ICM INTERNATIONAL DEFINITION OF THE MIDWIFE

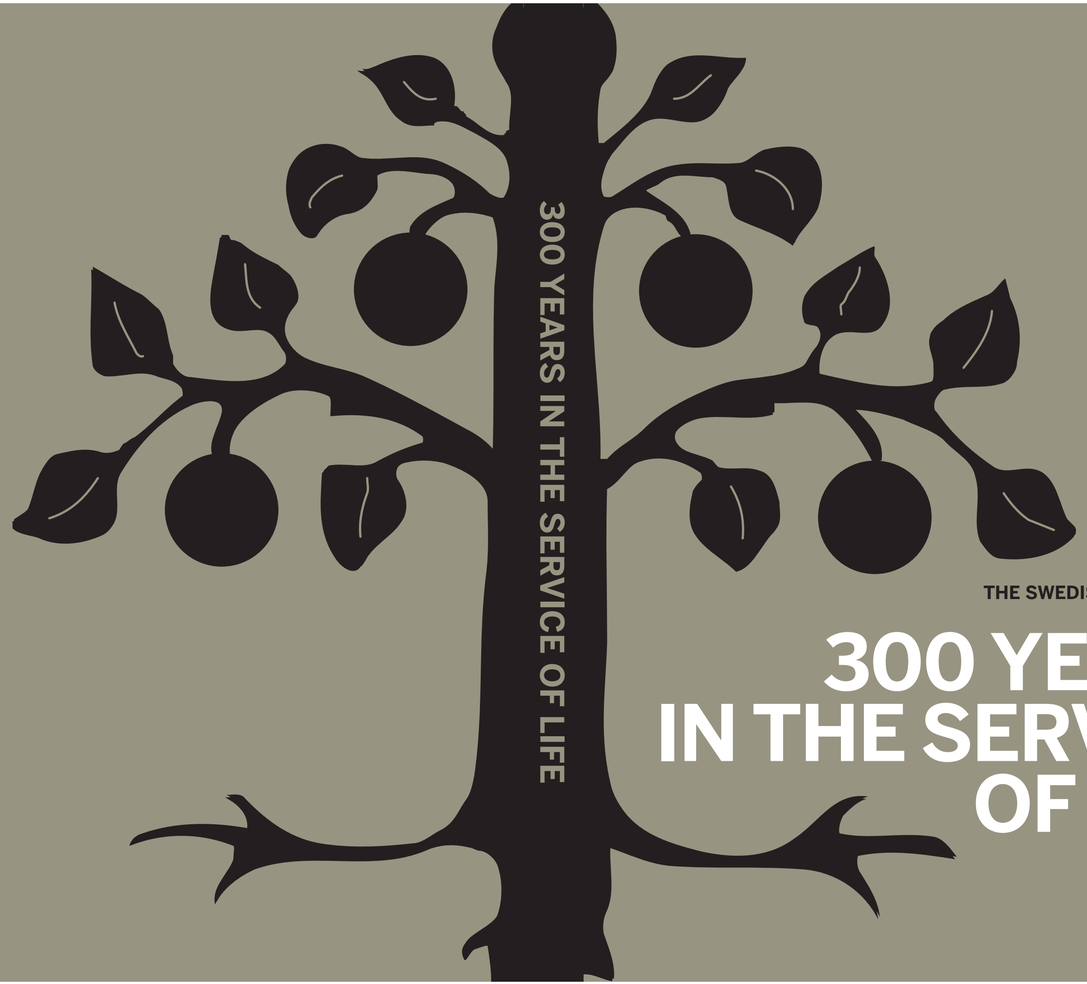
"A midwife is a person who has successfully completed a midwifery education programme that is duly recognized in the country where it is located and that is based on the ICM Essential Competencies for Basic Midwifery Practice and the framework of the ICM Global Standards for Midwifery Education; who has acquired the requisite qualifications to be registered and/or legally licensed to practice midwifery and use the title 'midwife'; and who demonstrates competency in the practice of midwifery.

Scope of Practice
The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the newborn and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and child care.

A midwife may practise in any setting including the home, community, hospitals, clinics or health units."

Core Document
Revised and adopted by ICM Council June 15, 2011
Due for review 2017
International Confederation of Midwives
www.internationalmidwives.org



THE SWEDISH ASSOCIATION OF MIDWIVES

300 YEARS IN THE SERVICE OF LIFE

SEXUAL AND REPRODUCTIVE HEALTH AND RIGHTS

"Definitions of sexual health, sexual rights, reproductive health and reproductive rights are based on existing international agreements. Sexual health refers to quality of life and personal relations, counselling and health care. Sexual rights include the right of all people to decide over their own bodies and sexuality. Reproductive health is a state of complete physical, mental and social well-being in relation to the reproductive system and all its functions, and is more than the mere absence of disease. Reproductive rights comprise the right of individuals to decide on the number of children they have and the intervals at which they are born. Everyone must be able to exercise these rights without risk of discrimination, violence or coercion."

Sweden's international policy on Sexual and Reproductive Health and Rights
Government Offices of Sweden, 2006
www.regeringen.se

SWEDEN

300 YEARS IN THE SERVICE OF LIFE

CONTENTS

300 YEARS IN THE SERVICE OF LIFE
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300 YEARS IN THE SERVICE OF LIFE

THE SWEDISH ASSOCIATION OF MIDWIVES

PHOTO: N. NILSSON STOCKHOLM

IN THE SERVICE OF LIFE

THE SWEDISH ASSOCIATION OF MIDWIVES CELBRATES 125 YEARS AS A PROFESSIONAL BODY AND 300 YEARS WITH TRAINED MIDWIVES

IN 1711 WE received the first regulations for midwives which stated that the midwives in Stockholm should be trained, examined and swear an oath. To be bound by oath meant an undertaking always to support women in childbirth whether rich or poor, high or low born; never to disclose anything said in confidence and to always support their colleagues.

