hildingsson, 2015). Through an agreement between the Swedish Association of Midwives and the Swedish Society of Obstetrics and Gynecology, midwives and physicians share the mutual task, with their overlapping competencies, of promoting the health of women and children, and to meet the needs of the whole family (SFOG-report, 2016).

To become a midwife in Sweden, a bachelor's degree in nursing is required, and in some midwifery education programmes it is recommended to work as a registered nurse for at least a year before entering midwifery education. The midwifery programme is 1.5 years at advanced level, after which midwives are accredited by the National Board of Health and Welfare, having double degrees and licenses in both nursing and midwifery (Thomas & Hildingsson, 2015).

There are more than five times as many midwives than obstetricians/ gynaecologists per 100,000 women in Sweden, 74 and 14 respectively, although

there is a growing shortage of midwives (Thomas & Hildingsson, 2015). Due to a stressful work environment with understaffing and a lack of resources, one in three midwives has symptoms of occupational burn-out and has considered leaving the profession (Hildingsson, Westlund, & Wiklund, 2013). There is an ongoing public debate on the 'Swedish maternity care crisis', regarding the shortage of midwives and political decisions to close smaller labour wards. For urban women, predominantly in the Stockholm area, this means being redirected to another hospital when in labour due to overcrowded labour wards, whereas women in rural areas are forced to travel long distances to the nearest hospital to give birth. Maternity care has in recent years received substantial governmental funding in order to improve women's health care, and a follow-up shows that although there have been improvements in some areas, such as decreasing rates of obstetric anal sphincter injuries, there is more to be done (The Swedish Agency for Health and Care Services Analysis, 2020). There is still a shortage of midwives, and inequalities in care persist between women born in Sweden and women born outside of Europe; between women of different levels of education; and between regions (Ibid.).

Swedish midwives are the primary providers of antenatal, intrapartum, and postpartum care for women with normal pregnancies and births, referring women to a physician or other professional, such as a physical therapist, dietician, or psychologist, when necessary (The Swedish Association of Midwives, 2018; Thomas & Hildingsson, 2015). In 2019, 59.0% of pregnant women saw a physician for problems related to pregnancy deviating from the norm (The Swedish Pregnancy Register, 2019). Maternity care is universal and publicly financed, and almost all women attend antenatal care, on average 9.3 visits during one pregnancy (The Swedish Pregnancy Register, 2019). As for postpartum care, the average length of stay is 1.9 days for a normal birth and 3.2 days after a caesarean section (Thomas & Hildingsson, 2015). Breastfeeding is encouraged, although rates are slowly decreasing. In 2019, 68.5% of new mothers were breastfeeding exclusively four weeks after birth (The Swedish Pregnancy Register, 2019).

In 2019, there were 114,523 births in Sweden, the birth rate was 1.7 children per woman, and the mean age for women to have their first baby was 29.6 years (Statistics Sweden, 2020). In 2015, about 24% of all childbearing women were born in countries outside Sweden, and 51% of all women had a college or university level of education (Thomas & Hildingsson, 2015). In 2019, the maternal mortality rate in Sweden was 4 per 100,00o live births and the neonatal mortality was 1.4 per 1,000 live births, among the lowest rates in the world (Statistics Sweden, 2020; World Health Organization, 2019).

Swedish labour care is of a high standard in an international comparison, and is not nearly as interventionist as in some other Western countries. However, the trend towards rising rates of intervention also exists in Sweden. Figure 3 shows the trends for both primi- and multiparas in use of epidural analgesia (41.0%), induction of labour (20.7%), caesarean section (17.7%), instrumental delivery (6.1%), and obstetric anal sphincter injury (2.6%) (decreasing trend). Despite increasing rates of induction of labour and caesarean section, the rate of neonatal mortality within the first 27 days of life has remained largely unchanged since 2005, 1.4 per 1000 live births, thus not justifying increasing intrapartum interventions (The National Board of Health and Welfare, 2019).

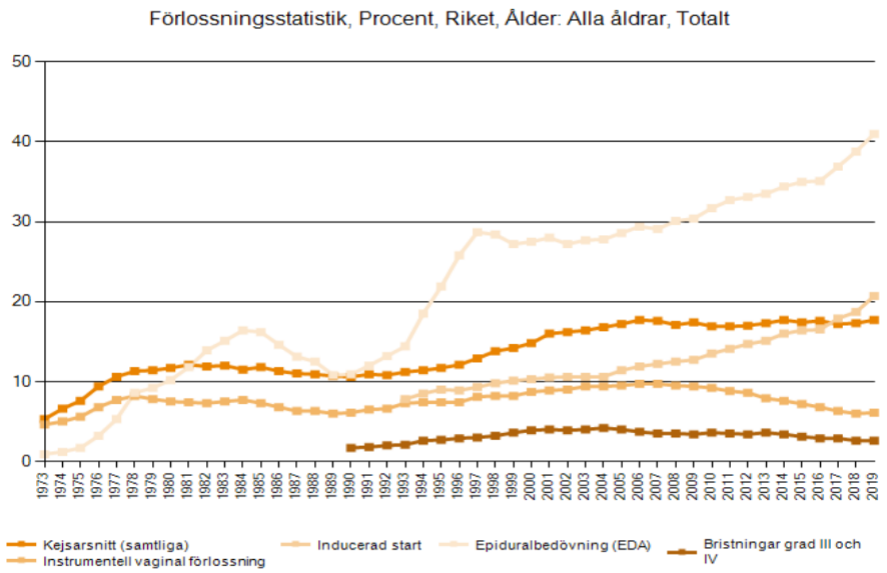
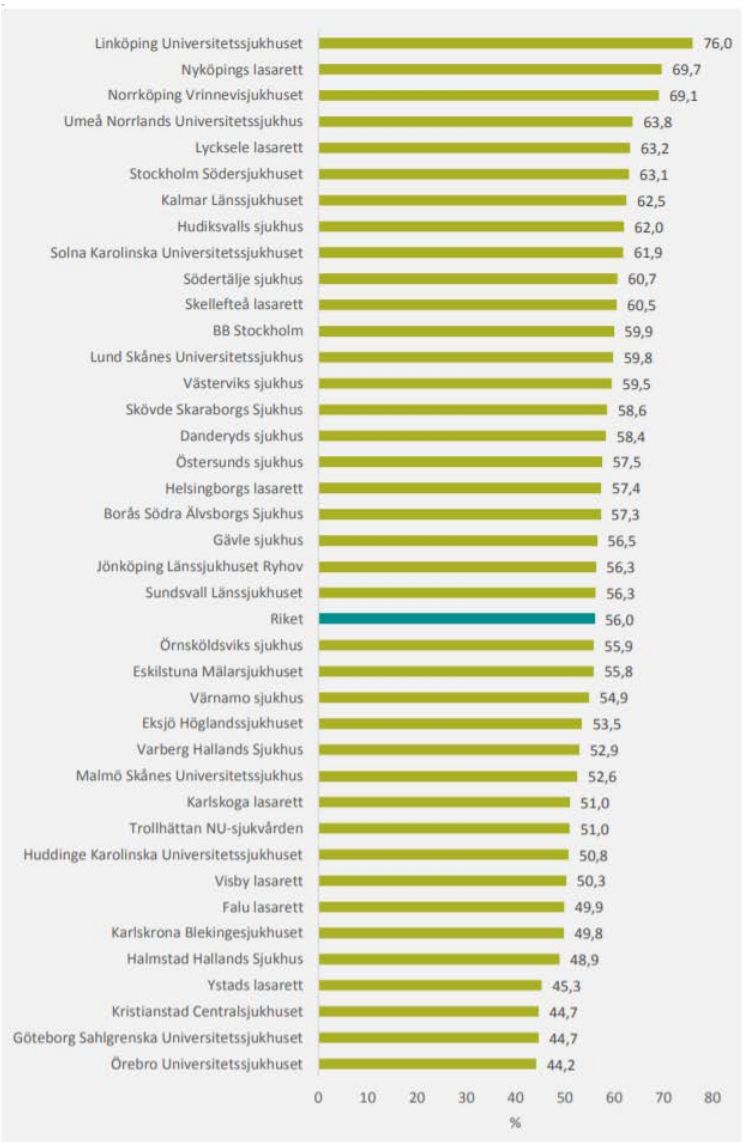


Figure 3 *Trends of interventions in Swedish labour care 1973-2019, all women* (The National Board of Health and Welfare, 2019)

Although intervention rates are on the rise, there are large variations between primi- and multiparas, and also between hospitals, affecting health outcomes in childbirth, such as obstetric anal sphincter injuries, haemorrhage > 1000 ml, postpartum infection, and Apgar < 4 at 5 min (Mesterton, Brommels, Ladfors, Lindgren, & Amer-Wåhlin, 2019; The Swedish Pregnancy Register, 2019). When comparing different hospital labour wards in Sweden, there are vast differences in rates of induction of labour, vaginal birth after caesarean section, use of epidural analgesia, use of synthetic oxytocin for induction or augmentation of labour, instrumental vaginal birth, episiotomy, obstetric anal sphincter injuries, haemorrhage, caesarean section (both planned and emergency), caesarean section after induction of labour, cord blood sampling, breastfeeding rates, and newborn formula feeding (The Swedish Pregnancy Register, 2019). Table 1 shows

the difference between labour wards in use of oxytocin for primiparas with spontaneous onset of labour, ranging from 76.0% in Linköping to 44.2% in Örebro. For multiparas with spontaneous onset of labour, the numbers range from 53.7% in Linköping to 11.5% in Halmstad (The Swedish Pregnancy Register, 2019). For primiparas, the national target value for oxytocin use is <50.0%, and for multiparas <15.0%, demonstrating a poor adherence to national recommendations in some clinics (The Swedish Pregnancy Register, 2019).

Table 1 *Rate (%) of treatment with oxytocin among first-time mothers with spontaneous onset of labour* (The Swedish Pregnancy Register, 2019)



The anticipated pain of childbirth is often of major concern for birthing women. In 1971, the Swedish parliament voted in favour of a law to guarantee the availability of pain relief during childbirth to all women who so desired, although it did not come into effect until 1976. Figure 4 shows the trends in use of pharmacological and non-pharmacological pain relief for both primi- and multiparas in Sweden between 1973 and 2019. According to the statistical database of the National Board of Health and Welfare (2019), the most commonly used method of pain relief is nitrous oxide, used in 81.3% of all births, followed by epidural analgesia in 41.0% of all births, pudendal nerve block in 16.2%, baths in 9.2%, transcutaneous electrical nerve stimulation (TENS) in 6.1%, acupuncture in 2.9%, and paracervical nerve block in 0.7%. Unfortunately, the database does not include data on non-pharmacological methods like massage or breathing and relaxation techniques, changing positions during birth, the presence of a support person such as a doula, or continuous support by a midwife. Neither does it report on pharmacological methods like analgesic tablets or opioid injections. Overall, midwives' documentation of intrapartum care has been found to be more focused on medical intervention than on emotional support during labour and birth (Sandin-Bojö, Larsson, Axelsson, & Hall-Lord, 2006). The trends for statistically available pharmacological methods are shown in the figure below.

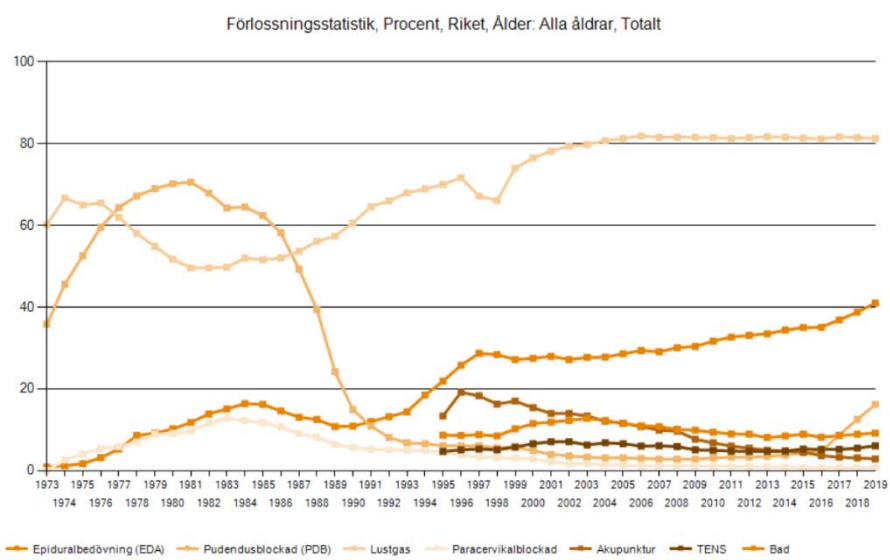
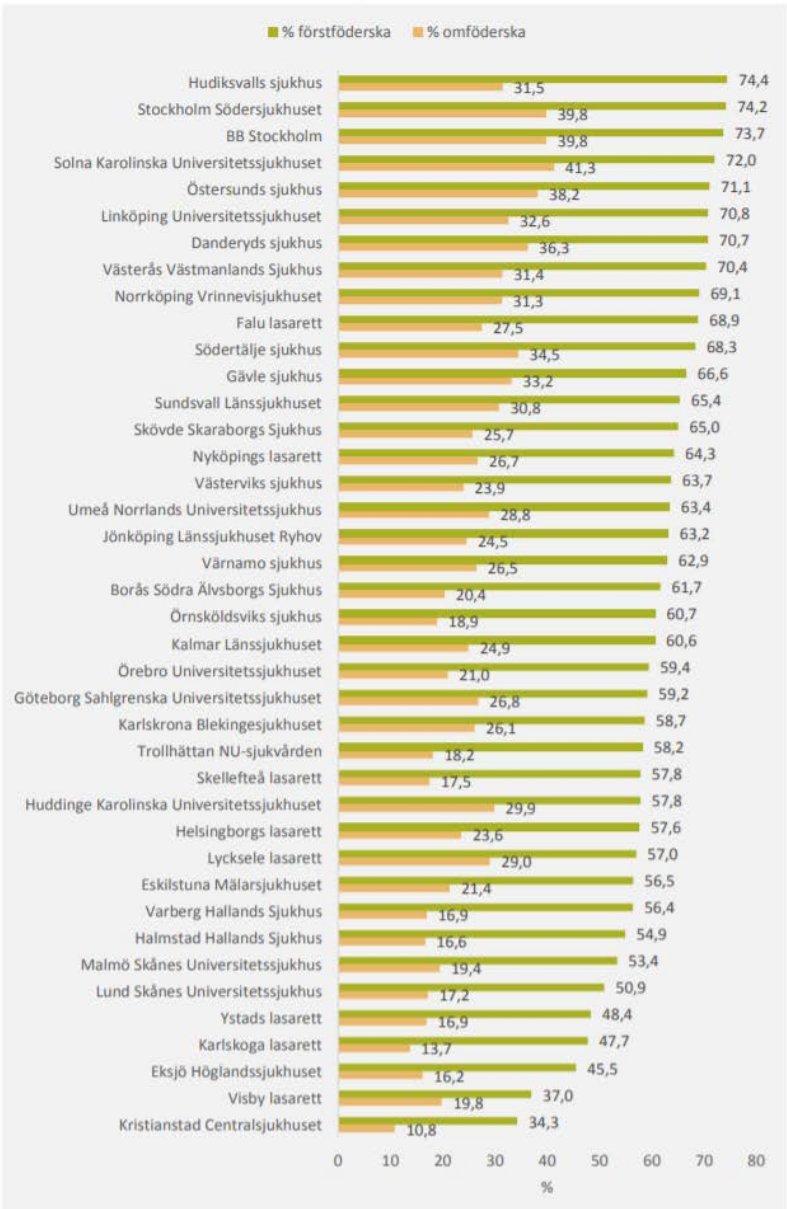


Figure 4 *Trends in use of pain relief in Swedish labour care 1973-2019, all women* (The National Board of Health and Welfare, 2019)

As Figure 4 shows, epidural analgesia is increasing nationally. In line with other interventions, there are however large variations between hospitals. Table 2 shows rates of epidural analgesia, for primiparas ranging between 74.4% to 34.3%, and for multiparas between 41.3% to 10.8% (The Swedish Pregnancy Register, 2019).

