

Trusting Women, Respecting Birth *Prenatal Care In Sweden*

For many years Sweden has been known as one of the best places in the world to have a baby. The reasons for this include many policies and services which create a safe, secure, and supportive environment for women and children. One critical factor is the availability and quality of prenatal care services. Drawing on a year of observation, participation, and interviews, I describe Sweden's prenatal care system from the perspectives of those who provide the services (midwives) and those who use them (pregnant women). I focus on three key aspects that help explain why care is good for mothers and produces good medical outcomes: a respect of birth as a natural process and women as capable of giving birth; accessible and standardized services; and childbirth preparation classes that focus on social support as well as medical information.

The experience of mothering depends in large part on the social, cultural, economic, and political context within which women live. In order for mothers to best care for their children they need access to resources such as: maternal and child health care, formal education, economic opportunities, and maternity leave benefits (Save the Children, 2008). For many years, Sweden has been rated the best country in the world to be a mother.¹ Women in Sweden have a high level of formal education, easy access to contraception, and guaranteed health care. In addition, Swedish women have generous paid maternity leaves (480 days), the highest percentage of women with seats in the national government, and the highest male to female ratio of earned income of the 146 countries studied by Save the Children (2008: 39). This constellation of resources, policies, and services in Sweden has resulted in one of the lowest infant mortality rates in the world (2.75/1000 estimated data for 2008 compared to 5.08/1000 in Canada and 6.3/1000 in the U.S.) (CIA World Factbook). In this study, I focus on

one of the factors that has made Sweden the best place to be a mother—their system of prenatal care. Prenatal care is essential to help insure the mother's health, the health of her baby, and to provide mothers with the information they need to help care for their children.

Based on interviews and participant observation, I examine the Swedish prenatal care system from the perspective of those who provide services (midwives) and those who use the services (pregnant women). I focus my description around three key aspects of the prenatal care system that I believe help explain why it is good for mothers and produces good medical outcomes: (1) birth is viewed as a natural process and women are viewed as inherently capable of giving birth; (2) services are easily accessible and designed to be equitable; and (3) free childbirth preparation classes focus on creating ongoing support systems as well as providing medical information.

Studying birth in Sweden

For several years I have been a co-leader of a study abroad course that takes students to Sweden for two weeks in the summer to learn about the health and welfare system. It was during these visits, and my previous research on women's health in the U.S., that I became very interested in birth in Sweden. With a few contacts from my summer experiences, I moved to a suburb of Stockholm, Sweden for the 2005-2006 academic year to learn first hand what made Sweden the "best country in the world to be a mother."

I began my research by being out and about in the city, learning a little Swedish, and basically trying to become a resident in my community. My two children were in a local compulsory school (grades 1-9), which brought me into contact with other parents. I also began talking to women I knew about their experiences giving birth. They introduced me to their friends, who also shared their stories. Eventually, I conducted semi-formal interviews with 13 new mothers, meeting them in their homes, joining them for walks, or sitting with them in cafes. These interviews lasted from one-and-a-half to four hours.

Through my previous contacts, I met several midwives who graciously allowed me to interview them and, in some cases, observe them in their work. I spent over 50 hours observing in four different prenatal clinics in Stockholm and surrounding cities. I sat with midwives as they met with patients, had coffee and lunch with them in between visits, and peppered them with questions at all opportunities. I also observed in five hospital maternity units spending over 40 hours with midwives as they assisted women in labor and birth. I conducted interviews with 12 midwives and had informal conversations with many of their colleagues. I took notes during the all interviews and observations and reviewed and summarized them on the train or bus ride home, completing them later in the evening if necessary. Throughout the year, I continually observed mothers, fathers, and children in public areas and spoke informally with many of them about my research.

Structure of prenatal care

Maternity care in Sweden is situated within the primary care system and reflects the country's overall guidelines that health care should be publicly financed and provided to all residents, on the basis of need. Care should be characterized by a high level of accessibility, good quality, and freedom of choice for the individual (Ministry of Health and Social Affairs, 2007). Prenatal care in Sweden is free and operated primarily through community-based public health clinics, with the midwife as the primary caregiver. Midwives are hired specifically to work in prenatal care centers, hospital labor and birth units, or postpartum units. Some work part-time in both prenatal care and labor and birth units but most are employed in only one area at a time.