The academic education of qualified midwives was a successful investment which contributed to the decrease in maternal mortality in Sweden as early as the 19th century.

A midwife can save lives – midwives are necessary. Our Swedish experience is of international interest today as one of the UN's millennium targets is to lower the instances of maternal mortality worldwide. Our past is many other countries' present.

We want to depict women, those giving birth, and their midwives from various points of view and from different epochs. We want to show the expertise of the midwife and highlight questions regarding sexual and reproductive health and rights with international outlooks and comparisons. We want historical insights and present demands to be clear.

All humans have the right to make decisions about their lives and bodies.

Women have the right to survive pregnancy and delivery. Today we know what is needed. We must dare to see how things are and decide that it is important to do something about it.

The Swedish Association of Midwives' Jubilee book is the history of us all and nearly everyone has their own idea of a midwife. We hope that you, the reader, will enjoy reading our story. Perhaps you even recognise yourself?

Once upon a time...

MARGARETA REHN, *Midwife*
The Swedish Association of Midwives

THE FOUNDER OF THE SWEDISH ASSOCIATION OF MIDWIVES

MIDWIFE JOHANNA BOVALL HEDÉN (1837–1912)

IN THE AUTUMN of 1858 Johanna Bovall stepped ashore at Huså works in Jämtland. She had recently qualified from the General Maternity Hospital and had sworn the midwives' oath in front of the Magistrate in Stockholm. She had attained the highest marks, with a distinction, and as a prize was given a pair of delivery forceps with an inscription. Her first post was as Parish midwife in Hall's and Kall's parish and Huså copper mine. She was 21 years old.

In her so called Stork letters to the midwifery journal, Jordemodern, she often wrote about this first year of practice. It was the most difficult but also the most instructive school.

In the minutes of the general parish meeting of Kall's parish on 7th February 1828 one can read:

> She will receive for her work specific remuneration as follows:
> For a delivery, whether long or short, natural or complicated
> of crofters or homesteaders 16 shilllings
> of a normal freeholder double 32 shillings
> or of a rich farmer or person of standing
> four times that of a cottager 1.16 (1 Riksdaler 16 shillings)

In these minutes her annual salary of 'payment in kind' was also fixed. She received a number of sacks of corn etc. But Johanna had a mind of her own. She wanted a salary and negotiated her contract as in the parish minutes of 31st October 1858 it states that: 'If the midwife is accepted into the service of the congregation she should receive an annual salary of two hundred riksdaler as well as free board and free firewood...'

Johanna was well liked in Huså and was referred to as "the Bovall woman". Although she mixed with persons of standing, as she put it, she herself came from a poor clerk's family in Närke. Above all she treated

all pregnant women the same, poor as well as rich and she did not flinch from setting out on journeys that were full of hardship in the district. There were many of those as one can read from a later description by one midwife in the district:

> Those midwives intending to seek work in Kall ought to have some information about the conditions there. The distance from a doctor is, if one is in the west of the parish, 11 Swedish miles (110 kilometres). The parish is approximately 9 Swedish miles (90 kilometres) long and the country road reaches about half of the parish. If you should travel to a patient in the summer, you must at times travel in a rowing boat, sometimes ride a horse and sometimes walk for a whole 5 kilometres where the terrain can not support the weight of a horse. But the lakes are the worst, as you will have to go out in all weathers. There are many places which you will have to reach by sea, as there is no main road on land.

IN A PICTURE from Kall's parish archive we can see the young Johanna. In the centre of the picture we can see her hands, the midwife's finest tool. With various manipulations during labour she saved many women.

> I was taken 5 miles to the area of Åreskutan (by every possible means of transport) to the home of a middle aged multigravida who was said to have been sick for 4 days. No one could tell me exactly when her waters had broken. An elbow (the baby's) presented itself but the underarm seemed to be stuck as if in a vice. When, after all necessary preparations, I managed to insert my whole hand into the uterus, the situation of the foetus seemed to be with the right hand shoulder presenting and with the feet in the woman's left side. When I had with difficult loosened the shoulder somewhat and got my hand up to the ribcage, a contraction came and squeezed my hand so violently, that my whole arm felt paralysed for several days afterwards. Now all I had to do was to try my luck with the other hand. I had the woman in the "knee-elbow" position but well lodged (with my hand inside the uterus) to try to shift the shoulder a bit more. The woman made such a hasty and violent jerk of her body that it was impossible to carry out anything in that position. She was once again laid on the short bed and I positioned myself on one knee in the hope of more easily being able to grip the child's feet and found that I could easily push the arm up, which I did without any further calculation. I then stood fairly irresolute, but after some thought it came to me: 'Think if I could get the head down far enough so that I could grasp it with the obstetric forceps'! With some difficulty I managed to force them up and got a good grasp of the neck and, after several good pulls, supported by pressure on the abdomen, I drew the head down and in less than half an hour after that a boy child was born – seemingly long dead, but which recovered and everything went well.

Johanna took an examination as Sweden's first female 'barber-surgeon' in the year 1863 "to the great annoyance of male professional practitioners, and then I practise at the works and often contributed in the case of illness.", wrote Johanna.

On 22nd October 1867 Johanna Bovall arrived in Gothenburg. She registered herself as a midwife in the town and was given number 113 in the directory of members. She then went to the (old) Sahlgrenska Hospital, where the Maternity Unit and the Midwifery school were situated on the third floor in the west wing. There were lecture halls, offices, labour wards, bathrooms, four wards and then the room for the Matron which Johanna moved in to.