Table 2 *Rate (%) of epidural analgesia in vaginal birth, primiparas (green) and multiparas (orange) respectively* (The Swedish Pregnancy Register, 2019).



Normality, risk, and models of care

It has been argued that with the hospitalisation of childbirth, midwives have lost their role as independent practitioners and that midwifery is becoming increasingly deskilled (Martin, 2001). However, Hunt and Symonds (1995, p. 142) maintain that it is rather a question of midwifery being reskilled than deskilled:

> 'On the one hand, technological interventionist techniques and hospitalisation have undoubtedly altered the craft-skill base of midwifery, but at the same time, they have enabled midwifery to claim a recognisable occupational space within professional health care.'

Through science, medicine, and technology, hospitalisation gave childbirth the recognition it had lacked when it was carried out in the seclusion of women's homes (Hunt & Symonds, 1995). By becoming technically skilled - inserting intravenous lines, managing infusion pumps, performing amniotomies, applying foetal scalp electrodes, interpreting cardiotocography, performing urinary catheterisation, managing labour through synthetic oxytocin, assisting at vacuum extractions and caesarean sections, to name a few - midwives have increased their status and become indispensable in the management of labour (Ibid.). But as Hunt and Symonds pointed out already in 1995, the new skills imposed by a medicalised hospital environment may have contributed to a loss of knowledge about how to support the physiological process of birth without routine intervention (Hunt & Symonds, 1995).

Influenced by the alternative birth movement, in the late 20th century there was a movement among Western midwives to counter an increasingly interventionist and risk-focused labour care, by re-establishing their professional identity and defining themselves as specialists in normal birth (Reiger, 2008). However, defining normal birth has proven a difficult matter, and there is a lack of consensus as to what counts as normal. In Sweden, there is no national definition of normal birth, as women on arrival at the labour ward are classified according to risk level, where the closest to 'normal' is 'low risk' (Vladic Stjernholm, Elvander, & Kangas-Flodin, 2020). In line with the World Health Organization's definition, the International Confederation of Midwives (ICM) (2014, p. 1) states that:

> 'Normal birth is where the woman commences, continues and completes labour with the infant being born spontaneously at term, in the vertex position at term, without any surgical, medical or pharmaceutical intervention.'

While fairly straightforward, this definition excludes women who for any reason want or need intervention during birth. There is also the need to consider the cultural and temporal circumstances of 'normality', where the usual, standard, or common way to 'do birth' in a society becomes the norm, which may include for example having epidural analgesia and/or enhancing contractions with synthetic oxytocin. This ambiguity around what may be considered 'normal' has given rise to the alternative term 'physiological birth' to describe a birth that progresses through the optimal release of neurohormones, produced under special circumstances by both the maternal and the foetal brain (Olza et al., 2018). Physiological birth may thus be defined as 'an uninterrupted process without major interventions, such as induction, augmentation, instrumental assistance, caesarean section as well as use of epidural anaesthesia or other pain relief medications' (Ibid.).

The promotion of birth without unnecessary interventions may have partly to do with contemporary and societal ideals of birth. A systematic qualitative review of what matters to women during childbirth globally found that most women wanted a physiological labour and birth (Downe, Finlayson, Oladapo, Bonet, & Gülmezoglu, 2018). However, there is also evidence that an overly interventionist labour care may carry more risk for both woman and baby, for example by the intervention cascade described above, or through caesarean section (Miller et al., 2016; Sandall et al., 2018). Newnham, McKellar, and Pincombe (2017) found that in order to maintain institutional safety and efficiency, maternity staff paradoxically introduced more risk to women, for instance by putting a time frame on their labour and not acknowledging the unique rhythm of the individual woman's labour. Midwifery discourse thus emphasises the midwife as a facilitator of physiological birth with as little disturbance and intervention in the process as possible.

Drawing on risk theories, MacKenzie Bryers and van Teijlingen (2010) argue that the development of a risk society in the 20th century contributed to the transition from a social to a medical model of maternity care. The two models of care represent two different ideologies and approaches to health care. In the context of childbirth, the social model is founded on the idea that childbirth is a natural, physiological event; that most women will have a normal and safe birth with little or no medical intervention; and that while the birth of a healthy baby is paramount, so is the woman's birth experience (Downe et al., 2018; MacKenzie Bryers & van Teijlingen, 2010). Conversely, the medical model is built on the assumption that childbirth requires medical control and surveillance in order to guarantee safety, and that childbirth is 'normal only in retrospect' (MacKenzie Bryers & van Teijlingen, 2010). An example of how the different approaches relate to childbirth is shown in Table 3. It is worth noting that not all midwives adhere to the social model, and not all obstetricians adhere to the medical model, as is

acknowledged by the authors. While the two models represent two polarised views, it is important to consider that practices exist along a continuum, and practitioners within the same occupation may have varying attitudes and approaches to care (MacKenzie Bryers & van Teijlingen, 2010).

Table 3 *An overview of the social and medical models of maternity care* (MacKenzie Bryers & van Teijlingen, 2010)

Social model	Medical model
Physiological/natural – pregnancy and birth as 'normal' natural life event; all will be well until something goes wrong	Scientific – pregnancy and birth can only be judged as normal after the event when nothing has gone wrong
Art – intuitive, holistic	
Social – family and community orientated; health and social care should not be considered separately	Medical – aims to reduce maternal and infant mortality; to cure rather than prevent
	Medically led – professional in charge of pregnancy
Holistic approach – acknowledgement of link between social structures and health care to attain state of well-being	Control – birth in hospital enables medical staff to be in control of the birth
	Interventionist – doing things to 'help' women
Qualitative – importance of a 'good' experience for women and their families	Quantitative – task orientated
Subjective	Objective
Spiritual – part of wider culture	Treat the problem – treatment of the disease (pregnancy) rather than care of the whole; anticipate problems
Intuitive – rely on experience, relationships and instinct as to what is right or wrong	
Environment – women give birth at home or in local community, supported by friends and family; her choice	Environment – centralised hospital maternity services; birth in hospital seen as the safe option
Feminine – woman centred, respect and empowerment; women feel in control	Masculine – paternalistic, empowerment of the medical profession
Outcome – aims at live healthy mother and baby, and satisfaction of mother/family	Outcome – aims at live healthy mother and baby

Acknowledging that care exists on a continuum, there is however evidence of the domination of the medical model in maternity care, despite midwives' being primary caregivers during pregnancy and birth in many settings (Reiger, 2008). Research demonstrates the challenges midwives encounter when doing midwifery between different belief systems or contrasting models of care (Blaaka & Schauer Eri, 2008; Nilsson, Olafsdottir, Lundgren, Berg, & Dellenborg, 2019).

In comparing hospital-based and community-based midwifery, Hunter (2004) found that hospital midwifery was dominated by a medicalised approach to care that seeks to meet the needs of the institution, resulting in standardised care, risk reduction, efficiency, and effectiveness, and reflecting a so-called 'with-institution' ideology. Community midwifery, on the other hand, reflected a 'with-woman' ideology, prioritising an individualised, natural model of childbirth, informed by a belief in birth as a normal physiological process. When midwives adopt the 'with-institution' approach, their ability to meet the supportive needs of the woman/couple has been found to decrease (Thorstensson, Ekström, Lundgren, & Hertfelt Wahn, 2012). Together with low salary, low staffing, stress, and a lack of professional recognition, the obligation to work against their ideals of doing 'real midwifery' has been found to cause frustration among midwives, and is a key reason for professional burnout and for midwives to leave the profession (Hildingsson et al., 2013; B. Hunter, 2004; Suleiman-Martos et al., 2020).

There is a growing body of evidence that a woman-centred, knowledgeable, skilled, and compassionate midwifery care from pregnancy to birth and beyond (i.e. the social model) reduces maternal and neonatal mortality and morbidity, reduces stillbirths and preterm birth, decreases the number of unnecessary interventions, improves maternal satisfaction with care, and improves psychosocial and public health outcomes (Fontein-Kuipers, de Groot, & van Staa, 2018b; Renfrew et al., 2019; Renfrew et al., 2014; Sandall, Soltani, Gates, Shennan, & Devane, 2016). At the same time, there is evidence of barriers to the implementation of physiological or 'normal' birth, including 'hierarchical decision-making led by obstetricians, midwifery acquiescence, obstetric and midwifery risk preoccupation, rationalisation of the routine use of clinical intervention and an erosion of midwifery skills and knowledge' (i.e. the medical model) (Darling, McCourt, & Cartwright, 2021b). This implies that birthing women may not always receive care according to best evidence, which is alarming and contradictory, and is, among other things, addressed in this project.

Rationale

There is no arguing that modern medicine has saved the lives of many pregnant and birthing women and their children. As mentioned, Sweden is one of the safest countries in the world in which to give birth or be born. However, like many other high-income countries, there is a trend towards increasing medical interventions during childbirth, and fewer women than ever give birth without any intervention (The Swedish Pregnancy Register, 2019). There are also vast differences between different hospital labour wards, indicating that in some places there may be an overuse of medical intervention, while in others women may not receive adequate care (Mesterton et al., 2019). In addition, the 'Swedish maternity care crisis' continues to attract media attention, with recurrent reports of overcrowded labour wards, overworked midwives, and of women who felt mistreated during labour and birth.

While there is an abundance of research on the implications of an increasingly interventionist labour care, a gender perspective is often lacking, globally as well as in Swedish midwifery research. This project addresses the knowledge gap in how gender influences women's expectations before birth; how it impacts labour care in terms of use of pain relief and intrapartum interventions; how it affects women's evaluations of their birth experiences; and how it influences the interaction between women and midwives in the birth room.

Aims

Overall aim

The overall aim of this research project was to explore the implications of a medicalised birth culture for birthing women and midwives in a Swedish context. Through a mixed-methods approach, combining qualitative and quantitative methods, focus was placed on women's expectations before birth; their preferences for and actual use of pain relief; rates of intrapartum interventions; women's level of satisfaction with the birth experience; their written evaluations of the birth experience; and interactions between women and midwives in the birth room. The project was informed by a gender perspective, aiming to illuminate the impact of gender on childbirth experiences and practices.

Specific aims

Study I – To elicit pregnant women's perceptions of childbirth as expressed in their birth plans, and through a feminist lens analyse their wishes, fears, values, and beliefs about childbirth, as well as their expectations of their partner and midwife.

Study II – To explore the medicalisation of childbirth through women's preferences for and use of pain relief, and to investigate whether the existence of a birth plan had any impact on use of pain relief, rate of intervention, and satisfaction with the birth experience.

Study III – To explore through a gender perspective the circumstances that contribute to women's assessment of a positive birth experience and those that contribute to a lack of satisfaction with the birth experience.

Study IV – To explore woman-midwife interactions and the everyday practices of midwives in two Swedish labour wards. More specifically, the aim was to investigate whether and to what extent medicalisation was manifested in the ideals, organisation, and practice of childbirth, and the implications thereof.

Theoretical framework

A gender perspective on the increasingly medicalised Swedish labour care may offer an alternative understanding of its origins; how it is promoted and preserved in contemporary practice; and how it might be changed – if desired. A short introduction to feminism and gender constructions is presented below. The concept of medicalisation in connection to feminism is also briefly discussed.

Feminism

Feminism may be described as the 'belief in and advocacy of the political, economic, and social equality of the sexes expressed especially through organised activity on behalf of women's rights and interests' (Merriam-Webster, 2021). Simplistically but succinctly put, two central tenets of feminism are: 1) that there is a subordination of women to men, and 2) that this needs to change (Gemzöe, 2008).

Women's struggle for women's rights is not new. In 1792, the English writer and philosopher Mary Wollstonecraft (1759-1797) wrote *A Vindication of the Rights of Woman*, in which she argues for the dissolution of gender roles, 200 years before 'gender' - the idea that the characteristics of women and men are socially constructed - became a feminist analytical tool (Connell & Pearse, 2015; Gemzöe, 2008). The first mass movement for women's rights, commonly referred to as the 'first wave' of feminism, took place in the USA and in Europe in the beginning of the 20th century, and concerned mainly women's suffrage (McAfee, 2018). The second large political feminist movement, or 'second wave' of feminism, came about through the women's liberation movement in the late 1960s and early 1970s, and brought to the table questions about equal opportunities in education, the workplace, and at home (Ibid.). A third wave began in the early 1990s, criticising second-wave feminism for its lack of intersectionality, i.e. overlooking the interaction of gender with race, class, sexual orientation, physical ability, religion, nationality, etc. (Lawrence, 2017).

While there are examples of women in powerful positions in society, both historically and today, and there are individual women who do not feel discriminated against on the basis of their sex or gender, feminism holds that there is structural discrimination against women as a group (Gemzöe, 2008). Through the struggle of our foremothers, rights that seemed almost unattainable to them are considered natural today, and in most societies, women are now allowed to vote and have the right to higher education; meanwhile, reproductive rights such as access to contraception and safe and legal abortion regrettably remain unrealised in many countries (Chrisler, 2012).

Paradoxically, while women have been (are?) considered by their nature the inferior and 'weaker' sex – submissive, passive, docile, dependent, etc. – they have always performed large amounts of physical labour both in the home and in the workplace, and are more likely than men to have insecure part-time jobs and lower salaries (Letherby, 2003). Although gender inequality has been brought to light by the feminist movement, a 'gender gap' prevails in a variety of sectors of society. The Global Gender Gap Report 2020, measuring economic participation and opportunity, educational attainment, health and survival, and political empowerment, reveals that although gender parity is improving, the overall gender gap will not close for another 99.5 years (World Economic Forum, 2019).

Gender constructions

Simone de Beauvoir (1908-1986), a French intellectual and feminist, argued that the subordination of women stems from the idea of the woman as 'the other', the non-man, defined in relation to what she is not:

> 'She is defined in reference to man and not he with reference to her; she is the incidental, the inessential as opposed to the essential. He is the Subject, he is the Absolute – she is the Other.' (de Beauvoir, 1997, p. 13)

This 'othering' relies on a dualistic thinking that is argued fundamental to the human mind and the very process of identity construction, and there are plenty of examples of two contrasting and mutually exclusive choices or realities being defined in terms of each other: light/dark, good/bad, reason/emotion, culture/nature, mind/body, man/woman (de Beauvoir, 1997; Gemzöe, 2008; Prokhovnik, 1999). Binary thinking may not be a problem per se, but the feminist critique of the dichotomisation that is so common in Western thought concerns the perpetuation of social hierarchy and valorisation of one over the other (Prokhovnik, 1999). Generally, traits associated with masculinity (strength, reason, action) are more valued than so-called feminine traits (weakness, emotion, passivity) (Annandale, 2009). Viewing women and men as polar opposites, and associating biological sex with certain predetermined characteristics and behavioural traits, has nourished the idea of biological determinism, i.e. that behavioural traits can be explained by physical and biological features like sex organs, chromosomes, or hormones (Annandale, 2009; Connell & Pearse, 2015; Mikkola, 2019). Biological determinism has in turn contributed to the gender order, one gender dominating the other politically, socially, and economically (Connell & Pearse, 2015; Gemzöe, 2008). Despite a considerable body of research concluding that there are no significant differences between women and men, girls and boys, in terms of general ability or intelligence, the belief in character dichotomy and women's inherent biological weakness is still strong (Annandale, 2009).