Pregnant women typically see the same midwife for the majority of their prenatal care. In uncomplicated cases, women usually have seven to nine prenatal visits. The focus of the first visit is primarily physiological assessment and history taking and occurs around week 10-12. New patient visits are typically 1-1.5 hours and follow-up visits are generally scheduled for 30 minutes in both private and public prenatal clinics. Ultrasound is generally done in the second trimester (week 17-19). The second visit with the prenatal midwife occurs around week 24 with one visit every two to three weeks for the rest of the pregnancy. In 2008, an early visit was added for women as soon as they learn they are pregnant. These are information and education sessions which may be held individually or in groups (SFOG and SBF, 2008). The content of prenatal care, as described above, is quite similar to prenatal care in the United States, although visits may be a bit longer. Overwhelming, women in Sweden are quite satisfied with their prenatal care (Hildingsson and Rådestad, 2005; Hildingsson, Waldenström, and Rådestad, 2002).

In countries like Sweden, with universal medical care, virtually every pregnant woman receives prenatal care beginning in the first trimester (Hildingsson, Waldenström, and Rådestad, 2002; Walker, 2005). In contrast, in the U.S., approximately 84 percent of women receive first trimester care, with significant disparities between racial/ethnic groups (Maternal and Child Health Bureau, 2005).

“The assumption is birth will be normal”

Since midwives provide virtually all prenatal care in Sweden, there is a strong emphasis on birth as a natural process that should not be interfered with unless necessary. The following brief statements, all from different midwives, emphasized the way they approach pregnancy and birth: “Midwives are protectors of natural birth,” “We generally trust in everything going right,” “If it's not necessary, we don't do it.” A female obstetrician I spoke with highlighted the difference in training between OB and midwifery:

In Sweden midwives have their own place. Women have always delivered other women. We have good statistics here because the moms get good educa-

tion through the midwives and the classes they hold. OBs do what they are trained in—pathology. I almost never attend a normal birth. I am so busy already I don't want more to do. (Female obstetrician, three children)

As she notes, obstetricians are regarded as those trained in pathologies, what goes wrong with birth, and that is their domain. Midwives are viewed as the appropriate providers for most births since they are trained in the way most births occur—normally. The cultural message that women receive has traditionally emphasized the normality of birth rather than the pathology. Media stories and American TV shows such as “Birth Stories” have begun to erode this belief in recent years. Midwives report spending a lot of time during prenatal visits reinforcing the view that generally everything goes just fine. There are several ways midwives and the prenatal policies support this.

Attending to fears

Midwives reported spending more and more time in recent years talking with women about fears, worries, and psychological issues. Midwives from three separate clinics mentioned that in the past most women's complaints were physical and now complaints are mainly emotional. Midwives often expressed frustration over encouraging women to “trust in nature,” “see pregnancy as healthy and empowering,” and respect the “mystery of birth” while women were wanting more “medical security” and “guarantees.”

Fear of birth has been regarded as a key factor in the increasing rate of C-sections (Eriksson, Jansson and Hamberg, 2006; Hildingsson, Rådestad, Rubertsson and Waldenström, 2002; Waldenström, Hildingsson, and Ryding, 2006) thus the government (funder of health care) has been interested in addressing women's fears. Most hospitals with birthing units now offer special programs for women who are extremely fearful of birth. These programs are run by specially trained midwives, obstetricians, social workers and psychologists and work with women to overcome their fears prior to birth and thus reinforce the notion that birth is a normal and natural event. As part of the maternity care system, these programs are also available free to women who are referred by their prenatal midwife.

Normalty and prenatal routines

There were some notable ways in which prenatal routines reinforced the notion of birth as a normal process, not a medical condition: women are not weighed at each visit, ultrasound is only preformed once during pregnancy, and women have access to their medical records. In the United States, a visit to the doctor's office typically begins with being weighed, regardless of the purpose of the visit. For women in the United States, weight gain can create anxiety given our society's obsession with women's rigid ideals of beauty. Thus, one of the first things I noticed about prenatal visits in Sweden was that I almost never saw a woman being weighed. When I asked midwives why women were

not weighed at each visit they simply replied that there was no need unless the woman was significantly overweight (BMI >30).