When Johanna took up her post as Matron in the Midwifery unit childbed fever was raging. The epidemic peaked at 10 percent maternal mortality during the years 1865–1875. On average 256 women per year were delivered. Those women with childbed fever lay in a room which was dubbed Isolation ward by the midwives as the women had to be isolated there until they left either living or dead. Childbed fever was treated with quinine and leeches on the abdomen and in the cervix inside the vagina.

During her lifetime Johanna experienced the breakthrough in antisepsis, when hand washing was introduced and cases of maternal mortality dropped drastically.

> ...Before she (the midwife) touches the woman, she should wash her hands thoroughly as far as her elbows with hot water and soap. She should then thoroughly scrub her nails with a nail brush, dry herself with a clean towel and then wash the same parts again with diluted carbolic solution, to which end, the midwife ought to be provided with a clean solution of carbolic acid (Acidum carbolicum depuratum) which can be found in every pharmacy."
> (The Medical Board circular 13 June 1881)

Carbolic acid, which they had to pay for themselves, was corrosive and damaged the midwife's hands. The midwives had very low social status during the 19th century and were often poor.

Johanna studied and developed the art of midwifery and taught her own methods to the students:

> My method consisted of lightly and gently placing a hand on the uterus (on the abdomen over the highest point of the uterus) until a placental contraction started, upon which I simultaneously pulled on the cord and pressed down on the uterus. In that way I easily and comfortably removed the afterbirth.
>
> In Gothenburg the pupils had probably at times seen the ease with which I removed the afterbirth when this became stuck for the duty midwife or 'supervisor' as she was called. One day an amusing thing happened. Professor H and I were sitting in the office which at that time was situated within the lecture hall and were working together. A smart pupil, who was originally from Norway, stuck her head around the lecture hall door and shouted loudly: "Madam! The placenta is stuck fast in the vagina!" Of

course I quickly went over to the labour ward and the professor, with a smile on his lips followed straight after to see what that meant. When my method proved effective and we had returned to the office, Professor Hjort said this: "That was not a bad idea! I'd like to include that in the new text book, if Matron is agreeable? And I was agreeable as you can imagine."

In Stockholm, after delivery the afterbirth was thrown into the privy and the sewage barrels were then carried out by women during the night. But in Gothenburg they were thrown on to the rubbish tips. "To lie and rot? Oh, no. They had barely been thrown down when a multitude of ships' rats were fighting over the delicious booty. And as the walled rubbish tip was situated next to one of his Royal Majesty's and the Crown's stables with a good supply of oats and fresh water, so these rodents were shining with good health..." wrote Johanna.

Johanna married a school teacher, Peter Hedén, in Gothenburg and moved to Kyrkogatan 33. When she was 40 she gave birth to little Ruth who died 11 months later. The following year Peter also died. Johanna then moved to Östra Larmgatan 14 and put up a sign on the door and began to work as a privately practising midwife.

From 1881 midwives were obliged to keep a Diary of notes. Johanna's Diary is kept in the City Archives in Gothenburg. Between 9th November 1881 and 8th November 1889 she delivered 176 women: on average 20 to 30 a year. Most of them lived at 'posh' addresses. Of these, 37 were prima gravida and of the multi gravida eight women had previously had between 6 and 8 pregnancies. Eight women were 40–43 years old. Most were around 20 years old. The youngest was 19. Three cases were breech deliveries, four women were delivered of twins, nine were delivered with forceps, eleven had severe bleeding, in five births she 'the midwife' had to turn the baby with her hand inside the uterus. One woman died with childbed fever (puerperal sepsis) and three babies died.

As a childless widow Johanna decided to dedicate the rest of her life to improving the situation and health of women in general and to the organisation of midwives. She became involved in the feminist movement. She was a member of both the Frederika Bremer Association and the Gothenburg Women's Alliance, which published the journal Framåt (Forwards), to which Johanna also contributed articles.

Johanna realised that the improvement in the wellbeing of midwives was a feminist problem but got little hearing from feminists at that time.

On 3 November 1885 six midwives put up a notice on their doors stating that they had been to Mrs Hedén in Östra Larmgatan 14 and there they decided to found an Association. Afterwards they celebrated its foundation in the Women's Association Cafe. The midwives also decided to try to gather all the midwives in the country to a general meeting

in Stockholm and Johanna wrote the message from the Gothenburg Midwives' Society:

> At a time when the most diverse professional practitioners are competing to form unions, for their own gain, we dare to hope that this strongly increasing movement will be capable of awakening even the most apathetic midwife, so that she also realises that harmonious unity within the corps is the best lever with which the midwives in our grim times can contribute to winning some general advantages for themselves and their patients...

On 10th July 1886 191 midwives from every corner of the country met for a general meeting in Stockholm and laid the foundations for the Swedish Association of Midwives.

PIA HÖJEBERG, *Midwife and author*
Has written the book Syster Stork – Barnmorskan Johanna Bovall Hedén 1837–1012 Liv och skrift-ställning (Carlsson 2007)

IN PURSUIT OF OPTIMISM

REPORT FROM THE CAIRO CONFERENCE

"COME IN AND watch", says the woman showing me round the maternity unit of a local clinic in Zambia. She lifts the curtain and there inside is a woman giving birth. I beg her to ask the woman if she really wants us in there with her.