By arguing that women are no more (or less) determined by their biology than are men, feminists have made a distinction between (biological) sex and (socially-constructed) gender, claiming that women's oppression is socially caused, rather than biologically given (Annandale, 2009). Simone de Beauvoir famously claimed that 'one is not born, but rather becomes, a woman', arguing that behavioural traits associated with women and men are culturally learned or acquired (de Beauvoir, 1949). From an early age, girls and boys are socialised into conforming to certain norms and expectations based on gender affiliation – a gender-appropriate behaviour so familiar that it can seem part of a natural order (Connell & Pearse, 2015). From this follows the development of a gender identity, where people construct themselves as feminine or masculine (or both, or neither), presenting them with benefits and possibilities on the one hand and/or injustices and disadvantages on the other (Connell & Pearse, 2015). West and Zimmerman (1987) thus proposed that 'doing gender' is a choice and shaped by an array of social arrangements, negotiated and dynamically constructed through time in a reciprocal exchange between the individual and their environment. Expanding on West and Zimmerman's argument that gender is not innate but something that one does, Martin (2003, p. 58) contends: 'As we do gender, we are interpellated by it; it becomes us.'

The 'doing of gender' is thus not only to seek social acceptance, but is fully incorporated as a sense of self, with individuals willingly engaging in self-discipline according to prevailing gender norms (Carter, 2009; Martin, 2003). Gilligan (1982) has highlighted how girls and women put the wants and needs of others ahead of their own, subjected to what she calls the 'tyranny of nice and kind': the societal demand to be relational, caring, polite, and selfless towards others, while losing themselves in the process. In the context of childbirth, this may prove detrimental to the birthing woman's agency, causing her to self-discipline into a compliant and apologetic 'good patient', socially programmed to gratefully accept whatever is suggested or done to her (Martin, 2003).

Medicalisation and feminism

Medicalisation literally means 'to make medical', and is a concept in sociology that describes a process by which non-medical human behaviours and conditions become defined in terms of illness and disorders (Conrad, 2007). Conrad's (1992, p. 211) definition of medicalisation is commonly used:

> 'Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to "treat" it. This is a sociocultural process that may or may not involve the medical

> profession, lead to medical social control or medical treatment, or be the result of intentional expansion by the medical profession.'

The concept of medicalisation was developed in the late 1960s, when it was observed that a wide range of human conditions were increasingly being defined as medical problems in need of medical treatment. Some examples are alcoholism and other addictions, mental disorders, eating disorders, learning disabilities, sexual preference, sexual dysfunction, and child and sexual abuse (Conrad, 2007). The concept claims that illness and disease are not inherent in any behaviour or condition but socially constructed, thus dependent on time, place, and economic and political factors (Riessman, 1983). Through the professionalisation of medicine and what has been called 'medical imperialism', physicians gained control over definitions of health and disease, i.e. the biomedical model, and by convincing people of the medical nature of their problems, they also gained social control and power over treatment (Riessman, 1983). Women, more than men, are particularly exposed to medicalisation, where normal events in women's lives such as menstruation, pregnancy, childbirth, and menopause have been defined as pathological and requiring medical attention (Purdy, 2002).

Although medicalisation has had far-reaching consequences for women, especially regarding pregnancy and childbirth, Riessman (1983) holds that women have not been passive victims of medicalisation, but have contributed to and in some cases also benefited from it. Paradoxically, the first-wave feminist activism that gave women the right to pain relief in childbirth, mainly in the USA and the UK, also distanced women from their bodies and helped redefine birth as an event requiring hospitalisation and the attendance of doctors, thus becoming itself a driver of medicalisation (Riessman, 1983). In *Of Woman Born: Motherhood As Experience And Institution*, Adrienne Rich (1986, p. 170) writes:

> 'At the onset of labor, the woman was placed in the lithotomic (supine) position, chloroformed, and turned into the completely passive body on which the obstetrician could perform as on a mannequin. The labor room became an operating theater, and childbirth a medical drama with the physician as its hero.'

As a reaction to the increased medicalisation of childbirth, the alternative birth movement, led by second-wave feminist birth activists and scholars, emerged in the late 1960s, advocating 'natural birth' where women were 'awake and aware' (Beckett, 2005, p. 253). During this time, natural birth advocates indignantly likened the birth process to an assembly line, where the emphasis was on a speedy and successful delivery of the product (the baby) through the management of the machine (the mother) (Hunt & Symonds, 1995). The birth activists turned against

the widespread use of medical procedures and technological interventions, which they claimed restricted women and shifted attention from the woman to the foetus, whose safe arrival into the world became the highest priority (Beckett, 2005; Belu, 2018). The high intervention rate was believed to narrow the definition of normality, and to diminish women's capacity to make choices regarding their own bodies, whereas home birth with a midwife was promoted as a preferable option to hospital birth (Ibid.).

Even though doctors are still gatekeepers for medical treatment, patients, or consumers of care, are becoming increasingly active in their demand for medical treatments for human problems (Bell, 2017; Conrad, 2007). Examples of this are women's struggle for pain-free births and for contraception, although feminist scholars are divided on its meaning for women's experiences. As Riska (2003, p. 67) argues:

> '... liberal feminists tend to view women's access to preventive services in the area of reproductive health as an equal-rights issue, while radical feminists tend to interpret preventive measures as a form of medical surveillance and part of a larger social control of women in a society guided by the interest of men and of the profit motive of corporate medicine.'

Critics of the widespread medicalisation of human experience, or the 'medicalisation of life', have expressed concern that it transforms aspects of everyday life into pathologies, narrowing the range of what is considered 'normal', and ultimately diminishing the tolerance for and appreciation of the diversity of human experience (Conrad, 2007; Riessman, 1983). Another criticism of medicalisation is that it places focus on the individual rather than on the social context, which has led to the treating of societal problems through medical, surgical, or pharmacological interventions on the individual (Conrad, 2007). In the context of childbirth, it has been argued that medicalisation has led women to lose confidence in their abilities to birth naturally, and to fear birth without medical assistance (MacKenzie Bryers & van Teijlingen, 2010). However, Purdy (2002) argues that perhaps medicalisation is not the problem per se, but rather the real challenge is to alter the ownership, production, and use of scientific knowledge, so that women can use medical means for their own ends. In the third wave of feminism, second-wave feminism has indeed received criticism for being essentialist and moralising, and the fact that it tends to ignore that some women have positive experiences of high-tech birth (Beckett, 2005).

Methods

As an interdisciplinary doctoral student affiliated with two university departments: Sexual and Reproductive Health at the Department of Nursing at the Medical Faculty, and the Graduate School of Gender Studies at the Centre for Gender Studies, hosted by the Faculty of Social Science, I have had the privilege of meeting fellow doctoral students from various scientific disciplines, brought together by an interest in gender research. During doctoral courses and seminars, and while reading and commenting on each other's texts, the divide between qualitative and quantitative research depending on academic discipline became apparent. While challenging at times, the interdisciplinary environment has above all proven rewarding, encouraging an outside-the-box thinking, and extremely valuable in revealing the abundance of ways to approach a research problem. Furthermore, my knowledge of feminist and gender research has deepened, which has enabled the analysis of labour care from a gender perspective.

Midwifery and birth as art or science

During my training to become a midwife, the major part of the Midwifery Education Programme consisted of courses in 'Förlossningskonst', which roughly translates as 'the art of delivery'. Setting aside for a moment the word 'delivery' – which forwards a view of the birthing woman as a passive object, being delivered by the real agent in birth, the midwife or obstetrician – the question is: is delivering babies an art? Or rather, if we consider the woman as the agent, is assisting a woman as she gives birth an art? Is midwifery an art? Is birth an art, a science, or a combination of both?

As for other health care professionals, incorporating research into practice is a professional requirement for midwives in order to provide the best possible care to women and their families (Cluett & Bluff, 2006b). To answer the questions above, midwifery has indeed been described as both 'art and science', using empirical, traditional, clinical, intuitive/tacit, and personal knowledge to underpin practice (Cluett & Bluff, 2006a; Gilkison, Giddings, & Smythe, 2016). Midwifery and childbirth being closely intertwined and situated at the boundary between cultural and biological processes, in order to mirror its complexities, research thereof may or should be undertaken from various perspectives – medical, sociological, philosophical, political, economic, and feminist, to name a few.

Evidence-based medicine or practice (EBP) has been described as an approach that 'integrates the best external evidence with individual clinical expertise and patients' choice' (Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996). While

this definition of EBP justly stresses both scientific evidence and clinical judgement (and patient involvement), there is a need to consider that 'best evidence' implies the randomised controlled trial (RCT) and/or the systematic review of several RCTs, which has become the 'gold standard' for evaluating the efficiency of a treatment (Ibid.). While RCTs may be the most appropriate way to answer certain research questions, for other questions concerning phenomena that are harder to measure, such as women's lived experiences of childbirth, or how emotion and intuition affects midwifery practice, i.e. the 'art part', the best evidence may come from other research designs.

Feminist epistemology

Feminist epistemology takes as point of departure the exclusion of women's lived experiences from traditional academic knowledge production (Hesse-Biber, 2012). Through the exclusion of women (based on the 'othering' described in the theoretical framework section) from the public sphere of organised religion, law, politics, and higher education, knowledge in its very definition has been 'man-made', and built on men's position in and in relation to the world and their understanding and definition of it (Letherby, 2003). Challenging androcentric bias and 'mainstream/malestream' knowledge production, feminist research evolved, bringing to light the experiences of 'the other/s', often women and other marginalised groups, and presenting it as legitimate knowledge (Hesse-Biber, 2012; Letherby, 2003). As with the two goals of feminism – to acknowledge and change the subordination of women (and other marginalised groups) – feminist research is also connected to the feminist struggle and intent to change the basic structures of oppression (Hesse-Biber, 2012).

There is no single feminist epistemology or methodology, but one common feature is the critique of positivist objectivism, which separates the knower from what is known, and holds that there is a single, true reality waiting to be discovered (Letherby, 2003). Instead, in feminist research the researcher's position is acknowledged and stressed, and the view of the neutral observer disputed. Throughout the research process, subjective judgements are made concerning choice of research topic, formulation of hypotheses, study design, data collection, and of interpretation and presentation of results (Harding in Hesse-Biber, 2012). By disclosing one's values, attitudes, and biases, and by practising strong self-reflexivity, the authenticity of the research is enhanced (Hesse-Biber, 2012). Or as Malterud (2001a, p. 484) puts it: 'Subjectivity arises when the effect of the researcher is ignored.'

Furthermore, Letherby (2003) suggests that feminist research should give continuous and reflexive attention to the significance of gender as an aspect of all social life, as well as consider the significance of other differences between women (race, class, ethnicity, sexuality, dis/ability, etc.); value the personal and the

private as worthy of study; develop non-exploitative research relationships; and value reflexivity and emotion as an essential part of research.

Overall study design

The data collection and analytical methods were guided by the overall research aim: to explore the implications of a medicalised birth culture for birthing women and midwives. Considering qualitative and quantitative research methods as complementary rather than conflicting (cf Malterud, 2001b), this thesis has a mixed methods approach, synthesising ideas from both qualitative and quantitative data (Johnson, Onwuegbuzie, & Turner, 2007). Table 4 gives an overview of the different studies.

Table 4 *Overview of studies*

Study	Aim	Design	Data collection and analysis	Participants
Study I	To elicit pregnant women's perceptions of childbirth as expressed in their birth plans	Qualitative	Birth plans Qualitative content analysis	132 women with birth plans
Study II	To explore women's preferences for and use of pain relief, and whether the presence of a birth plan had any impact on use of pain relief, rate of intervention, and satisfaction with the birth experience	Quantitative	Birth plans Medical records Birth evaluation forms Descriptive statistics Logistic regression	129 women with and 110 women without birth plans (n=239)
Study III	To explore the circumstances contributing to women's assessment of a positive or negative birth experience	Qualitative	Birth evaluation form Word frequency Thematic analysis	190 women with written evaluations of their birth experiences
Study IV	To explore woman-midwife interactions and the everyday practices of midwives in two Swedish labour wards. More specifically, the aim was to investigate whether and to what extent medicalisation was manifested in the ideals, organisation, and practice of childbirth, and the implications thereof	Qualitative	Focused ethnography Thematic analysis	8 women who gave birth and 8 midwives who assisted them (n=16)

Settings

Studies I-III

The studies were conducted at an obstetrician-led labour ward with an annual birth rate of approximately 2,000 births, situated at a large tertiary hospital in a mid-sized city in Sweden, providing specialist care to patients from a large catchment area. Midwives were the primary caregivers for all women but worked closely together with obstetricians, especially when caring for women with complicated pregnancies. Apart from three midwives and one assistant nurse on each work shift, on site and available around the clock were residents, obstetricians or gynaecologists, anaesthesiologists, and a neonatal intensive care team and unit.

Study IV

The study was conducted in two obstetrician-led hospital labour wards, both with an annual birth rate below 1,000 births, and situated in two smaller towns in Sweden. Both sites provided labour care as well as postnatal and gynaecological care in the same facilities. All shifts were covered by at least two midwives and one or two assistant nurses. Residents, obstetricians, or gynaecologists were present on the wards during daily rounds, and when on call some slept at the hospital and some in their own homes. The same applied to neonatologists/ paediatricians who were available in the hospitals during the day, and during evenings and nights some of them were on call in their homes. Anaesthesiologists were often but not always available at short notice.

On both study sites, the notion of birth as risky and in need of intervention to keep it safe was visible in the design of the birth rooms, which could be classified as technological birth rooms where medical functionality was in focus (Bowden, Sheehan, & Foureur, 2016). Although slightly different in size and colour scheme, the birth rooms on the two sites had similar design. The bed was placed in the centre of the room and surrounded by medical equipment such as cardiotocography machine, monitors, intravenous drip stands with infusion pumps, tubes for nitrous oxide (hidden behind sliding doors on one site), and a bright surgical light hanging over the bed. The impression of birth as a clinical and hygienic event was reinforced by the presence of white, ironed bed linen and smooth, shiny, easy-to-clean counters and floors. Birth tools such as walkers and birthing balls were available but not kept in the birth rooms, and were therefore not visible to the women to encourage them to move around and be active in birth. One site had a large bathtub, and showers were available on both sites.

Participants

Studies I-III

A consecutive sample of 400 women, who gave birth in the above-mentioned tertiary hospital between March and June 2016, were invited to participate regardless of age, parity, length of pregnancy, ethnicity (although they needed to be able to understand Swedish or English), preferences for pain relief, or mode of delivery. Of the 400, 259 women (primiparas n=115 and multiparas n=144) gave their written consent to participate, which entailed granting access to their birth plans, antenatal and intrapartum electronic medical records, and an evaluation form filled in within 48 hours of birth. Participants were then selected according to the aim of the study. Thus, for Study I, women with birth plans (n=132) were included. For Study II, women with and without birth plans were included (n=239) after the exclusion of women with elective caesarean section (n=16), as their choice of pain relief was non-optional; twins (n=3); and extremely premature births (less than 28 weeks of gestation) (n=1). For Study III, women who gave a written evaluation of their birth experience were included (n=190). Table 5 shows the characteristics of the participants and a selection of birth data.

Study IV

Through focused ethnography in two hospital labour wards in August and November 2016, the interaction between women and midwives during birth was observed, and both women and midwives were interviewed after birth about their experiences. With the intent to observe vaginal birth, women with planned caesarean section were excluded, as were women who did not speak Swedish or English. Inclusion criteria were thus all (other) women, regardless of age, parity, ethnicity, length of pregnancy, onset of labour, or preferences for pain relief. Eight women agreed to participate, five in one hospital and three in the other. The characteristics of the women who gave birth, along with some data from their births, is shown in Table 5.

Along with the eight women giving birth, eight midwives were also observed and interviewed. The average age of the midwives who agreed to participate was 39.6 years, all were women and Swedish speaking, and the average amount of work experience as a midwife was 6.8 years (median = 3.3 years), ranging from two months to almost 30 years.