There is no use of weighing every visit; you can't do anything too much about too much weight gain or too little. Some women want to check their weight gain and, of course, they can but in the standard visiting schedule we weigh women at the initial visit, week 28 and week 39. (midwife from northern Sweden)

The attitude that weight is not a significant health issue during pregnancy and that women are generally free to monitor it themselves, is very different from the continual surveillance model of women's weight gain in the United States. Weight gain is a normal part of pregnancy and need not be focused on unless there is some specific indication of a problem.

Ultrasound examinations are another example of a less medicalized approach to pregnancy. Since there is no evidence to suggest that ultrasounds improve outcomes in normal pregnancies (Kirkham, Harris, and Grzybowski, 2005: 1311), Swedish women typically receive only one ultrasound during their pregnancy, which is used to determine gestational age, detect multiple pregnancies, and screen for fetal anomalies. While there are no national policies about this, information about the sex of the baby is not typically revealed since it is not a necessary function of the screening, can be wrong, and "not knowing is part of the mystery of birth" (midwife at a Stockholm hospital). Women can go to a private clinic and pay for another ultrasound scan on their own and these clinics often do tell women the sex of the baby. However, this is not covered by the national health care system and is not part of prenatal protocol.

Finally, women's medical records are shared freely with them. Until recently, women carried their medical record with them. They brought them to each prenatal visit and took to them to the hospital when they were in labor or for any other test or appointment. In most areas, women's medical records are now kept on a computer and filled out by midwife throughout the prenatal visit. The computer screens are positioned in such a way that the woman can see her record and the data the midwife is entering. In most locations, this record can now be accessed electronically by birthing hospitals. However, in many locations women are also given a copy of the record to keep with her if she chooses. This form of record keeping helps remove any secrecy from the process and makes women more of a partner in her own care. Having a woman be the primary monitor of her weight and sharing her record with her reinforces the idea that pregnancy is a normal, healthy process in women's bodies and that the midwife is there simply to monitor and assist women through the process.

Accessibility and equality

One of the most important ways Sweden maintains its excellent birth outcomes is through the availability of free prenatal care. While most medical

services have small co-pays, there is no fee for prenatal care. Prenatal clinics are conveniently located on major transportation routes and often in community centers near libraries, shopping, and schools or in a larger medical building housing various other medical or social services. Sweden's emphasis on providing health care "on equal terms" dictates that services are fairly standardized regardless of where one obtains them. A prenatal clinic in Stockholm should offer the same services and same quality of care as a prenatal clinic in any rural area, or in any region of Sweden.

In urban areas such as Stockholm, women can choose a private or public prenatal center. The standard services are the same, services are free in all centers and providers are all paid the same rates by the government. Private prenatal centers, like other private health services are privately owned and managed but still publicly financed.

Most of the women I interviewed in Stockholm had attended one of two major private prenatal clinics for their care. Word of mouth, referrals from friends, and convenience to work or home seemed to be the main factors in choice of prenatal clinic. However, there was also a belief among some mothers that private centers were more selective in their hiring so you would get better midwives. As one mother told me, "If you want to work there you have to be selected. Private alternatives are good. You get good quality" (Elin, mother of one). Private prenatal clinics did offer more flexible work hours, bonuses, and better salaries than the public center; however, many midwives prefer the regular hours and somewhat slower pace of public clinics. The main difference I found in the two clinic sites were in appearance and extra services.

Private prenatal clinics were typically located in old, renovated buildings in very desirable parts of town (near central business, in exclusive housing areas) while public clinics were typically located in more institutional settings (two to three story brick buildings housing other government services). All clinics I visited were very clean and comfortable but there was an attention to aesthetic detail (soft, recessed lights, arm chairs, and decorative pillows, etc.) in the private clinics that was not present in the public ones.

Private clinics usually offered a wide range of extra services including boutique shops for high quality maternity and baby products such as nursing bras, toys, and Babyroos (a tube-style baby sling very popular in Stockholm). They also have their own ultrasound equipment so women do not have to go to the hospital radiology department. This was especially appreciated by some working moms. Private clinics often contracted with pediatricians and/or obstetricians in their building to provide "one-stop shopping" services to their clients. Private clinics in Stockholm also offered some evening hours which public clinics did not. However, businesses are required by law, to give women (and men) time off for prenatal appointments so extended hours were not mentioned by women as a critical difference and getting appointments was not generally an issue.