I personally would not want to have a study visit if I were in the middle of labour but the woman smiles between contractions and says that of course we can come in. What else could she say? I stay for a few minutes and feel uncomfortable in my perceived rôle as a rich, white woman on a study visit. When the woman has given birth to her child she is permitted to stay for a while before she is collected and sent home on the same courier's cycle that brought her to the clinic.

Although I have felt embarrassed many times I have learnt a considerable amount from all the visits I have had the opportunity to make. I have met women giving birth, crying, happy and worrying how it would go. Some women have come to a place where they can give birth in a safer manner than innumerable women in the world's poorest countries.

Nearly half a million women die in childbirth. Many die because there is no qualified midwife at their side. They give birth at home, often with the support and help of another woman, but seldom with a woman who has the knowledge to cope in an emergency. Women give birth at home for various reasons: because they cannot afford to get to the nearest clinic or because they cannot find any transport. Many children who live or survive a complicated labour are forced to live without their mothers. This increases their own risk of dying before they are five years old.

Some years after the event in Zambia I am in a labour ward at the Karolinska University Hospital in Stockholm. My daughter, who has just had her 20th birthday and her husband have invited me to be present when my first grandchild is born. My daughter is at an age when two thirds of poor girls in many countries already have one or two children. But in Sweden she is considered young. Midwives come and go. They introduce themselves, ask how she feels. They palpate and measure.

My daughter says, "How lovely that they are so calm and professional. It makes me feel calm as well."

Her delivery goes well and Lucas, my first grandchild, comes into the world in calmness and harmony without anxiety. I knew that even if the delivery had been difficult and long-drawn-out we would not have had to worry that she would die. This does happen here but very rarely. We had complete trust in the midwife and with reason.

This was not my daughter's first encounter with a midwife. In common with nearly all young people in Sweden she had already met a midwife at the youth clinic. The youth midwife was one that she could rely on, who did not question her need for contraceptives. Many young people in Sweden meet their first midwife, (apart from the one who delivered them), in the school sex education class.

This is called SRHR which stands for Sexual and Reproductive Health and Rights. This concept, which is so obvious for us in Sweden, is unknown to many women, men and young people throughout the world.

The idea of SRHR was born in Cairo during the United Nations Conference on Population and Development in 1994. However, the conference did not accept the final 'R', which stands for Rights. There still remains a lot of work to be done within the UN to get sufficient support for the idea of sexual rights. It will take time so it is a question of being patient.

In Cairo 20,000 people met from all the countries, cultures and religions of the world. The idea was to come together and agree on what was important to ensure the life and health of all people around the world. This was an enormous challenge. Not only were the representatives of the various countries present, but also many of the voluntary organisations. There were fundamentalists such as the Vatican and other opponents of a woman's right to make her own decision regarding abortion and young people's rights to contraceptives. There were feminists, family planning organisations and rights' activists. Governments with great openness regarding questions of sexuality and reproduction were represented – as well as representatives of governments with opposing points of view.

The intention of this giant conference was to be united on sensitive questions such as abortion, sexual education and young people's rights to decide their own sexuality. When the participants came to Cairo the civil servants of the various governments had already been negotiating for a long time but had only been able to agree on about half of all the texts that had to be decided on. All the difficult questions remained.

The voluntary organisations played an important part. There were many of us working together on the texts that we wanted to get the

governments to accept and we succeeded, surprisingly often, to obtain support for our ideas.

In the middle of the 1990s 80,000 women each year died from unsafe abortions, (nearly as many as today, 15 years later). Despite this, there was an exceptionally strong opposition against giving women themselves the right to decide about abortion. Many chose, then as well as now, to disregard the fact that it is always the woman herself who in the end decides about abortion. She carries out her decision with the accompanying risks in countries where the right to abortion is limited or completely absent. The difference between the women of the world regarding abortion is that the decision of many of them on abortion carries with it great medical, social, economic, psychological and legal risks.

Without a doubt the abortion question took up most of the time during the conference. A small working party was formed which had to work out a formula that everyone could agree on. The group comprised both feminists and opponents of abortion, who sat closeted for endless hours in a small room where the air soon became vile. It was said that someone fainted from the pressure and exhaustion.

At last they came up with the world community's best compromise on this question; that abortion should be safe where it is legal. In certain countries which permit abortion the stigma is so great that women choose unsafe methods to carry out their decision in secret. To make abortion safe and accessible is a challenge for countries such as India, which has a reasonable abortion law.

The Cairo Conference also stated clearly that abortion is a general health issue and that all women who have undergone an abortion, irrespective of whether it was legal or not, have the right to good aftercare. This was an important emphasis.

Maternal mortality was an issue raised in Cairo as at so many other conferences over the past 20–25 years. It is one of the world's greatest scandals that nothing has happened yet. One can only wonder what would have happened if nearly half a million men died every year because they had become fathers.

Many good decisions came out of the Cairo Conference. But no United Nations conference since 1994 has succeeded in agreeing on the next step. On the contrary, the right to decide on one's own sexuality and reproduction has become even more controversial, especially when it concerns women's and children's rights.

When the world was to unite on the most important goals for the next millennium, (the Millennium Goals), the starting point was the decisions taken at all the UN conferences in the 1990s – except for the Cairo Conference! Therefore the fundamental questions on rights such

as safe abortion, contraception, sexual education and the right to decide on one's own sexuality are missing in the world's common priorities for the next millennium.

Mother and child health are included as well as equality and, after intensive international opinion-building work, the millennium goal on maternal health has been complemented with the demand to revaluate the global access to reproductive health. A bit paltry, compared to Cairo one would think. But on the eve of the 21st century that was all that could be agreed on.

It is important to remind ourselves that other goals cannot be achieved before many of the Cairo conference's most important decisions have been carried out.