Table 5 *Characteristics of the women who gave birth and a selection of birth data. All studies.*

CHARACTERISTICS	n (%) or min-max (mean)			
	Study I n=132	**Study II[c] n=239**	**Study III n=190**	**Study IV n=8**
Age (years)	18-43 (30.5)	18-42 (30.7)	18-41 (30.8)	23-38
Parity				
Primipara	78 (59.1)	111 (46.4)	79 (41.6)	5
Multipara	54 (40.9)	128 (53.6)	111 (58.4)	3
Geographical background				
Swedish	118 (89.4)	213 (89.1)	168 (88.4)	6
Non-Swedish	14 (10.6)	26 (10.9)	22 (11.6)	2
Civil status				
Cohabiting	128 (97.0)	233 (97.5)	187 (98.4)	8
Live-apart	4 (3.0)	6 (2.5)	3 (1.6)	0
Level of education[a]				
Higher education	83 (62.9)	136 (56.9)	106 (55.8)	3
Primary or secondary education	30 (22.7)	75 (31.4)	64 (33.7)	4
Not specified[b]	19 (14.4)	28 (11.7)	20 (10.5)	1
BIRTH DATA				
Gestational age at onset of labour (weeks)	-	36-42	32-41	37-41
Induced labour	-	54 (22.6)	33 (18.6)[e]	3
Artificial rupture of membranes	-	98 (41.0)	78 (44.1)[e]	3
Continuous foetal monitoring	-	154 (64.4)	117 (66.1)[e]	7
Augmentation of labour	-	109 (45.6)	79 (44.6)[e]	6
Epidural analgesia	-	82 (34.3)	58 (32.8)[e]	4
Urinary catheterisation	-	107 (44.8)	74 (41.8)[e]	6
Vacuum-assisted birth	-	15 (6.9)[d]	6 (3.7)[f]	1
Episiotomy	-	11 (5.1)[d]	8 (5.0)[f]	-
Emergency caesarean section	-	23 (9.6)	16 (9.0)	-
Elective caesarean section	1 (0.8)	-	13 (6.8)	-

[a] According to the Swedish Standard Classification of Occupations (Statistics Sweden MIS 2012:1, 2012)

[b] Students, unemployed or on parental leave

[c] Elective caesareans (n=16), twins (n=3), premature birth (n=1) excluded

[d] Emergency caesarean section excluded (n=23)

[e] Elective caesareans excluded (n=13)

[f] Emergency (n=16) and elective (n=13) caesarean section excluded

Data collection

Studies I-III

Prior to commencing the data collection, midwives and assistant nurses were informed of the study and asked to hand the women written information about the study a few hours after birth. Attached to the information letter was a consent form to grant access to the women's birth plans, antenatal and intrapartum electronic medical records, and to an evaluation form. All women, regardless of age, parity, length of pregnancy, preferences for pain relief, or mode of delivery were to be asked. Women who did not understand Swedish or English were excluded.

Birth plans

As a response to increasing interventions in childbirth and women's sense of loss of agency in institutionalised care, the birth plan was originally intended to encourage women to communicate their needs, expectations, and preferences to their caregivers (DeBaets, 2017; Simkin, 2007). In a fragmented health care system where antenatal and labour care have different providers, although all are midwives, the birth plan can be a useful tool for the labour care midwife to quickly assess the needs of a labouring woman she has probably never met before. There is no standardised or universal birth-plan template; the one used in this study was designed by midwives to be used as part of routine antenatal care as a way to help women prepare for birth, but was optional for women to use (Appendix 1). The template consisted of a sheet of paper with four open-ended questions inquiring about women's expectations before birth and the first few days thereafter (translated from Swedish to English by AW):

- *Is there anything you consider important to convey about yourself that could be of significance during birth?*
- *What methods for relaxation and pain relief would you prefer when you give birth?*
- *How can we support the collaboration between you and your partner during birth?*
- *How do you imagine the first few days after birth?*

The plans were given to the women by the antenatal midwife, and the women filled them in by hand at home. Once in labour, the women brought the plans with them to the hospital, in order for the labour care midwife to have a quick overview of the woman's birth preferences. After birth, the plans were scanned and stored in the woman's electronic medical record.

Antenatal and intrapartum medical records
From the electronic medical records, background data was gathered, such as age, geographical background, civil status, level of education, parity, and BMI, as well as information about the birth, such as length of pregnancy at birth, onset and length of labour, use of pain relief, rate of intrapartum interventions, mode of delivery, birth position, vaginal tearing, and Apgar score.

Birth evaluation forms
Given the significance of the birth experience on women's and babies' well-being, assessing and understanding maternal satisfaction is important for health care providers, administrators, and policymakers in order to provide optimal care (Goodman, Mackey, & Tavakoli, 2004; Hodnett, 2002). Women were asked to fill in an evaluation form before being discharged from the hospital, usually within 48 hours after birth, as part of routine care. The form was locally designed and consisted of a sheet of paper where the women were asked to rate their birth experience on a Visual Analogue Scale (VAS) (Heller, Manuguerra, & Chow, 2016) (Appendix 2). As part of the labour ward's quality management, women who rated their experience as a three or lower were offered counselling within three months postpartum by a trained midwife. The form also included a paragraph of text encouraging the women to write something about their experience on five dotted lines (translated from Swedish to English by AW):

> *Congratulations on becoming a mother! The staff who work in health care development and postpartum follow-up at the delivery ward would like to know how you experienced your birth. What do you feel when you think about your birth? What do you think was good? What could have been done better?*

The form was handed to each woman a few hours after birth by the midwife who had assisted her during birth, and later collected by another midwife at the postpartum ward. Almost all women wrote between one and three sentences, while a few women described their experiences in more detail.

Study IV

Gatekeeping and gaining access to the field
The first step in ethnographic data collection is to gain access to the field. This is often dependent on so-called gatekeepers who can facilitate or hinder access to the intended study site (Dykes & Flacking, 2016). After being turned down by gatekeepers, in the form of two heads of department at two different hospitals, a third hospital was contacted, whose head of department looked favourably on the study, recognising the importance of midwifery research and the potential for the

clinic to benefit from the study. A few weeks later, I visited the labour ward, presenting myself and the study to two head midwives, who also stressed the value of midwives researching labour care. When ethical approval had been obtained from the regional ethics board, another visit was made to the clinic, this time to provide information about the study to the midwives whom I was to observe. While awaiting an answer from the third hospital, contact was made with yet another hospital in case the third hospital also declined to participate. After receiving a positive response from the head of department in the fourth hospital, I made a visit to that hospital to inform the staff of the study. As in the previous hospital, the midwives were interested in participating in midwifery research and welcomed me back to conduct the study.

Focused ethnography

Through the means of focused ethnography and participant observation, women and midwives were observed during labour and birth and interviewed separately about their experiences afterwards (Cruz & Higginbottom, 2013). In addition to the interviews, data thus included the documentation of my observations and reflections thereof in the form of field notes, as well as drawings of the labour ward and birth rooms to support my recollection of the setting.

Having been granted two weeks on each site to perform the study, the aim was to observe at least five births in each labour ward. I stayed in the vicinity of the relevant hospital for the duration of the study period and was on constant call when not on site. Unfortunately, not many babies were born during the study period, and on a few occasions, there were quick births where the staff did not find the time to call me. Data collection was also affected by the midwife in charge, who first had to accept participation herself, then make a first selection of participants when they arrived on the labour ward. Thus, some women were excluded due to perceived language barriers, or for psychosocial reasons where the midwife felt that the birthing woman would benefit from having fewer people in the birth room.

If the midwife herself consented to being part of the study and found the woman suitable, she asked the woman if she would consider having a researcher, who was also a midwife, present during labour and birth, and to be interviewed about her experiences afterwards. All midwives accepted participation, as did all of the women who were asked. In total, eight births were observed, and thus, eight women and eight midwives were interviewed. Informed and written consent was gathered from both the woman and the midwife who was to assist her, stating that participation was optional and that they both had the right to rescind consent at any time. When the consent form had been signed, participant observation ensued until the baby was born, between four and 10 hours. The interviews were conducted on site one or two days after birth in all but one case where, due to

work scheduling issues, one midwife was interviewed a few hours after birth. The interviews were recorded; those with the midwives lasted on average 47 minutes, ranging from 34 minutes to one hour, and with the women on average 22 minutes, ranging from 12 to 32 minutes. The midwives were talkative and informative and enjoyed discussing their profession, although some interviews were cut short as they were noticeably stressed by the idea of sitting down for too long while their colleagues were working, even though the midwives themselves had chosen the time and place for the interview. The women, on the other hand, were less expressive, although not dissatisfied, with most answering the interview questions succinctly and not really expressing any opinions on the care they had received. This is further discussed under 'Methodological considerations'. At Site 1, all women had their partners present during the interviews, while at Site 2, there were no partners present.

An observation guide (Appendix 3) was designed beforehand by the research group, partly to ensure consistency across sites and participants, but also to serve as a reminder of the key points of observation, and of the importance of a reflexive approach towards the observations, i.e. how the observer is affected by the observations (Roller, 2016). The observation guide focused on the interaction between the midwife and the birthing woman, such as use of language (verbal and non-verbal), coping strategies for handling labour pain (both woman and midwife), and routines and intrapartum interventions. Also taken into consideration was the physical environment of the birth room, such as interior design, access to showers, bathtubs, birth tools, etc. In order to not disturb the very sensitive process of giving birth by making the woman feel observed, I avoided jotting down observational notes in the birth room, instead stepping outside to fill in the observation guide, or write short notes or reflexive comments. Longer field notes were produced in private, directly after each observation. As for the interviews, they were guided by two interview guides, one for the women (Appendix 4) and one for the midwives (Appendix 5), also designed by the research group, and focusing on the woman's and the midwife's perceptions of pain and pain relief, support during labour, and the balance of power in the birth room.

Analyses

Paper I – Qualitative content analysis

Increasingly used in health care research, qualitative content analysis can be described as a research method for the subjective interpretation of the content of a text through the systematic process of coding and identifying themes or patterns (Hsieh & Shannon, 2005). This study aimed to elucidate the latent content of women's perceptions and expectations before birth. The analytic procedure of

organising the text from the birth plans into meaning units, condensed meaning units, codes, subcategories, categories, and themes, was performed in line with the steps of qualitative content analysis as described by Graneheim and Lundman (2004). Moreover, the analysis was informed by feminist theory on dichotomous thought according to Prokhovnik (1999).

The first step of the analysis was to type up the women's handwritten birth plans (n=132) in a word-processing programme, which also served as a way of becoming familiar with the data. The data was then sorted into units of analysis according to questions answered in the birth plan: 'about the woman', 'about pain relief', and 'about partner support'. The question inquiring about the first few days after birth was excluded, as the focus in this study was on women's perceptions of the birth itself.

The text was broken down into meaning units, which were condensed, i.e. shortened while still preserving the core message, and then labelled with codes. The codes were grouped and sorted into subcategories, which can be described as groups of content that share a commonality. The subcategories were then sorted into categories of diverse levels of abstraction, still expressing the manifest content of the text. In the final step, a theme was identified, linking the categories together and expressing the latent content of the data.

Paper II – Descriptive statistics and logistic regression

The primary aim of this paper was to explore the medicalisation of childbirth though women's preferences for and use of pain relief. The secondary aim was to investigate whether the presence of a birth plan had any impact on use of pain relief, rate of intervention, and satisfaction with the birth experience. Women with (n=129) and without birth plans (n=110) were therefore included in the study. Through quantifying the data and analysing it statistically, certain patterns and associations were made visible in a way that would not have been possible through a qualitative approach.

Drawing on the qualitative content analysis in Paper I, women's preferences for pain relief, as expressed in the birth plans, were dichotomised and classified into five variables: Non-pharmacological methods, Nitrous oxide, Epidural analgesia as a second choice, Epidural analgesia, and Conferring with the midwife. Data on actual pain relief used was gathered from the medical records, also dichotomised as 1 if the condition was met, and 0 if not. Data on intrapartum interventions gathered from the medical records and previously entered into a spreadsheet was also dichotomised and then transferred to IBM SPSS Statistics 25, together with the data on preferred pain relief from the birth plans. This procedure allowed for a comparison between women with and without birth plans and between primi-

and multiparas in terms of use of pain relief, intrapartum intervention, and level of satisfaction with the birth experience.

The statistical methods used were descriptive statistics, including the independent-samples t-test for continuous variables, complemented with the Mann-Whitney U Test for groups with a sample size of less than 30; the Pearson's chi-square test for categorical or dichotomous variables to compare data across groups, using the two-sided Fisher's exact test when expected cell frequency was below 5; logistic regression to explore relationships between the epidural as exploratory variable and different interventions as dependent variables, establishing odds ratios (OR) with 95% confidence interval (CI); and the Spearman Rank Order Correlation to calculate the strength of the relationship between level of satisfaction and number of interventions. Statistical significance was set at $p < .05$. Missing values were few and randomly distributed.

Paper III – Word count and thematic analysis

With the aim of exploring the circumstances contributing to women's assessment of a positive or negative birth experience, thematic analysis proved a flexible analytical method that is especially apt for summarising key features of a large data set. The six steps of thematic analysis according to Braun and Clarke (2006) guided the analysis of 190 women's evaluations of their birth experiences: familiarisation with the data; initial coding; searching for themes; reviewing themes; defining and naming themes; and producing the report. Stating epistemological position may mitigate the risk that the flexibility of thematic analysis may lead to inconsistency and lack of coherence in developing themes (Nowell, Norris, White, & Moules, 2017). Thus, a gender perspective was used both to inform the analytical process and as a foundation for the discussion of the findings.

Familiarisation with the data revealed that most women wrote positive evaluations; some women wrote one positive comment and one comment on something they thought could have been done better; and some expressed ambiguous feelings about the experience within the same sentence. Only two women wrote exclusively negative comments. The evaluations were grouped and labelled positive, negative, and ambiguous (Table 6).

Table 6 *Distribution of evaluations*

Written evaluations, n=190		
Exclusively positive evaluations, n=102	Evaluations including both positive and negative comments, n=51	Exclusively negative evaluations, n=2
	Ambiguous comments, n=35	

On reading through the data again, it appeared that some words and expressions were used more frequently than others. As meaning depends in part on number (of recurring words or patterns), numbers are integral to qualitative research, and displaying information numerically can help to avoid over- or underweighting data (Sandelowski, 2001). By running the anonymised evaluations in a word counter, the presence of recurring words was confirmed, at least for the positive evaluations. Figure 5 shows a word cloud of the most frequently used words from the positive evaluations. As the negative and ambiguous comments were fewer in number and more disparate, single words became unintelligible without a wider context. Therefore, the analysis of the positive evaluations is based on recurring words, while the analysis of the negative and ambiguous comments is based on recurring expressions. From these words and expressions, preliminary themes were identified, reviewed, and refined. Through a constant moving back and forth between the data set, codes, and themes, three overarching, latent-level themes were defined. These not only describe what the women wrote and how frequently, but also provide, through the perspective of gender constructions, an interpretive explanation as to why they wrote it.

Figure 5 *Word cloud of major word groups from the positive evaluations (www.wordart.com)*

Paper IV – Focused ethnography and thematic analysis

Ethnography is a research methodology for studying people and cultures, where the researcher, through different levels of participation over an extended period of time, becomes immersed in a social setting or community of people, observing them as they go about their daily lives, developing relationships with them, listening, and asking relevant questions (Dykes & Flacking, 2016; Emerson, 2011). Gaining ground in health care research, focused ethnography has developed from the original ethnographic method (Higginbottom, Pillay, & Boadu, 2013). The focus on cultures and subcultures remains but is limited to a specific community or context, whereby participants have specific knowledge about an identified problem (Higginbottom et al., 2013). In this study, doing focused ethnography in the context of the birth room, allowed the investigation of whether and to what extent medicalisation is manifested in the ideals, organisation, and practice of childbirth, and the implications thereof.