While the women I interviewed believed the main difference between

private and prenatal was in the quality of midwives, the midwives felt differences were more in the management and orientation of the clinics. Although both public and private clinics scheduled prenatal visits for 30 minutes (dictated by the County Councils who are paying the providers for the service), the pace at the private clinics felt much faster. One midwife commenting on her previous job in a private clinic said, “The clinic I worked in had been open about 1 ½ years. The organization was somewhat chaotic. We had to see more patients but we didn’t have longer hours.”

Quality assurance measures were gathered at all clinics but there was a greater focus on them at private prenatal clinics. In part, this may be because private clinics, at least in Stockholm, tend to attract older, well-educated clients who were “shopping” for the best services. At one private clinic in Stockholm, 63 percent of their patients were between the ages of 31-40 and 70 percent had post high school or university educations (ImproveIt, 2006). The additional emphasis on quality assurance may also be due to the fact that private prenatal clinics do not have any given “catchment area” of clients like the public clinics do. They must compete with the public clinics for clients and for contracts from the County Council to provide services.

Private and public prenatal clinics offer the same standard package of services. Equal access to services ensures that prenatal care is free to all and that medical care is similar regardless of where one lives. The choice of private prenatal care, however, is not available in all parts of Sweden and many rural areas have only one public prenatal clinic. Another issue regarding access and equity of prenatal care is the use of these services by foreign-born women in Sweden.

Approximately 22 percent of births registered in Sweden are now to foreign-born women (Landes, 2008). Finns, Iraqis, Bosnians (ex-Yugoslavians), Somalis, and Iranians make up the largest immigrant groups and over 17 percent of the Swedish population is foreign-born or have two parents born abroad (U.S. Department of State 2008). While prenatal care is easily accessible and free to all legal residents,² immigrant women are more likely to delay getting prenatal care, attend fewer prenatal appointments, make more unplanned visits to the hospital delivery ward, and have poorer health outcomes (Essèn et al., 2002; Ny, Dykes, Molin, and Dejin-Karlsson, 2007; Robertson, Malmström, and Johansson, 2005).

Issues of inequalities in care and outcomes seem to be related to cultural differences and a lack of knowledge about, and attention to, these differences by providers and the health care system. The study by Essèn et al. (2000) on Somalian women illustrates the importance of understanding the cultural norms around pregnancy and birth in a woman’s home country. Women in their study reported that they did not view prenatal care as necessary since pregnancy was a healthy, normal state for women. They were also fearful of having a caesarean section and had developed strategies in their home country to restrict their eating in order to have a smaller baby (Essèn et al., 2000, 2002). Unfortunately,

by not attending regular prenatal visits, Somalian women often did not receive information about proper nutrition and fetal development or have routine preventive screenings. They also did not develop a trusting relationship with a midwife at the local prenatal clinic and often went to the emergency room or hospital delivery unit if they had questions or concerns.

Several strategies have been suggested to make care more accessible and equitable for foreign-born women. Health care providers need to be more aware of the diverse cultural patterns regarding pregnancy and birth that may motivate pregnant women, and they need to be aware that pregnant women may not be receiving routine prenatal care at community clinics (Ny, Plantin, Karlsson and Dykes, 2007). New models for prenatal care may be necessary in some communities such as extended hours and walk-in clinics (Robertson et al., 2005). More frequent appointments, especially early in pregnancy, may help build a trusting relationship with a midwife and increase preventive screenings. Outreach efforts are also necessary to educate foreign-born women about prenatal health issues (for mothers and babies), the importance of regular prenatal care, and the resources available to them in their new country.

Childbirth and parent education classes

In addition to providing all pregnant women with medical care, prenatal care in Sweden attends to women's needs for social support during pregnancy and after birth. Prenatal education classes help prepare parents for birth and life with a new baby. Previous research has shown that almost all (93 percent) of first-time mothers attend prenatal education classes in Sweden (Fabian, 2008). Most classes include five to ten hours of instruction and information focusing on labor, birth, pain relief, possible complications, and breastfeeding. Following national guidelines, they also discuss resources available to parents such as family counselors and social insurance benefits. Some classes also offer a tour of the hospital birth ward. There is usually one additional class a few weeks after the birth to discuss baby care. Typically, these classes are offered in the evenings or on a weekend in two to three hour blocks of time. In many areas, material has been condensed into fewer classes.