Is there any point in continuing to work for more and sometimes reasonable compromises on SRHR questions?

My reply would be an unequivocal YES. It is important to consolidate wise decisions so that they continue to live and at the same time work so that the mediocre decisions are reinterpreted and reformulated and not least that the bad ones are given less space.

Perhaps the question of sexual and reproductive health and rights are the most difficult to solve. Power brokers at all levels, in all countries and in all the various sections of society would prefer to regulate sexuality. Something which perhaps is coloured by the fact that it also concerns themselves and their families.

Fault and shame are often combined with laws and regulations which hit women and young people particularly hard.

We need to keep the decisions of the Cairo conference alive and continue to develop them!

Sexual and reproductive health and rights concern everyone's lives and are therefore a part of the wide political endeavour – nationally as well as internationally.

KATARINA LINDAHL, *writer and former General Secretary of RFSU, the Swedish Association for Sexuality Education.*

WITH THE WORLD AS A WORKPLACE

WHEN I WAS 20 YEARS OLD, I had the privilege of working as a volunteer in the Congo, which in many ways influenced my future. Two years in Africa made an indelible impression on me and my husband and I decided to return. But before this I wanted to gain as useful a training as possible. I returned home to Sweden and became – a midwife. There were several reasons for this. I had seen how much they were needed for the health of both women and children but above all, I had met some fantastic midwives, both Swedish and African who, day and night, were on hand for the women who needed their help. They were Barbro, Stina, Majken, Eva, Maj-Britt and all their Congolese colleagues, Hélène, Marie, and Julienne among others. They became my rôle models and it was with great inquisitiveness, but also a sort of respect, that I sometimes accompanied them to the 'maternity' and observed a delivery or accompanied them on their rounds among the sick or newly-delivered women.

In 2006 Barbro wrote in the Swedish Association of Midwives' journal 'Jordemodern'

> A multigravida was bleeding heavily. The doctor was called and he decided to remove the uterus. I asked him if he had done this before and he answered in the negative. I informed him that it was a complicated operation and called to mind a lecture during my midwifery training when we were told that one could stuff the uterus full of cloths and then carefully pull them out one at a time, whilst supervising closely and massaging the uterus with the hand. The woman needed blood and my blood was a match, but as I was also menstruating I felt dizzy after giving blood. I remained lying down and was wheeled to the delivery bed where the doctor asked what we should do. We removed the cloths one at a time and I kept massaging the uterus with my hand. When the last cloth was removed the uterus had became as hard as a rock and the bleeding stopped. The woman was ecstatic. She still had her uterus and could bear more children.

I worked for a further four years in the Congo as a qualified midwife on various assignments. Midwife Kristina Norman and I worked together on a health care project in northern Congo. I was a clinical tutor at the IME hospital in Kimpese in a combined Gynaecological and Obstetric

department. The Head Midwife, Luzayadio Ntelamani Georgine, usually called 'Mama Luz', became my friend for life. We are regularly in contact by letter where she writes about the fate of various women she meets and about how she fights to make the resources last. In a letter from 2008 she tells me that:

> A woman came to the delivery room. She walked in on her own. She was fully dilated and quickly gave birth to a premature baby which weighed 1.2 kg. The woman had breathing problems even during the delivery and she died soon afterwards. We later learnt that she had bled copiously in the cottage hospital that she had gone to first. The child is still on the ward and one wonders what will happen to the little mite...
> We try to carry out the recommended care for the pregnant woman; we give them malaria prophylactics, de-worming medicine and iron tablets. We sell mosquito nets at a low price. But sometimes we have no medications at all and the mosquito nets run out.

My research training offered new opportunities for international exchanges, namely scientific conferences. One of the first that I attended with my colleagues Gunilla Aneblom and Elisabet Häggström-Nordin was a world congress in Washington where the question of access to safe abortion was far too politically sensitive to put onto the agenda. We became extremely upset with all the talk of giving good care to women who sought help for complications after illegal or unsafe abortions, without any mention of the most important measure for dealing with the problem – namely to legalise early abortions. Mama Luz explains how they deal with such cases at her hospital.

> We also get many women who become ill after having an abortion, something which is not permitted in the Congo. We never ask them if they have had an abortion or a miscarriage, but take care of them as best we can. But I believe that half of our deaths may be due to unsafe abortions.

For two years I was part of a network of Swedish midwives who worked within the UN system at the World Health Organisation (WHO) in Geneva, the others being Barbro Fritzon, Ulrika Rehnström, Anneka Knutsson and Ingela Johansson. Thanks to the internet we could keep in contact, support each other and exchange experiences. Barbro, who worked as a midwife for the UN's Population Fund, UNFPA, in Mozambique wrote in October 2006:

> One of my major tasks is to call attention to and defend midwives in every situation not least at the health ministry. Sometimes it feels as if I have quite a strange task. An important part of the job is to be irascible, stubborn and make a lot of noise about the midwife's great potential so that Mozambique's mothers will have access to their human rights and good, safe reproductive health.

> In the corridors of the health ministry I have on occasion heard folk whisper:
> "That's her, you know, the midwife"…Yes, then I feel that I have won a small victory.

Ulrika recounted how she, as a midwifery adviser for UNFPA in Bolivia, fought stubbornly to get midwifery training set up, something which has now become a reality:

> Opposition to getting a midwifery training programme started in Bolivia is both a power and gender issue. There is still a macho culture in Latin America. Discrimination against women is widespread and the patriarchal structures are strong. There are divided opinions within the health care ministry regarding the project. Two national universities have accepted the suggestion and we are working to get the third involved. All three universities are situated in country areas. In this way we hope that in the future we will have midwives in the areas where there is no access to doctors and my dream is to be able to meet young, hopeful midwifery students before I leave Bolivia.