The data gathered from the focused ethnography consisted of field notes and reflexive notes and memos, as well as transcribed interviews with the eight women and eight midwives. Thematic analysis inspired by Braun and Clarke (2006) was used as method of analysis. The interviews and field notes were read and reread, coded, and merged into preliminary themes. As in the process of thematic analysis described for Paper III, through a constant moving back and forth between interviews, field notes, codes, and preliminary themes, four main themes were defined and named.

Methodological and ethical considerations

Trustworthiness

To convince the reader that the research is 'worth paying attention to', the truth value or trustworthiness of the study must be addressed (Lincoln & Guba, 1985, p. 290). There are several evaluation criteria for trustworthiness in qualitative studies, depending in part on the choice of research method. In present work, the concepts of credibility, transferability, dependability, and confirmability, according to Lincoln and Guba, are considered, in addition to positionality and reflexivity, which are important to discuss in qualitative research in general, and in ethnographic studies in particular. It is important to note that there is no single correct meaning or application of research findings, only valid arguments for the most probable interpretation from a certain perspective (Graneheim & Lundman, 2004).

Qualitative methods (Studies I, III, and IV)

Positionality and reflexivity

Feminist research acknowledges and values the subjectivity of the researcher, and their active role in the development of knowledge (Cruz & Higginbottom, 2013; Letherby, 2003). Reflexivity aims to make explicit and transparent the effects of the researcher's positionality, i.e. background, preconceptions, and ideological stance on the whole research process: choice of research topic, research question, method of data collection and analysis, interpretation, and conclusions drawn (Hesse-Biber, 2012; Malterud, 2001a).

It goes without saying that my being a woman and my background as a mother, doula, childbirth educator, and midwife, as well as my affiliation as a doctoral student to the Graduate School of Gender Studies, have influenced the research process. Since my feminist awakening in the early 1990s, I have been aware of the systemic inequalities, hierarchies, power relations, and gender constructions that affect people in every aspect of their lives. More concretely, this awareness has enabled me to ask questions and make interpretations that someone without or with less previous knowledge and experience of childbirth or gender theories would perhaps not have made.

Credibility

In qualitative research, presenting a thorough description of the analytical process, i.e. how the coding was done and how categories or themes were derived, as well as including quotes from participants, are ways of enabling readers to judge the credibility and authenticity of the findings (Graneheim, Lindgren, &

Lundman, 2017). For enhanced credibility, there are tables showing the coding process and/or representative quotes from the participants.

Through the use of triangulation – 'the combination of methodologies in the study of the same phenomenon' (Denzin in Johnson et al., 2007, p. 114) – the research question may be approached from several different angles, enhancing credibility. This project thus includes data triangulation, using multiple sources (i.e. birth plans, medical records, evaluation forms, observations, interviews); investigator or researcher triangulation, involving several researchers knowledgeable in midwifery science, gender studies, public health, ethnology, and statistics, in the research process; and methodological triangulation, using a combination of qualitative and quantitative methods for data collection and analysis (Ibid.).

Transferability

Transferability in qualitative research corresponds to external validity in quantitative research, and concerns whether the findings of a study can be transferred to other contexts (Malterud, 2001a). Providing a detailed account of the study setting is a way to enable someone interested in the transfer of the findings to another setting, to reach a conclusion on whether that transfer is possible (Lincoln & Guba, 1985). Although there are large differences between hospitals, intrapartum interventions are rising throughout the country (The Swedish Pregnancy Register, 2019). It is thus feasible that studies in other labour wards in Sweden would produce similar results, at least in a similar study setting with participants with similar background characteristics.

Dependability

Dependability corresponds to reliability in quantitative research, addressing the consistency of a measure. To achieve dependability, the research process needs to be logical, traceable, and clearly documented, whereas other researchers, through an audit trail, may examine the documentation of the data, the methods, decisions, and the end products (Tobin & Begley, 2004). In order to achieve dependability, several researchers were involved throughout the research process. Furthermore, all papers underpinning this thesis, have been presented and discussed in text seminars, involving both junior and senior researchers from different academic backgrounds.

Confirmability

Confirmability is comparable with objectivity and neutrality and ensures that the findings are not figments of the researcher's imagination, but clearly derived from the data (Tobin & Begley, 2004). In order to demonstrate how conclusions and interpretations have been reached, it is recommended to be open about theoretical, methodological, and analytical choices throughout the study (Nowell

et al., 2017). Confirmability is established when credibility, transferability, and dependability are all achieved (Lincoln & Guba, 1985).

Quantitative methods (Study II)

A cross-sectional study provides a 'snapshot' of the prevalence of an outcome and the characteristics associated with it, at a specific point in time (Levin, 2006). The generalisability of the study depends on how representative the sample is of the population of interest. There is also the need to consider both nonresponse and biased response, the latter meaning that a person is more likely to respond when they have a particular characteristic (Ibid.).

Because of the nature of the study, comparing women with birth plans to women without, a randomised trial was not possible. Power calculation showed that the required sample size for detecting statistically significant differences between groups (birth plans/no birth plans) was approximately 100 individuals per group. A consecutive sample of 400 women were thus invited to participate, of which 259 women consented (response rate = 64.8%), 132 women with a birth plan and 127 women without. Although women with birth plans were more likely to be primiparas and have a higher level of education, which may affect the representativity of the sample, when comparisons were made across groups, there were no differences between primiparas with or without birth plans or between women with higher or primary/secondary education regarding use of pain relief, rate of intervention, and level of satisfaction.

In order to compare wishes for pain relief with outcome (actual use of pain relief and intrapartum intervention), and to explore how satisfied women were with their birth experiences, data from birth plans, medical records, and a Visual Analogue Scale was collected. The birth plans were part of routine care in the hospital under study, and provided rich data for the analysis of women's preferences for pain relief.

The electronic medical records provided data also used in a national quality registry for statistics on Swedish maternity care (The Swedish Pregnancy Register, 2019). The Visual Analogue Scale is a validated instrument, but it must be taken into consideration that the women were asked to rate their birth experiences within 48 hours after birth, as there is evidence demonstrating that women's memory of childbirth may change over time (Waldenström, 2003). The findings in Study II showing that women were generally satisfied with their birth experience when assessed shortly after birth are in line with data from the national Swedish Pregnancy Register (2019).

Other considerations

Studies I-III

Out of 442 women who gave birth during the period of data collection, 400 women were invited to participate. Prior to the beginning of the study, hospital staff had been asked to distribute written information to all women who gave birth during that time. In order to facilitate the data collection procedure for the staff, the information about the study was attached to other forms routinely handed to women after birth in the specific labour ward. For unknown reasons, 42 women were not asked to participate, possibly due to staff being misinformed, under stress, or having forgotten. Since these women were not asked for consent, their medical records could not be attained, whereby a non-response analysis remains speculative.

The birth evaluation forms were handed to the women a few hours after birth by the midwife who had assisted them during birth, filled in by the women during their stay at the postpartum ward, and collected by another midwife or assistant nurse prior to discharge from the hospital, usually within 48 hours. It is possible that the women were hesitant to criticise their caregivers while still in the hospital, leading to socially desirable responses and/or ingratiating response bias (van Teijlingen, Hundley, Rennie, Graham, & Fitzmaurice, 2003). The matter of the timing of the evaluation has been addressed above.

Study IV

Gaining access

Regarding gaining access to labour wards for the focused ethnography, I can only speculate as to why access was denied by the first two hospitals. There was no existing connection between me as a researcher and either of the hospitals, and they may have preferred local or known researchers for reasons of competition. Also, there is the 'expectation of critical surveillance' and the view of the researcher as the expert and the critic (Dykes & Flacking, 2016), which may have caused the gatekeepers to feel uneasy and ultimately decline to participate.

Conflicting roles

Prior to entering the field, I considered that there may arise occasions where my role as a researcher would be confused or in conflict with my professional role as a certified midwife. One way to mitigate this was to do the fieldwork in clinics other than the one in which I normally practise. Recognising the sensitive nature of the physiology of childbirth, which can be easily disturbed if the birthing woman feels observed, I decided to dress in scrubs (cf Hammersley & Atkinson, 2019), to introduce myself as a researching midwife, and not to take notes while in the birth room. During labour and birth, I chose to be a participant observer, partaking in conversations, giving a hand here and there if requested, while at the

same time trying to keep a low, but accommodating and courteous profile, so as to also mitigate the midwives' potential feelings of being under scrutiny.

For the sake of the birthing woman and professional codes of conduct, and also in accordance with my subjective understanding of ethical and moral conduct, I decided before commencing fieldwork that I would intervene in situations where I felt the woman's well-being was at risk. During my fieldwork, there was no medical emergency that the staff did not handle in an exemplary fashion. There were however several incidents where the midwife left the woman with her waters dripping onto the floor, as described in the introduction, whereupon my role as a researcher and my role as a midwife clashed. In those situations, I prioritised (my perception of) the woman's need for support and information over my intention to remain in the background as much as possible, while always being mindful to not overstep any boundaries and take over the work of the midwife.

Developing non-exploitative relationships

There is the concern in qualitative research that in order to obtain rich data, the researcher sometimes puts on an act in order to persuade the informant to tell their story, and hopefully reveal such things that could be advantageous for the research (Duncombe & Jessop, 2002). Gaining access to and being welcomed into the labour wards to observe midwives as they work and women as they give birth is, in my opinion, to be entrusted with a great gift of confidence which cannot be betrayed. Just as the term 'midwife' means 'with woman', I believe that the ethnographer should conduct research *with* rather than *on* informants, the development of non-exploitative relationships within research being one of the criteria for feminist research (Letherby, 2003). For midwives, a friendly demeanour is often vital to gaining the woman's trust to be able to assist her during birth, and although it is a matter of a relatively short acquaintance, this does not mean that it is not authentic, but merely professional. It is my understanding that the same goes for the relationship between researcher and study participant, and I prefer to view being courteous and friendly as part of good human interaction rather than (or as well as) a methodological approach.

Reticent women

Two of the women who were interviewed about their experiences of birth for Study IV were relatively taciturn, and had comparatively little to say about the overall experience, pain, pain relief, control, and support. Both were more than satisfied with their experiences, rating them as 8 out of 10, and compared to the other, more informative women, there was no difference in age, parity, ethnicity, level of education, or whether the partner was present during the interview or not, which might have affected their answers. Considering that all the interviews with the women were shorter than the ones with the midwives, it is possible that the timing of the interviews – only one or two days after birth – meant that women were still feeling overwhelmed by birth and having a new baby. However,

it is also worth considering that although birth most often takes place in public institutions, it still remains a private and unseen event, with procedures and practices hidden from insight. Women may therefore have little or no idea of what to be critical of, assuming that 'what is, must be best' (van Teijlingen et al., 2003). Also, as with the evaluation forms in Study III, it is feasible that the women were hesitant to criticise their caregivers, which may have affected their responses (Ibid.). Further, my being dressed in scrubs during the participant observation may have led the women to see me as a representative of the labour ward work force.

Ethical approval

Ethical approval was obtained from the Regional Ethical Review Board in Umeå, Sweden, 2015/476-31Ö. Prior to giving their written consent, the participants received verbal and written information about the studies as well as information on whom to contact should there be any questions. Participants were informed that they could end their participation at any time without stating a reason and without reprisal, in line with ethical guidelines for medical research (World Medical Association, 2013). The birth plans and written birth evaluations were transcribed into a word-processing programme, and data from the medical records as well as the VAS-ratings were entered into an Excel spreadsheet. All data was anonymised and stored in password-protected files. All original data has been kept confidential and stored in line with university guidelines for data retention.

Main findings and discussion

The findings in short show that women with birth plans opted for a natural and midwife-supported, unmedicated birth, but that their plans were seldom realised, at least not in terms of pain relief. First-time mothers with birth plans used more pharmacological pain relief than intended, and 93.6% of them had some form of intrapartum intervention. Parity, rather than birth plan, affected use of pain relief, rate of intervention, and level of satisfaction. Women were generally very satisfied with their birth experiences, mainly with the emotional support they received from the midwives. Women's internalised sense of gender was suggested to affect their birth experiences. In the interaction between women and midwives in the birth room, the midwives continuously bridged the gap between the medical and the social model of care, integrating medicalisation into midwifery practice.

The findings are interpreted and discussed through a gender perspective, recognising a socially and culturally constructed, internalised, hierarchical gender order that affects the view of women's bodies, birth, and midwifery, while also considering the hegemony of medical science (Connell & Pearse, 2015; Martin, 2003). Table 7 shows an overview of the aims and main findings of each study, synthesised and further discussed below.

Table 7 *Overview of aims and findings, papers I-IV*

	Aims	**Findings**
Paper I	To elicit pregnant women's perceptions of childbirth as expressed in their birth plans, and through a feminist lens analyse their wishes, fears, values, and beliefs about childbirth, as well as their expectations of partner and midwife.	Three categories emerged: *Keeping integrity intact through specific requests and continuous dialogue with the midwife*; *A preference towards a midwife-supported birth regardless of method of pain relief*; and '*Help my partner to help me' - women anticipating partner involvement*. The overall theme linking the categories together was *Autonomous and dependent - The dichotomy of birth*, portraying women's ambivalence prior to birth: expressing a wish to remain in control while simultaneously being able to let go of control by entrusting partner and midwife with decision making regarding their own bodies.
Paper II	To explore the medicalisation of childbirth through women's preferences for and use of pain relief, and to investigate whether the presence of a birth plan had any impact on use of pain relief, rate	Parity rather than birth plan was a greater determinant for use of pain relief, frequency of interventions, and level of satisfaction; primiparas used more pain relief, had more interventions, and were less satisfied with their birth experiences than multiparas. Epidural analgesia was associated with a two to threefold increase in interventions, but 79.5% of all women had some form of intervention during birth, regardless of having an epidural

	of intervention, and satisfaction with the birth experience.	or not. Women were generally highly satisfied with their birth experiences, women without epidural analgesia and interventions slightly more so.
Paper III	To explore through a gender perspective the circumstances contributing to women's assessment of a positive birth experience and those contributing to a lack of satisfaction with their birth experience.	Three themes were identified. *Grateful women and nurturing midwives doing gender together* demonstrates how gender-normative behaviour may influence a positive birth experience when based on a reciprocal relationship. *Managing ambiguous feelings by sympathising with the midwife* shows how women's internalised sense of gender can make women belittle their negative experiences and refrain from delivering criticism. *The midwifery model of relational care impeded by the labour care organisation* describes how the care women receive during labour and birth is regulated by an organisation that is not always adapted to the needs of birthing women.
Paper IV	To explore the woman-midwife interactions and the everyday practices of midwives in two Swedish labour wards. More specifically, the aim was to investigate whether and to what extent medicalisation was manifested in the ideals, organisation, and practice of childbirth, and the implications thereof.	Four themes describe the conflict between non-medicalised ideals of birth and the medicalised reality of labour care. *Midwives' ideals of childbirth* addresses how the midwives strive to promote normal birth. *Women's views on childbirth* shows how the women 'go with the flow' and place their trust in the midwives. *The organisation of labour care* captures the restrictive effect of a medicalised organisation on midwives' work, resulting in stress of conscience and feelings of inadequacy for the midwives. *Childbirth practices* focuses on the consequences for midwifery practice of working in a medicalised organisation, resulting in an interventionist birth culture that challenges women's bodily autonomy.