Public clinics that I observed tended to offer smaller, more intimate prenatal education classes. In Sala, (population about 15,000), the midwives at the public prenatal clinic call their class, "Parentcraft." One of the midwives there described these classes:

We usually have five sessions, about two hours each in the afternoon and one session after the birth. We encourage couples to begin in week 30-32. We usually have five to seven couples and they are mostly first-time parents. Mostly we want to talk to them about normal birth, Swedes are very natural, and we try to make them feel safe and relaxed.

The private prenatal clinics in Stockholm often held larger, more formal

information sessions rather than the smaller, more intimate groups found in the public clinics. Maja described her parent education class offered by one of the private clinics:

There were three classes, each two to three hours long. They were held in a school lunchroom and there were lots of parents there. The midwife was excellent! She covered things like, "This is what happens.... When the midwife asks you to do this, here's why." She also talked a lot about pain relief.

Ella, pregnant with her second child, had also chosen this private clinic and estimated that there had been 400–600 people in attendance at her classes. Even though it was large, she found the course very helpful for “factual information” about such things as pain relief. Factual information is also coupled with structured opportunities to meet other new mothers.

The goals of childbirth and parenting classes have changed over the years and now include a focus on the family as well as the woman (Fabian, 2008; Premberg and Lundgren, 2006). Classes are designed to go beyond simply preparing couples for birth and parenthood. Social support is a specific goal. Prenatal clinics arrange post-partum groups so new parents can meet others whose children were born about the same time. The prenatal clinic typically sets up several meetings with speakers and information and then the mothers often continue to meet on their own. Parent groups tend to meet during the day so they are primarily mothers. Every woman I interviewed was connected to a group of other women who had given birth about the same time.

Parent education classes, like prenatal care services, are less well attended by foreign-born women and their partners. Ny, Plantin, Karlsson and Dykes study (2007) of Middle Eastern immigrant women found that some women did not feel they needed parent education classes since they already had friends and family for support and information. Some women were also uncomfortable with the inclusion of husbands in these groups. Women coming from countries with patriarch structures also faced challenges created by different gender role expectations in Sweden (ibid). Parental education classes specifically for foreign-born women, addressing their unique issues, may be one approach to increasing participation.

The foundation for a safe and healthy birth

Good prenatal care is only one reason why Sweden is the best place in the world to be a mother, but it is a critical one. In this paper, I have highlighted some of the important aspects of prenatal care in Sweden that help facilitate excellent outcomes for mothers and babies. In particular, birth is promoted as a natural event and women are viewed as capable of giving birth and of caring for themselves. Even though popular media increasingly medicalizes birth, policies and programs are designed to decrease women's fears and give women confidence in their abilities to give birth.

Accessible prenatal care and standardization of services is also a critical component of Sweden's success. While geographic inequalities do exist in terms of the number of choices women have for prenatal care, attempts have been made to locate centers in easily accessible places and services are always free. Hours of operation are not as extensive in the United States but employers are required to give women and their partners' time off for prenatal appointments. This helps encourage women to utilize services and men/partners to be involved. Outcomes for foreign-born women lag behind those of Swedish-born women indicating an area of inequality within the system. As Sweden's immigrant population grows, it is important that these women's needs are also addressed.

Finally, attention is paid not just to providing medical services but also to providing social support services. Prenatal education classes address physiological aspects of labor and birth but they also address social insurance benefits, support services such as family counselors, and help create support groups for new parents. While overall satisfaction is high, if women are dissatisfied with care it is most likely to be because they were not feeling listened to or supported (Hildingsson and Rådestad, 2005). Creating parent groups and fostering bonds between new parents helps create support systems beyond the clinic, however, special groups for foreign-born women may be necessary to address their unique challenges and help facilitate their transition to motherhood in Sweden.

Sweden's ranking as the best place in the world to have a baby is due to the recognition that good medical care is a necessary component of maternal health and well-being, but not the only component. Good medical care must be available and accessible to all pregnant women. That is the cornerstone of good medical outcomes. However, women must also be empowered to give birth, their concerns must be recognized and addressed, and on-going social support must be available during and after pregnancy. The transition to motherhood begins during pregnancy and prenatal care is an important aspect of learning to mother.

¹In the 2008 report, Canada ranked 20th and the United States ranked 27th (Save the Children 2008:40).

²Illegal immigrants do not have a right to free health care however; there is currently discussion of providing free maternity care and health services to children (Simpson, 2008).

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