The task of lowering maternal mortality has been emphasized by the initiative, 'Safe Motherhood', and because one of the eight millennium goals is to improve women's health between now and 2015. Indicators which will be measured if the goal is reached are: maternal mortality and the number of births that are handled by qualified personnel. Nearly every country understands the midwife's unique opportunity of contributing to the fulfilment of this goal and in many places there is investment in midwifery training and in building up a professional midwifery body. Important players in this task are the national midwifery associations, but principally the international Midwifery Associations (ICM) under the leadership of Bridget Lynch. With the help of Swedish Aid and in cooperation with UNFPA, new midwifery advisers are recruited and employed in those parts of the world which have the greatest challenges. The Swedish Association of Midwives, The Karolinska Institute and Uppsala University work together with their Indian partners in order to strengthen midwifery training in India, an unbelievable challenge of which I am part. At home in Sweden we can give our own midwifery students international competence by including global issues during training and offering study periods abroad. This gives young people the opportunity for the same life-changing experiences that I myself had 40 years ago in the Congo.

MARGARETA LARSSON, *Midwife, senior lecturer at the Department of Women's and Children's health, Obstetrics and Gynaecology, Uppsala University.*

"MUTTER CATRIN" COURT MIDWIFE

CATHARINA WENTIN – or Went (1637–1707) travelled from Germany in 1682 to become midwife at the Swedish Court. She delivered Queen Ulrica Eleonora at the birth of Karl XII. Catharina Wentin knew her worth and made strong demands. She wanted a substantial salary of 600 Daler in silver coins, written confirmation of her appointment and the title Royal Court Midwife. She further wanted to be allowed to practise her 'craft' freely under royal protection and without the interference of the civic authorities. She wanted free accommodation near the palace, free firewood for the household and once a week free meat and salt as well as a can of Rhine wine.

Wentin's demand to be allowed to practise her profession without interference from the civic authorities is witness to the fact that midwives at that time were aware that the practice of their profession was restricted by doctors and the authorities.

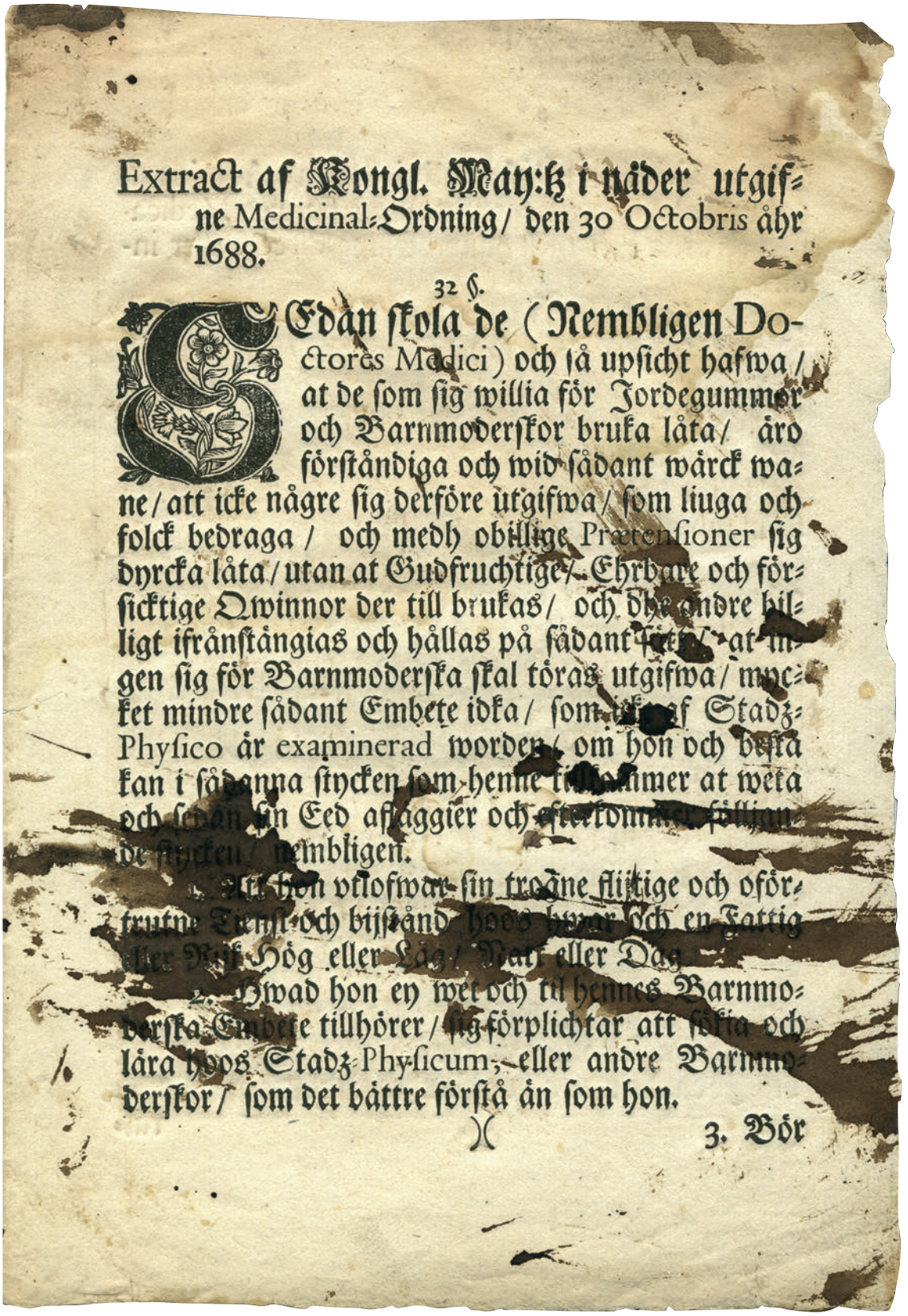
When Catharina Wentin arrived at the palace she was questioned on her knowledge by the queen's personal doctor. This she passed with flying colours.