Listening to women's voices

One of the pillars of feminist research is giving a voice to women who have been left out of mainstream research, and to recognise women's life stories as knowledge (Hesse-Biber, 2012). The birth plan may be seen as a tool for making women's voices heard. Introduced by natural birth advocates in the USA in the 1980s as a response to women's sense of loss of agency in institutionalised childbirth, the birth plan was intended to promote women's decision making and to facilitate communication with care providers (DeBaets, 2017; Simkin, 2007). But women having a say in circumstances regarding their own bodies has proven controversial and not always well received. In popular culture, the derogatory term 'bridezilla' (derived from the Japanese movie monster Godzilla) is used to describe a bride-to-be who becomes self-centred, demanding, difficult, and unpleasant because she wants to control every aspect of her wedding (Cambridge Advanced Learner's Dictionary & Thesaurus, 2021). This concept has given rise to 'birthzilla', an expression used both by the public and by health care providers,

at least in English-speaking countries, to refer to a woman with a birth plan in the same patronising way (Hill, 2019). The popular notion of women with opinions as being difficult is also confirmed by research. Women whose birth plans state that they want to avoid routine intervention in childbirth are considered difficult and demanding, and as having rigid and unrealistic expectations (Lothian, 2006). Having a long 'wish list' of expectations may also be perceived as insulting, humiliating, and disrespectful of the midwives' professional competencies (Larsson, Aldegarmann, & Aarts, 2009). Jones et al. (1998, p. 39) concluded that birth plans may negatively affect labour outcome, as 'patient's birth plans usually provoked some degree of annoyance', resulting in less support from the staff.

The way in which women express themselves in their birth plans may be seen as a reflection of contemporary societal and cultural views of childbirth and of women. It is therefore disturbing to note that among the greatest concerns for women in Study I was the fear of loss of control, autonomy, and dignity, whereby they had many specific requests about how they wanted to be approached during birth. Some of these requests concerned physical matters, such as not wanting to see blood, wanting to avoid injections because of a fear of needles, or asking the midwife to do everything in her power to minimise the risk of vaginal tearing. This may in part be explained, especially for first-time mothers, by the feeling of finding oneself on the threshold of the unknown, not knowing what to expect from the physical experience of giving birth: how the contractions will feel, whether there will be vaginal tearing, whether a caesarean section will be necessary, etc.

However, most requests regarded maintaining bodily integrity, and a fear of losing control and being withheld information. It is important to consider that in Sweden, as in many other countries, antenatal and labour care is fragmented and provided by different organisations, with the woman seeing an antenatal midwife during antenatal visits and a labour midwife she has never met before during birth. To be dependent on an unfamiliar person during one of the most emotional and challenging times in life is, as previously discussed, relatively new in the history of childbirth. This is not to question hospital birth per se, but it is important to stress that when birth moved from women's homes to hospitals during the 20th century, the social experience of birth changed: women found themselves giving birth alone, without their social support network, and in a new, unfamiliar environment, often subject to a number of interventions, such as pubic shaving, enemas, episiotomies, and having the baby taken to a nursery shortly after birth (Lothian, 2006). While these interventions have since been abandoned in Swedish labour care, they have been replaced by other routines and interventions, such as intravenous lines, augmentation of labour with synthetic oxytocin, epidural analgesia, and continuous foetal monitoring, to name a few. Hospital birth transformed the woman from host to guest, expected to follow the

'house rules' established by physicians and hospital administrators, and placing her at the bottom of the hierarchy where the physician is on top, and the midwife in the middle (Benoit, Zadoroznyj, Hallgrimsdottir, Treloar, & Taylor, 2010; cf Hunt & Symonds, 1995, p. 141). When scoffing at difficult 'birthzillas' who want to have a say in who does what to their bodies and when, it is important to keep in mind the context in which the birth plan was born.

Women's expectations, wants, and needs, as expressed in their birth plans in Study I, must be viewed from the perspective of their fear of both physical harm and of losing agency and control over what happens to their bodies. There is also the need to consider the historical legacy of the subordination of women and the view of women's bodies as deficient machines. While no modern midwife or obstetrician or birthing woman would consciously place themselves in the position of the oppressor or the oppressed, the power imbalance happens on a structural level, making it elusive and therefore more difficult to grasp. However, women's insistence on being involved in decision making and having their integrity and dignity respected during birth is indicative of the birth culture they expect to encounter, making the structural oppression towards women in general, and birthing women in particular, quite palpable.

Expectations vs reality

The desire to remain autonomous and have a say in their care also involved expressing preferences for pain relief. As shown in studies I and IV, there were some women who wanted epidural analgesia as soon as possible, while most women expressed a preference towards a natural and unmedicated birth, with the assistance of her partner and the midwife. Simultaneously, many women expressed a 'go with the flow' approach to birth, dealing with matters as they came along, and trusting the midwife to make the right decisions for them. Women's birth choices were thus heavily influenced by the midwife's own preferences and recommendations.

As was shown in Study II, of all women with birth plans, 71.3% primarily preferred non-pharmacological methods of pain relief, such as breathing techniques, relaxation, massage, a bath or shower, hot packs, TENS, acupuncture, and sterile water injections. They also wished to be active during birth, able to move around freely and change positions; and to have a calm atmosphere in the birth room through the use of music, dimmed lights, and affirmations. Nitrous oxide was listed as a viable option by 63.6%, and 44.2% considered epidural analgesia a last resort to be used under certain circumstances, such as overwhelming pain, prolonged labour, or if the midwife recommended it. Slightly more multiparas than primiparas expressed a desire for epidural analgesia: 19.6% vs 16.7%.

The use of a birth plan had limited effect on women's use of pain relief, which depended to a greater extent on parity. Primiparas overall in Study II, birth plan or no birth plan, used significantly more pharmacological pain relief than multiparas. Indeed, the relationship between primiparas' wishes for and use of pain relief was inverted: the majority listed non-pharmacological methods as their first choices, and preferably no epidural analgesia, but ended up using fewer non-pharmacological methods and more epidurals than expected. Considering the association of epidural analgesia with additional interventions, women who had epidural analgesia had twice or sometimes three times as many interventions, compared to women without. Of the 82 women who had an epidural, all of them had some form of further intervention.

The rates of intervention for primiparas and multiparas with and without birth plans are listed in Table 8. Altogether, birth plan or no birth plan, 94.6% of all primiparas and 66.4% of all multiparas ($p<.001$) had one or more interventions during labour. Of all the women in the study, 190 out of 239 (79.5%) had some form of intervention during childbirth. According to the ICM (2014, p. 1) definition of normal birth, 4.2% (n=10, all multiparas) of the whole cohort had one.

> 'Normal birth is where the woman commences, continues and completes labour with the infant being born spontaneously at term, in the vertex position at term, without any surgical, medical or pharmaceutical intervention.'

The findings of Study II demonstrate high rates of medical intervention in spite of the majority of women being healthy, having normal pregnancies, and being expected to have straightforward vaginal births. The same went for women with birth plans, in spite of their ideals of a natural birth. Previous research has shown that natural childbirth is highly valued in Western countries, but despite women's intentions, the probability of an intervention-free birth is close to non-existent (Cole, LeCouteur, Feo, & Dahlen, 2019; Lindholm & Hildingsson, 2015; Malacrida & Boulton, 2014). The discrepancy between what women want and what they get in terms of pain relief has been interpreted as women having unrealistic expectations and poorly predicting how they will cope with labour pain (Bar-On, Benyamini, Ebrahimoff, & Many, 2014). While this may partly account for women not having their wishes fulfilled, along with the unpredictability of childbirth, women's birth choices do not exist in a vacuum but are intertwined with contemporary cultural and societal discourses on childbirth (Beckett, 2005).

Table 8 *Interventions and level of satisfaction, women with and without birth plans (Study II)*

INTERVENTIONS	Women with birth plans n=129 n/%			Women without birth plans n=110 n/%		
	Primiparas n=78	Multiparas n=51	*p* value	Primiparas n=33	Multiparas n=77	*p* value
Induction of labour[1]	18 (23.1)	9 (17.6)	0.459	12 (36.4)	15 (19.5)	0.059
Amniotomy	35 (44.9)	21 (41.2)	0.679	13 (39.4)	29 (37.7)	0.864
Continuous foetal monitoring	68 (87.2)	28 (54.9)	**0.000**	24 (72.7)	34 (44.2)	**0.006**
Augmentation of labour[2]	54 (69.2)	12 (23.5)	**0.000**	20 (60.6)	23 (29.9)	**0.002**
Urinary catheterisation	53 (67.9)	15 (29.4)	**0.000**	17 (51.5)	23 (29.9)	**0.031**
Vacuum extraction[3,4]	5 (7.5)	2 (4.1)	0.697	6 (22.2)	2 (2.7)	**0.005**
Episiotomy[4]	5 (7.5)	0 (0.0)	0.072	4 (14.8)	2 (2.7)	**0.044**
Emergency caesarean section[5]	11 (14.1)	2 (3.9)	0.060	6 (18.2)	4 (5.2)	0.063
Accumulated interventions	73 (93.6)	35 (68.6)	**0.000**	32 (97.0)	50 (64.9)	**0.000**
Level of satisfaction (VAS)[6]	7.37[a] (sd = 1.8)	8.49 (sd=1.5)	**0.000**	7.64[b] (sd=2.3)	8.29[b] (sd=1.8)	0.120

[1] Due to premature rupture of membranes, induced within 24 hours, or clinical indications (post-term gestation, pre-eclampsia, hypertension, oligohydramniosis, intra-hepatic cholestasis of pregnancy), or elective (non-medical)
[2] Via synthetic oxytocin
[3] Vacuum extraction
[4] Emergency caesareans excluded (birth plans n=13 vs no birth plans n=10)
[5] Out of the 23 emergency caesarean sections, reasons like exhaustion, fear, failure to progress, occiput posterior baby, foetal distress, uterine fibroids, and preeclampsia were listed
[6] 0=Very negative, 10=Very positive
[a] 4 missing values, [b] 1 missing value

The valorisation of natural birth, as opposed to birth according to the technocratic, medical model, has been suggested to be rooted in social and political processes that perpetuate constructs of normative femininity and idea(l)s of 'the good mother', where sacrifice, selflessness, and enduring pain is seen as necessary for the rite of passage to full motherhood (Beckett, 2005; Cole et al., 2019; Malacrida & Boulton, 2012, 2014). It has also been argued that the normal birth ideology has set up women to fail by promoting an ideology of 'vaginal birth as all cost' (Dietz, 2017). However, as Beckett (2005) argues, the emphasis on 'natural' and 'normal' that birth activists place on birth may also be interpreted as a response to medicine's pathologisation of childbirth, making it into a 'high risk' event in need of management and control. As previously stated, there is evidence that an overuse of practices to 'initiate, accelerate, terminate,

regulate or monitor the physiological process of labour' does indeed increase the risk of both short- and long-term complications for both woman and baby (Jansen et al., 2013; Miller et al., 2016; Peters et al., 2018; World Health Organization, 2018, p. 1). There is also the need to consider that the feelings of disempowerment and lack of control that some women experience when their expectations of a natural birth are not met, have been found to impact women's confidence in their bodies, their transition into motherhood, and their choices for subsequent births, such as planned caesarean section (Beckett, 2005; Lupton & Schmied, 2013; Malacrida & Boulton, 2014).

The manifestation of medicalisation

The fact of women's desire for a natural birth not always being met should also be viewed from the perspective of the organisation of labour care. In a highly technologically- and medically-advanced labour ward, women may have to be very determined or even fortunate to reach their goals of a natural birth (Preis, Eisner, Chen, & Benyamini, 2019). The first step towards an interventionist birth is being assigned a 'patient' role once in the hospital, with the implicit presumption of compliance with medical authority (Benoit et al., 2010; Lee & Kirkman, 2008). In the Swedish setting, in an attempt to minimise adverse outcomes, there are national recommendations for conducting a risk assessment upon the woman's arrival at the hospital labour ward, where she is categorised as either low risk (green), risk (yellow), or high-risk (red) (Vladic Stjernholm et al., 2020). This is reminiscent of the previously discussed 'body as a machine' metaphor, where the female body is viewed as defective, at risk of malfunctioning at any time, thus in need of manipulation and control in the form of various interventions (Davis-Floyd, 2001). When classifying all birthing women in terms of risk, birth can never be viewed as normal.

Study IV, a focused ethnography in two hospital labour wards in Sweden, revealed a conflict between the non-medicalised birth ideals of women and midwives and the medicalised reality of the labour care organisation. This situation resulted in feelings of inadequacy and bad conscience for midwives, especially among junior midwives, and led to an interventionist birth culture that challenged birthing women's bodily autonomy. The midwives described their ideals of midwifery care as being in line with the social model of care, i.e. viewing birth as a normal and natural life event, stressing the importance of relational and equal care, and of incorporating emotion and intuition into practice. The women themselves valued a trusting relationship with the midwife based on reciprocity, which led them to take a 'go with the flow' approach to birth, trusting the midwives as 'birth experts' to make the right decisions for them.

However, in a risk-oriented and efficiency-driven organisation, the woman-centred care ideals of both midwives and women may be difficult to uphold (Darling, McCourt, & Cartwright, 2021a; Fontein-Kuipers et al., 2018b). The notion of birth as risky was conveyed through the design of the birth rooms, which had medical functionality as the primary focus. The birth bed was centred in the room, suggesting it to be the most appropriate place to give birth (Bowden et al., 2016). Furthermore, the bed was surrounded by medical technology such as a cardiotocography machine, monitors, drip stands, infusion pumps, tubes for nitrous oxide, and a surgical light hanging over the bed. Although it takes more than the appearance of the birth setting to support physiological birth (Stark, Remynse, & Zwelling, 2016), it is important to consider what messages about birth are being communicated through the design of the birth room.

Due to low staffing and the many responsibilities of the midwife, the midwives in Study IV were constantly on the move, which may have contributed to them, when in the birth room, sometimes becoming task-oriented and focusing more on a 'doing' than on a 'being'. Despite the ideals and good intentions of the midwives, the medicalisation of childbirth was thus normalised and manifested through midwifery practice. Although there were many examples of positive encounters in the birth rooms and women having positive birth experiences, there were also examples of a normalisation of medicalisation through birth practices and interventions that were done to, on, or in the woman's body, without her explicit consent. These interventions were presented as part and parcel of hospital birth, such as use of IV lines, repeated vaginal examinations, continuous foetal monitoring, urinary catheterisation, pudendal blocks and other injections, non-upright birth positions, and directed pushing, to name a few. Importantly, while these interventions are justified at times, their routine use is against evidence and not recommended (Miller et al., 2016; World Health Organization, 2018). This is not to criticise any individual midwife, who in spite of challenging working circumstances, did their best to accommodate the birthing women. The combination of the organisational risk rhetoric of birth as dangerous and always in need of several interventions to keep it safe; the professional prerogative of the midwives as birth experts; and the reproduction of femininity norms evident in the friendly and accommodating attitude of both birthing women and midwives; made the prospect for women to decline intervention and to have a say in matters regarding their bodies, dismal and often close to non-existent, which manifested the medicalisation of childbirth. Moreover, Malacrida and Boulton (2014) found that once women accepted one type of intervention, this inevitably led to a 'cascade of interventions', making it more or less impossible for the women to exercise free choice once the process was in motion.

Similar findings as those of Study IV, have been presented by Newnham, McKellar, and Pincombe (2017), who found in a hospital ethnography that in

focusing on technologies, the institutional needs trump those of the individual woman. By the use of active management of labour and the partogram, whereby women's labours are augmented with synthetic oxytocin if they do not reach a cervical dilation of 1 cm per hour, Newnham et al. identified an institutional demand to 'push women through' the system, which paradoxically introduced new areas of risk in the attempt to keep women safe (Newnham et al., 2017). Waldenström (2005) attributes the overuse of medical technology to midwives and physicians becoming 'speed blind' over what is medically and technologically possible, and them not always considering the psychological or ethical dilemmas that come with new innovations. Other reasons may be the fear of litigation should a decision have a fatal outcome, a lack of competence in handling a complicated birth without hastily resorting to caesarean section, and the issue of understaffing (Ibid.). In the latter case, also demonstrated in Study IV, a midwife who is assigned more than one woman in labour may use continuous foetal monitoring as a way to simultaneously monitor them all on a screen in the midwives' station, without being physically present in the birth room herself, or may suggest epidural analgesia as a replacement for the midwife's presence and support (Ibid.).