Catharina had her requests granted and her salary was increased to 800 Daler in silver coins. Thus her salary was higher than that of the court doctors themselves; Johan van Hoorn and Urban Hiärne. For example Hoorn demanded 300 Daler in silver coins.

Johan van Hoorn had great respect for "Mutter Catrin" as he called her and referred to many of her methods and observations. Meconium-coloured (green) amniotic fluid was, according to "Mutter Catrin", an indication that the foetus had died in the womb. At that time the foetal heartbeat had not been 'discovered' and meconium-coloured amniotic fluid is quite correctly a warning sign during delivery.

Queen Ulrica Eleonora gave birth to seven children. Four died in infancy. She paid Mutter Catrin so that she could support poor women when they were in labour and in 1682 gave Urban Hiärne the task of formulating a plan for the care of women during delivery. But unfortunately the queen died in 1693 without this care having been organised.

PIA HÖJEBERG, *Midwife and author. She has written the book Jordemor, barnmorska och barnaföderska. Födandets historia. (Carlsson 2011).*



Extract af Kongl. May:tz i nåder utgifne Medicinal-Ordning / den 30 Octobris åhr 1688.

32 §.

Sedan skola de (Nembligen Doctores Medici) och så upsicht hafwa / at de som sig willia för Jordegummor och Barnmoderskor bruka låta / äro förståndiga och wid sådant wärck wane / att icke några sig derföre utgifwa / som liuga och folck bedraga / och medh obillige Prætensioner sig dyrcka låta / utan at Gudfruchtige / Ehrbare och försichtige Qwinnor der till brukas / och dhe andre billigt ifrånstängias och hållas på sådant sätt / at ingen sig för Barnmoderska skal töras utgifwa / mycket mindre sådant Embete idka / som icke af Stadz Physico är examinerad worden / om hon och weta kan i sådanna stycken som henne tillkommer at weta och sedan sin Eed aflaggier och efterkommer fölliga de stycken / nembligen.

1. Att hon vtlofwar sin trogne flitige och oförfrutne Tienst och bijstånd hoos hwar och en Fattig eller Rik Hög eller Låg / Natt eller Dag.

2. Hwad hon ey wet och til hennes Barnmoderska Embete tillhörer / sig förplichtar att söka och lära hoos Stadz Physicum, eller andre Barnmoderskor / som det bättre förstå än som hon.

3. Bör

Extract from His Royal Majesty's, by Divine Grace, Medical Decree, the 30th October in the year 1688. Written order regarding the education of a midwife: qualification, regulations and supervision (competence and proficiency). The Medical Decree states that those who wish to be midwives shall be wise, God-fearing, honest, meticulous women.

Collegium Medicum (now the Swedish National Board of Health and Welfare), was founded in 1663 and was given the task of supervising practising midwives in 1686. The midwife shall be apprenticed, pass an examination and swear an oath.

3 Bör hon utlåfwa aldrig willia befrämia något miſsfödzel hoos någon/det ware ſig med Medicamenter, råd eller egen handräckning/directe eller indirecte.

4. Då hon ey kan med all ſin wettenſkap hielpa den i Barnsnöden ſtälte Qwinnan/ hon då tillhåller och förmanar weder börande i tijd at låta kalla Doctare, och jemte flere Barnmoderſkor till hielp med dem ſackteligen och förnufftteligen öfwerlägger/ och hwad då rådeligit finnes och ſlutes/ efter ytterſta förmågo till den nödſtältes bäſta wärckſtäller.

5. När någon Barnmoderſka af någon Rätt ordnat blifwer att examinera och beſee det hennes Embete tillhörer/ hon då troget Råd gifwer och ſanfärdeligen berättar ſakſens rätta ſammanhang/ intet för wänſkaps/Skylldſkapz/ Owänſkapz eller annan Intereſſes och nyttas ſkulld något ſom bör wetas/ förtijger eller utſäger det ey ſandt är/ och det hon eij förſtår att gifwa ſitt omdöme om.

6. Skall hon låta Stadſens Phyſicum hwar Månat weta hwad förelupit är i hennes Embete/och det på de dagar/ ſom Doctoren med dem öfwerens kommer/ då hon och får inhämta underwijſning uti det/ ſom hon ey weet finna ſig uti.

7. Enär hon blifwer kallader till någon Haſwande Qwinna ſom med oächta barn går/ hon då den Födande med allwarſamhet tillhåller att nämna rät-

rätta Barn-Fadren / deß Namn hon hoos wederbörande wid anfordran utsäija måste.

8. Skall hon aldrig utan någons Medici Förordning / ingifwa drifwande Medicamenter dem i Barnsängiar stadde Qwinnorna / ey heller i sielfwa Barnsången / eller der utom låta bruka sig uti några krankheter / dereft att ingifwa Medicamenter.

9. Skola deße Edsworne Qwinnor wara förplickade at låra andra / låtandes deras Nampn upskrifwa hoos Stadz-Physicum, och skall den som låra will / 4 åhr uti Låran tillbringa / och sedan utskrifwas / i medlertijd skall hon hwar Månad eller hwart 4dedels åhr hoos Stadsens Physicum berätta hwad hon lärt hafwer och sökia hoos honom underrättelse uti dhe saker hon icke förstår eller weet läggia handen wid.