Birth satisfaction – Why are women so satisfied?

Despite most primiparas ending up having more pharmacological pain relief than they anticipated in their birth plans, Study II shows that they were generally very satisfied with the birth experience. Furthermore, there was no significant difference between women with or without birth plans. Multiparas were more satisfied than primiparas, 8.4 vs 7.4, (p<.001), and women without epidural analgesia were more satisfied than women with epidural, 8.3 vs 7.2, (p<.001). The higher the number of interventions, the lower the level of satisfaction.

Analysing women's written birth evaluations through word frequency and thematic analysis, and interpreting the results through the perspective of gender normativity in Study III, allowed for a deeper understanding of the women's ratings of their experiences. In the predominantly positive evaluations, the women focused on the midwives' attitude, attributes, and the emotional support they provided. The women appreciated a midwife who was relation-oriented, sensitive to the needs of others, perceptive, sweet, calm, compassionate, and accommodating – nurturing traits usually associated with a socially constructed norm of femininity. In the cases where women had ambiguous feelings about the birth experience, being satisfied and dissatisfied at the same time, they belittled their own feelings, made excuses for the midwives' absence from the birth room, perceiving she was busy assisting other women, and were very understanding towards the midwives' stressful work conditions. The negative comments mainly concerned women's experiences of feeling invalidated and neglected; lack of

information and dialogue; criticism of care, routines, and physical environment; and pain and discomfort. Most of the women's criticism was directed not towards the midwives, but towards the labour care organisation, and included suggestions to hire more midwives and increase their salaries.

The positive evaluations may be indicative of a well-functioning labour care where women are satisfied with the care they receive. But there is a paradox in women having ideas, wishes, and expectations before birth, not having them met in terms of pain relief, being subjected to various intrapartum interventions, and still being very satisfied and grateful. This may in part be explained by the timing of the evaluation. An evaluation of one's birth experience within 48 hours after birth may perhaps not give an accurate picture, as the more negative aspects may take longer to process (Waldenström, 2004). Also previously briefly touched upon, there is the spatial aspect of contemporary childbirth. In Sweden, most women give birth in hospitals, which despite being public institutions still remain a secluded space, relatively free from insight. Women may therefore not know what to be critical of, but are inclined to value whatever care they have experienced, assuming that 'what is, must be best' (van Teijlingen et al., 2003).

In a society and a labour care built on risk, and where childbirth has become equated with one of the most dangerous things a woman can do, the birth evaluations may be coloured by relief at labour being over and having a healthy baby (MacKenzie Bryers & van Teijlingen, 2010; Waldenström, 2004). It is worth considering that the outcome measures of childbirth have until quite recently been focused on a healthy mother and baby, without acknowledging the feelings and experiences of the woman or the interpersonal relationships between the woman and her carer/midwife (Hunt & Symonds, 1995; World Health Organization, 2018). Women have been told that 'all that matters is a healthy baby', but while the welfare of the baby is the most important aspect for most women as well as for labour care, women's experiences matter, too (Hill, 2019). Childbearing women have indeed been found to value physical safety and psychosocial well-being equally, and placing focus on the baby, or on health and survival alone, risks downgrading women's sometimes traumatic childbirth experiences and effectively silencing potential criticism of care (Downe et al., 2018; Hill, 2019). Drawing on Prokhovnik's (1999) feminist critique of dichotomous thought, it is not a matter of 'either/or', but 'both-and'. In this line of reasoning, there is no contradiction in women having both a safe birth and a positive birth experience. Exploring how and why women define the experience as positive then becomes all the more important, which was the aim of Study III.

Normative femininity – The tyranny of nice and kind

One way to interpret women's reported satisfaction with their birth experiences is through the lens of gender normativity, exploring how birthing women and midwives conform to socially accepted gender norms (Carter, 2009; Martin, 2003). Study III and IV showed that both women and midwives displayed traits associated with normative femininity according to Western standards, being thankful, sympathetic and understanding towards the needs of others, relational, caring, polite, and selfless, subject to what Gilligan (1982) calls 'the tyranny of nice and kind'. These traits are similar to the ones that the women in Study I used in their birth plans to describe how they wanted their midwife to be or act – wanting a midwife who was 'kind, caring, compassionate, perceptive, sensitive, funny, older, informative, motivational, and firm'. This shows that even before birth, there is an expectation on the midwife to behave according to gendered norms. In a woman-centred care, built on the reciprocal, equal, and trusting relationship between woman and midwife, this may not pose a problem, and may even enhance the birth experience (Fontein-Kuipers, de Groot, & van Staa, 2018a).

However, in the case where relational and emotional care is considered secondary to medical care – which is common in a patriarchal, hierarchical, and medicalised care context, the standard of many Western labour care organisations – displays of normative femininity may instead prove disadvantageous to women, both birthing and midwives. In such an environment, women's internalised sense of gender may lead them to self-discipline into compliant 'good patients', and gratefully accept nearly anything that is suggested or done to them, especially coming from a nice and kind midwife (Martin, 2003). For the midwives, working in a hierarchical organisation, the drive to be nice, kind, and selfless, places them in the precarious position of 'piggy in the middle', trying to accommodate the needs of everybody – birthing women, colleagues, and organisation (Murphy-Lawless, 1991). This was revealed in the interviews with the midwives in Study IV, where they described feelings of inadequacy when being torn between supporting birthing women and supporting colleagues. In this respect, being nice and kind does have the potential of becoming tyrannical, at least towards the midwives themselves.

The art of doing 'nothing' well

Returning for a moment to the hypothesis of the obstetrical dilemma discussed in the beginning of this thesis, positing that women's deficient bodies, flawed by design, made birth dangerous to both herself and her baby, and was thus the reason why women surrounded themselves with people during birth: for assistance in case of a complication (Rosenberg & Trevathan, 2002; Washburn, 1960). Birth support, or midwifery, has been described as one of the oldest

professions in the world, but while handling certain birth complications is part of midwives' work, this is not their only task, as birthing women may need birth support for other reasons. Since Washburn presented his hypothesis in the 1960's, there has been substantial evidence to the benefits of physical, social, and emotional support during labour and birth, for the birthing women and their babies, in terms of satisfaction with the birth experience and health outcomes; for the midwives in terms of job satisfaction; and for the birth organisation in terms of lower costs (Bohren et al., 2017; Renfrew et al., 2019; Renfrew et al., 2014; Sandall et al., 2016).

As shown in studies I, III, and IV, relational and emotional care was central to both women and midwives, visible in women's expectations before birth, in the women's birth evaluations, and in the observations and interviews with both women and midwives. The kind of intuitive and skilled midwifery support that they valued is sometimes described as 'being with woman', the core concept of midwifery, as the word 'midwife', derived from Old English, literally means 'with woman'. (Hunter, 2002). 'Being with woman' entails 'the provision of emotional, physical, spiritual, and psychological presence and support by the caregiver as desired by the labouring woman' (Ibid., p. 650). For the midwife this could mean using all her senses to observe and support the woman, and to know if and when to intervene – watching how the woman moves, the tone of her skin, the dilation of her pupils, her facial expression; listening to the sounds she makes and to the heartbeat of the baby; smelling the scent of the woman's labour; tasting the atmosphere in the birth room, offering encouragement and reassurance; and using touch to give a massage or to feel how the baby turns and moves down the birth canal (cf de Jonge, Dahlen, & Downe, 2021). In order to promote this aspect of midwifery care, de Jonge et al. (2021) propose the term 'watchful attendance' (in Swedish 'vaksam närvaro'), which expresses a combination of continuous support, clinical assessment, and responsiveness.

Maintaining a supportive presence and staying with the woman as she desires has been described as the 'art of doing "nothing" well', more accurately termed as 'being with' and only intervening when necessary (Powell Kennedy, 2000, p. 12). The elusiveness of 'being with' may in part have to do with it being based on intuitive and tacit knowledge, difficult to articulate and only possible to reveal in practice, if even then (Barnfather, 2013). There is also the need to consider the gendered nature of relational and emotional support, emotion work often perceived a 'natural female' skill. According to Western societal and cultural gender constructions, women are considered inherently caring, empathising, negotiating, and relational (Connell & Pearse, 2015; Guy & Newman, 2004). When conflating emotion work with gender, work skills and abilities may be taken for granted, making predominantly women's (here the midwives') work

undervalued, uncompensated, and something that becomes invisible, even to the midwives themselves (Guy & Newman, 2004; James, 1989; Renfrew et al., 2019).

However elusive, doing 'nothing' is a skill. Considering the technology and interventions available in modern labour wards, midwives (and obstetricians) constantly need to weigh the possible benefits of one intervention against its potential detrimental effects for mother and baby, and to also be aware of the 'cascade of interventions' which easily follows once the first step is taken (Jansen et al., 2013; Malacrida & Boulton, 2014). One-to-one care, the midwife focusing on one woman at a time, and being able to practice 'watchful attendance', is a good place to start doing 'nothing'.

Just as this thesis begins with an observation of the interaction between a birthing woman and a midwife, it ends with one, this time an example of a 'being with' and doing 'nothing'.

> *The midwife is close to the woman, breathes with her through the contractions, and when she talks to her, she is aware of her non-verbal language and sits on a low stool so as to not look down on the woman and avoid making her feel inferior and out of control. Her voice and her movements are calm, she uses simple language, lots of affirmations, focuses on the positive, explains what is happening, and she also addresses and involves the partner. She guides the woman to 'do the right thing', and to trust her body. The woman owns the room. In a couple of hours, a healthy baby is born, no vaginal tearing, normal blood loss, no stress, parents crying tears of joy and relief.*
>
> ~Field note from a labour ward, AW~

Conclusions

Sweden is considered one of the safest countries in the world to give birth and to be born in. Thanks to the medical, technical, and surgical proficiency of Swedish midwives and obstetricians, the rates of maternal and neonatal mortality in a global comparison are very low. But outcomes cannot be measured solely in terms of survival. Besides being a biological and physiological process, birth is also a social and cultural event; and perhaps above all, birth is existential, bringing about new life, new mothers, new parents, new families, and new members of society.

Drawing on a long history of the subordination of women and a medicalised view of women's bodies as deficient, and – especially during childbirth – in need of surveillance and control, labour care has come to be equated with various

interventions in order to manage the process of childbirth. Interventions are sometimes vital for a safe birth, but overuse introduces more risks to women and their babies, partly in the form of a 'cascade of interventions'. In Sweden, fewer women than ever give birth without interventions such as induction and augmentation of labour, epidural analgesia, and caesarean section (The Swedish Pregnancy Register, 2019).

This thesis shows that women and midwives alike have similar ideals of childbirth, many valorising natural childbirth and a woman-centred, relational care, based on trust and reciprocity. When comparing women's expectations and wishes for pain relief, as expressed in their birth plans, with actual pain relief used, first-time mothers used more pharmacological pain relief than intended, and 93.6% of them had some form of intrapartum intervention. Regardless of having a birth plan or not, primiparas used more pain relief, had more interventions, and were slightly less satisfied with their birth experiences than multiparas. Nevertheless, the women were generally very satisfied with their birth experiences when asked within 48 hours of birth, especially with the emotional support from the midwives. In a manner that is suggested to affect their birth experiences, women displayed examples of gender-normative behaviour, being thankful, sympathetic, and belittling of their own feelings or requests, despite some women feeling that they did not have the support or birth experience they had hoped for. In the interaction between women and midwives in the birth room, the midwives continuously bridged the gap between the medical and the social models of care, integrating medicalised practices into midwifery care. Although very passionate about their work, low staffing, hospital hierarchies, and working against their ideological convictions came with a price, at times leaving midwives with feelings of inadequacy and a bad conscience, as they attempted to meet the disparate needs of birthing women and colleagues, as well as the demands of the work place.

Women's birth choices and experiences and midwives' working conditions are closely intertwined, and mirror contemporary discourses not only on childbirth, but also on women's rights and position in society. The present work illustrates that women's and midwives' birth ideals, i.e. relational, one-to-one care, incidentally supported by a growing body of evidence, is in conflict with a medicalised and efficiency-driven labour care organisation, leading to job strain for midwives, and a fragmented and interventionist birth care for women. More attention needs to be drawn to the impact of societal and cultural gender norms on contemporary birth practices. There is also the need to recognise birth as existential, emotional, and potentially empowering experiences for women. To achieve this, women need to be informed of, and offered, choices in the way they give birth. At the same time, midwives must be given the time and the support of

the organisation to be able to practice 'watchful attendance', acknowledging the values of relational care and emotional support.

In response to the 'Swedish maternity care crisis', the government has provided substantial funding to improve women's health care, and there are indications of improvements in some areas. However, there is more to be done. Based on women's preferences and birth evaluations, midwives' ideals of care, and best evidence, below are some suggestions for taking Swedish labour care beyond medical and technical excellence and safety, to a woman-centred labour care that also recognises and values the emotional, existential, and empowering aspects of birth. Importantly, regardless of mode of birth, choice of pain relief, or birth interventions: women's bodies are not deficient, they are divine.

Implications for practice

Based on the findings in Papers I-IV, in order to curb the increasing medicalisation of childbirth and to support physiological birth, the following measures are here presented as suggestions for practice:

Increasing the chances for a physiological birth starts with eliminating stress. To this end, increased midwifery staffing is needed in order to facilitate one-to-one care, ensuring that the midwife can give her undivided attention to one birthing woman at a time. Furthermore, efforts should be made to keep senior midwives in the profession, functioning as mentors for junior colleagues and teaching them the art of midwifery – skills that take years to acquire.

The physical environment in the birth room can have a profound influence on the birth experience. Without compromising safety, birth rooms need to be designed to reduce stress and anxiety, which are known to inhibit the physiology of labour. Some suggestions are visual scenery on the walls; making the labour bed less prominent; creating space for moving about and changing positions; installing bathtubs in every room with the possibility to use nitrous oxide when bathing; and having birth tools, like mattresses, birth balls, birth stools, birth ropes, walkers, etc. visible in the room.

The current electronic medical record system for labour care does not specify the physical, social, and emotional support that midwives provide, such as breathing and relaxing exercises, massage, counterpressure, changing birth positions, use of birth tools, encouragement, and use of the midwives' senses, making their work largely invisible and thus unacknowledged. Making midwifery support explicit in the medical records would make it visible not only to the midwives themselves and to colleagues, but also in routinely collected data for national statistics, which

in turn may result in greater recognition for the art of midwifery, and remind providers, policymakers, and funders of its value.

Midwives, being the primary caregivers in normal antenatal, intrapartum, and postnatal care, need to be represented on all levels – local, regional, and national – in executive groups with decision-making power. Midwives also need to be involved in the development of clinical guidelines and other matters affecting both their own work and the women in their care.

Other models of care than obstetrician-led, hospital-based labour care could serve as an option for healthy women with normal pregnancies on request – for instance, midwife-led continuity models of care, such as case-load midwifery, midwife-led units, and home births. Evidence has shown such care to be less interventionist, increase women's satisfaction with the birth experience, and increase midwives' job satisfaction, in addition to having a cost-saving effect.

Further research

In Study I, the women revealed high expectations of their partners. They were greatly dependent on their partner's active involvement, both as a supportive birth partner to share the birth experience with, and as a spokesperson in case she herself would be unable to communicate, make decisions, or process information. Due to low staffing, midwives do not always have the time for one-to-one care, and many couples are thus left alone for a large part of labour. Further research into partners' experiences of their perceived responsibilities is therefore needed, either through individual interviews or via focus group discussions.

Obstetricians, trained in handling complicated births, are by the power of medicine in charge of labour care in Sweden. Through the use of individual interviews or focus group discussions, investigating their attitudes towards the increasing intrapartum intervention rates would greatly add to the body of knowledge on medicalised birth practises.

Focused ethnography, used in Study IV, is a valuable research method to study subcultures in a specific health care setting. However, participant observation of one's peers in a familiar care setting, raises questions on how to juggle the insider/outsider perspective. Thus, a methodological study to address issues that arose during the conduct of Study IV, may be relevant for future ethnographers studying birth culture and midwifery practice.

Overall, when conducting midwifery research, a gender perspective may prove a valuable tool in listening to and making women's voices heard, and in offering a deeper understanding of the forces that shape women's lives.

Acknowledgements

Även om jag har levt och andats denna avhandling sedan jag blev antagen som doktorand, så har den författats i ett sammanhang. Jag vill därför rikta ett stort och hjärtligt tack till alla som på ett eller annat sätt bidragit till dess tillblivelse:

De kvinnor som lät mig granska deras förlossningsplaner, journaler och utvärderingar. Ett särskilt tack till de kvinnor och deras partners vars förlossningar jag fick vara med på och till de barnmorskor som assisterade dessa kvinnor.

Huvudhandledare Monica Christianson. Jag har verkligen uppskattat ditt engagemang och dina snabba och kloka återkopplingar. Stort tack för roliga och kreativa samtal och för att din dörr alltid stått öppen närhelst jag behövt dryfta något.

Bihandledare Kerstin Edin. Tänk att det här är den fjärde förlossningen du assisterar mig igenom. Stort tack för din klokskap och ditt aldrig sviktande engagemang för förlossningskonst. Du är en sann förebild för alla barnmorskor.

Denis Walsh, Marie Lindkvist och Bo Nilsson, mina medförfattare på varsin artikel. Jag är enormt tacksam för era bidrag som varit ovärderliga och lyft artiklarna till nya nivåer.

Birgitta Olofsson, min examinator som hållit ordning på alla delmål och uppföljningar under doktorandutbildningen. Stort tack för att du alltid hållit huvudet kallt och avdramatiserat hela doktorandhypen.

Ledning och arbetskamrater på institutionen för omvårdnad. Tack för god stämning och glada tillrop. Ett särskilt tack till Majken Hjalmarsson som kan svaret på alla möjliga och omöjliga frågor, samt till Larry Fredriksson som snabbare än blixten fixat krånglade dator. Ett stort tack också till alla gamla och nytillkomna doktorander, ingen nämnd, ingen glömd.

Bästa, finaste, fantastiska Karin Jonsson. Vi har delat både arbetsrum och tårar men mest skratt. Fasen, vad mycket roligt vi haft! Jag är så tacksam för att vi fått följas på vägen och göra den här helt omöjliga resan tillsammans. Du är den mest omtänksamma människa jag känner och utan ditt stöd hade det aldrig gått.

”Gammdoktoranderna” Annica Backman, Annika Bay, Jenny Molin, Ulrika Öberg. Vår tid i doktorandrummet är oförglömlig. Att få skratta på jobbet trots stor arbetsbörda har betytt enormt mycket. Ser fram emot att få ses på riktigt, även om vår grupp online är ett bra substitut tills vidare.

Doktoranderna och Superstjärnorna Rebecca Baxter, Cecilia Hultstrand Åhlin, Anette Nyberg, Anna Sjöström, Anna Unneby. Allteftersom ”gammdoktoranderna” flyttade

ut ur doktorandrummet så flyttade ni in och fortsatte bidra till den goda stämningen. Stort tack för all pepp jag fått. Ni är guld värda!

Lena Kroik, din sköna inställning till livet är inspirerande. Det har varit så roligt att få lära känna dig och följa ditt spännande projekt.

Nina Smulter, nu är bilderboken klar! Stort tack för skratt genom åren och för att du gjorde statistikkursen ännu roligare än vad den redan var.

Ledning och medarbetare på Umeå Centrum för Genusstudier och Genusforskarskolan med trojkan Linda Berg, Annelie Bränström Öhman och Veronika Lodwika i spetsen. Stort tack för alla klokord och uppmuntran och alla aktiviteter med Genusforskarskolan ni styrt upp under min tid som genusdoktorand. Tack också till superskärpta seminariegruppledarna Bodil Formark, Eva Silfver och Maria Carbin för ert insiktsfulla och fina sätt att leda det goda akademiska samtalet.

Mina doktorandkollegor i Genusforskarskolan. Tack för utmanande och lärorika seminarier och trevligt umgänge på våra awaydays. Ett särskilt tack till Desirée Enlund, vars kloka och ettriga sällskap jag verkligen uppskattat under de här åren, och till Hannele Junkala som inspirerat stort med smarta synpunkter och cool attityd.

Alla kollegor från olika yrkeskategorier på BB- och Förlossningsavdelningen på NUS, Umeå. Jag saknar er och jag saknar barnmorskeriet. Tack för pepp och för visat intresse för min forskning och tack för det oerhört viktiga arbete ni på daglig basis utför.

Susanne Edenor, du är en sann förebild med ett fantastiskt driv. Stort tack för våra goda samtal och för allt stöd och uppmuntran.

Bodil Frey, driftigare människa får man leta efter! Ditt engagemang för födande kvinnor och tidigt föräldraskap är fantastiskt. Din målning ”Kvinnans skapelse” gjorde djupt intryck på mig när jag såg den för snart 10 år sedan och jag är så tacksam för att jag fick använda den att pryda framsidan på min avhandling.

Caisa Hellborg, goaste, finaste söstra mi. Stort tack för alla härliga sms, samtal, brev och paket som hjälpt mig hålla näsan ovan vattenytan. Let’s do this!

Lena Hjerm och Ewa Lindh. Från sjuksköterskeutbildningen till kladdkakor och småbarnsträffar till restaurangmiddagar utan barn. Jag är så tacksam för att ni har funnits i mitt liv så länge. Dags för en ALE-träff snart!

Johanna Högdal, det finns inga ord för hur mycket du betyder för mig. Utan våra samtal om smått och stort hade jag inte varit där jag är idag. Du har sagt så mycket klokt men jag väljer detta: Det är bara på lek! Livet, alltså.

Malin Sandström Blümer, jag är så glad att vi hittade varandra igen efter alla år. Din positiva energi knockar mig varje gång. Tack för att du är du!

Cia Sandström, du imponerar djupt med ditt engagemang för att kvinnor ska kunna föda på sina villkor, och ditt arbete är något jag har kunnat använda som drivkraft i avhandlingsarbetet. Stort tack för pepp och stöd under de här åren!

Mina två GF's Elvira Sjöstedt Frisén och Elin Thomasson. Jag saknar våra fantastiska dinnerdates och er underbara humor. Stort tack för skratt och pepp!

Tiina Valham, första GF och bara helt fantastisk! Tusen tack för att du inte gett upp hoppet om mig när jag har varit världens sämsta polare den sista tiden. Dina jämna nedslag har betytt och betyder så mycket för mig. Du är så klok och jag är så tacksam för att du finns.

Klanen Westergren: Pappa Ingvar, mina syskon Per, Annika, Ulrika, Lars, respektive och syskonbarn och nya och kommande klanmedlemmar. Mamma Ethel lade grunden till vår starka sammanhållning och det vi har är unikt. Att veta att ni alltid finns där betyder allt. Även om alla är helt fantastiska så vill jag rikta ett särskilt tack till Ulrika utan vars dagliga kontakt jag hade kastat in handduken för länge sedan. Du är min avhandlingsdoula och bara helt amazing!

Luigi Meucci, tack för att du har funnits vid min sida i över 30 år och för att du alltid har stöttat mig och trott på mig under alla infall jag haft under årens lopp. Vi har gjort det bra. Grazie di cuore.

Mina underbara, kloka, fina, fantastiska, vackra, älskade barn Alessandro, Emilio, Daniele, Amanda, Federico, Nicola. Utan mig, inget ni. Utan er, inget jag. Ni är mina läromästare och det bästa jag någonsin gjort. Tack för mat och städ och goda bakverk, för språklig input, bildredigering och filosofiska bidrag till avhandlingen, för stöd, förståelse och kärlek. Jag är så tacksam och stolt över att få vara er mamma och jag älskar er så att hjärtat svämmar över.

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Appendix

Appendix 1, Birth plan

Förlossningsplan

Namn:_____ Personnr:_____

I förlossningsplanen kan du som blivande mamma uttrycka vad som är viktigt för dig när du ska föda barn. Den bidrar till att personalen lär känna dig och dina önskningar och därigenom kan bemöta dig på ett så bra sätt som möjligt under förlossning och eftervård. Det du skriver kan ligga till grund för samtal med mödravårdsbarnmorskan och barnmorskorna som du möter på förlossning- och BB-avdelningen.

1. Finns det något som du tycker är viktigt att förmedla om dig själv som kan vara av betydelse under förlossningen?

_____
_____
_____
_____
_____

2. Vilka avslappnings- och smärtlindringsmetoder skulle du föredra att använda när du föder?

_____
_____
_____
_____
_____

3. Hur kan vi stödja samarbetet mellan dig och din partner under förlossningen?

_____
_____
_____
_____
_____

4. Hur tänker du dig de första dagarna efter att du har fött?

_____
_____
_____
_____
_____
_____

Välkommen till förlossningen och BB!

Förlossningsplanen är en del av din förlossningsjournal och kommer att sparas på Kvinnokliniken.

Appendix 2, Birth evaluation form

Namn:.....

Förlossningsdatum.....

TILL DIG SOM NYSS HAR BLIVIT MAMMA!

Grattis!

Vi som arbetar med vårdutveckling och uppföljning på förlossningsavdelningen vill gärna veta hur du upplevde din förlossning.

Vad känner du när du tänker på din förlossning?

Försök skatta din upplevelse genom att sätta ett kryss på skattningsskalan nedan.

0 ---------- 10

Negativ Positiv

Vad tyckte du var bra? Vad kunde göras bättre?

.....

.....

.....

.....

.....

Appendix 3, Observation guide, page 1

Kvinna (initialer/obs.nr/datum/tid): **Barnets kön:**	**Barnmorska (initialer/obs.nr):**
Ålder:	Ålder:
Etnicitet:	Etnicitet: (Kön):
Civilstånd:	Yrkesverksamma år som bm/förlossningsbm:
Yrke:	Tid på sal/gör på sal (dokumentation?):
Paritet:	Andra uppgifter samtidigt:
Grav.längd:	Hur använder hon sig själv (andning, avslappning, massage, lugn, närhet, beröring):
Normal grav/komplikationer:	Position i rummet, språkbruk, riskmedvetenhet:
Spontan start/induktion:	Mjuk, följsam/bestämd (min tolkning, ge exempel):
Förlossningsplan (ja/nej) önskemål (i intervjun):	Rutiner vid kryst- och framfödande:
Användande av hjälpmedel:	Emottagande/hanterande av barnet:
Värkhanteringsstrategier:	Rutiner, lugnt och stillsamt eller hetsigt och påskyndat: Enligt PM?
Smärtlindring:	Amningsstöd:
Förlossningslängd:	Efterskötning:
Förlossningsställning:	
Sugklocka/kejsarsnitt/blödning/annan komplikation:	
Bristningsgrad:	
Amning:	

Appendix 4, Observation guide, page 2

Om förlossningssalen

Storlek på rummet, inredning, färger, ljus, sängens placering i rummet, är lustgas och annan medicinsk-teknisk utrustning dolda, andra möbler/inredningsdetaljer, tillgång till toalett/dusch/bad, tillgång till hjälpmedel som gåbord, pilatesboll, saccosäck, rep i tak, förlossningspall, säng med ombyggnadsfunktion, tillgång till promenader utomhus

Interventioner och rutiner

PVK, amniotomi, oxytocinstimulering, urintappning, skalpelektrod, kontinuerligt CTG, yttre press, klipp, forcerad krystning, perinealskydd, avnavling, third stage active management, Oxytocin, Konakion, mössa

Interaktionsobservation

Personkemi(?)/inställning till bm/kvinnan (bm som kameleont), maktförhållanden, gester, blickar, språkbruk, ordet ”inte”, vem säger vad, vem uttrycker behov av smärtlindring först, vems är förlossningen, vem äger rummet, var är fokus i förlossningen

Mina reflektioner efteråt:

Appendix 5, Interview guide women

Intervjuguide kvinna

Kvinna (initialer/obs.nr/datum/tid):
Barnets kön:

Teman
Förväntningar, förberedelser och önskemål. Vad vill kvinnor ha? Vad är hennes bild av/inställning till att föda?
Smärta. Synen på smärta som guide eller onödig/medicinskt behandlingsbar.
Smärtlindring, egna strategier, önskemål. EDA/ingen EDA? Nöjd?
Upplevelse av stöd från bm.

Specifikt om observerad förlossning
Berätta om din förlossning. Från början till slut. Hur började det? Hur gjorde du då? När åka in? Bra? Mindre bra? (Ev).
Hur upplevde du emottagandet på Förlossningsavdelningen? Hur var det att etablera kontakt med bm?
Hur upplevde du miljön på Förlossningsavdelningen?
Hur tänker du om stöd under förlossningen?
Vad har du för tankar om den barnmorska som assisterade dig när du födde barn?
Vad är din syn på smärta/förlossningssmärta? Skillnad? Vägledande? Onödig?
Hur hade du tänkt dig och hur blev det? Nöjd? Blev det som du hade tänkt? Kanske inte, men blev det på egna villkor? Känsla av autonomi? Empowered eller överrumplad? Hur mkt får man bestämma?
Om du fick ändra på något under förloppet, vad skulle det vara?
Hur upplevde du att din partner var med under förlossningen?
Hur skulle du skatta din smärta? 0-10
Hur skulle du skatta din förlossningsupplevelse? 0-10
Är det något du vill tillägga? Något jag glömt att fråga om som du tycker är viktigt/vill ha sagt?

Appendix 6, Interview guide midwives

Intervjuguide barnmorska

Barnmorska (initialer/obs.nr):

Teman
Smärta. Synen på smärta som guide eller onödig/medicinskt behandlingsbar.
Smärtlindring
Stöd
Känslor i yrket
Synen på bm-yrket och dess utveckling
Makt

Generellt
Hur skulle du beskriva en vanlig arbetsdag?
Vad är en barnmorskas roll under förlossningen?
Hur hanterar du olika känslor som kan väckas under en förlossning? Lycka, glädje, sorg, ilska, frustration? Hos dig? Hos kvinnan? Tar du med dig jobbet hem? Är du ditt jobb?
Hur ser du på födandet? Vad är att föda barn?
Vad är din syn på smärta/förlossningssmärta? Vägledande? Onödig?
Hur ser du på smärtlindring? Vad är smärtlindring för dig?
Hur ser du på partnerns roll under förlossningen?
Hur ser du på stöd? Vad är stöd? Känner du att du har möjlighet och tid att ge kvinnan det stöd hon kanske behöver?
Känner du att du har hittat ett bra arbetssätt eller skulle du vilja jobba på ett annat sätt? Hur då? Finns tid till utveckling/reflektion? Hur fungerar dialogen bm-obstetriker? Vem bestämmer i slutändan om t ex utformande av PM?

Specifikt om observerad förlossning
Hur upplevde du förlossningen du just bistod?
Berätta vad du anser var din uppgift under just den här förlossningen?
(Hur du upplevde att partnerns närvaro?)
Kan du berätta om själva förlossningsförloppet? Upplevde du att det fanns något som hade kunnat göras på något annat sätt?
Hur tänkte du om kvinnans sätt att hantera sin smärta? Om hennes val/behov av (vilken) smärtlindring?
Jag observerade att du gjorde…? Kan du berätta hur du tänkte då?
Man kan tänka lite olika på vem det är egentligen som är expert på kvinnokroppen – kvinnan i vars kropp det händer eller barnmorskan som sett många andra liknande förlopp. Hur tänker du runt det? Hur mkt kan kvinnan egentligen bestämma själv?
Är det något du vill tillägga? Något jag glömt att fråga om som du tycker är viktigt/vill ha sagt?