10. Så är det och högst tiänligit / för swåra tillstötande tillfällen skull / att deße Barnmoderskor / när som hålles några Anatomier öfwer Qwinfolck / sig då angifwa måge hoos den samma som Sectionen förrättar / på det dhe måtte blifwa Privatim underwiste uti sådanne Stycken / som till deras wettskap nödwändeligen erfordras.

Midwife Anna Johansson

PHOTO: SVEN-GÖSTA JOHANSSON

THE DECLINE IN MATERNAL MORTALITY

"OF 651 CASES of women dying in childbirth, 400 could have been saved if they had had adequate access to a midwife."

So wrote Collegium Medicum, (the then National Board of Health and Welfare) to Sweden's Parliament in 1751. And history has shown that their statement was correct. With the arrival of parish midwives the instances of maternal mortality declined by two thirds. What Collegium Medicum did not know however, was that this would take 150 years to achieve.

During the eighteenth century childbirth was one of the most common causes of death among Swedish women of childbearing age. The fear of death was widespread and pregnant women prayed to the Virgin Mary to use her 'keys' (the orchid, 'Virgin Mary's Keys') to facilitate the delivery by opening the " locks", or that the Virgin Maria would "lend me your shift, the wide one". One eighteenth century country priest noted that: "When a woman gives birth, she is sorrowful; for she knows that her time has come."

Approximately 15% of all women are affected by complications during pregnancy, delivery and the lying-in period. Without access to antenatal and obstetric care 1–2 mothers die for every 100 live births. This is how it has been since prehistory and it is the same today – irrespective of whether the society is affluent or is one where there is poverty, malnourishment and disease. The most common causes of death were, and still remain, fatal haemorrhage, pre-eclampsia, infections and complications in connection with obstructed delivery. Always last at the meal table, anaemic and susceptible to infection a woman's chances of surviving such complications are poor.

Of all the married women in the age range 20–34 who died during the eighteenth century, almost half died as a result of complications during childbirth. Calculated as a cause of death, this means that every 14th woman died during childbirth. We know this as Sweden was the first country in the world to collect countrywide statistics of births and deaths. We also know that the information from the then Tabellverket (now the SCB, the Central Bureau of Statistics) shocked society at the time.

WITH MIDWIVES THE INSTANCES OF MATERNAL MORTALITY WOULD DECLINE

We can follow the various precautions taken to combat deaths in childbirth throughout Swedish history: the development of obstetrics as an academic discipline, the training of doctors in obstetrics, midwifery training, the professionalisation of delivery assistants, the establishment of maternity hospitals and the introduction of aseptic techniques (a method of preventing the spread of bacteria).

The fight to lessen maternal mortality became a social concern which would engage the country's authorities in the capital, at county level, as well as at local parish councils. The authorities' intention of instituting equal access to health and medical care irrespective of where people lived was ratified by the Health Commission in 1737–1766. This, to a great extent, came to characterize the foundation of obstetric care.

The Swedish Medical Society was founded in 1663 with a proposal by Karl XI's council of regency. In this proposal was a paragraph stating that Collegium Medicum should supervise midwives to ensure that they were God fearing, modest, wise and conscientious. This was ratified as a medical decree in 1680. Doctor Urban Hiärne (1641–1724) suggested in 1682 that "a maternity hospital should be set up for the education of midwives."

Johan von Hoorn (1662–1724) was to make the first ground-breaking contribution. Prompted by the cases of maternal mortality in his own family he travelled abroad at the age of 16 to study as a doctor and obstetrician. He followed his academic studies at Leiden in Holland, but learnt the art of obstetrics in Paris. He obtained his expertise in uncomplicated deliveries with the midwife Madame Allegrain and complicated deliveries he learnt with the accoucheur, Monsieur Frad. His studies culminated with the thesis: De partu praeernaturali (The unnatural delivery). At the age of 29 Johan van Hoorn returned to Sweden. His objective in obstetrics was to prevent death and on his return he did not think much of the quality of the delivery assistants in Stockholm:

> Out of 100 babies born dead five had died in the womb, the others were live births, and of these at least 80 could have been saved if a competent midwife had been on hand. My heart weeps blood every time I have to see that these innocent souls unwittingly had to fall prey to death through fault and neglect.
>
> Now the dear Reader might ask why this important service, which has heretofore been served by fair and respectable matrons, has fallen into the hands of so many drunken old women without a conscience, who, rather than serve their neighbours would abuse them for a piece of bread and for the opportunity to have their fingers in the dish and their noses in the wine jar, rather than help a frightened wife in fear of death in her difficult childbed.

REGLEMENTE

För

Jorde-Gummorne.

Af Kongl. Maj:t Nådigst Stadfästadt,
Then 14 October 1777.

Cum Gratia & Privilegio S:æ R:æ Maj:tis.

STOCKHOLM, Tryckt i Kongl. Tryckeriet.

The first Regulations for Midwives applicable to the entire country published in 1777.

TRAINING AND CERTIFICATION

The training and certification of midwives became Johan von Hoorn's life's work and in 1708 he started the first midwifery training school. Three years later the first Swedish regulations for midwives were introduced prescribing a two year training followed by an examination at the Collegium Medicum. Johan von Hoorn's text books established the foundation for the training. 'The Swedish well-trained Midwife' (1696) and 'The two God fearing Midwives Siphra and Pua, true to their vocation and therefore well rewarded by God' (1715).

In 1757 a suggestion for a national training programme for midwives was approved by His Majesty's Collegium Medicum which would include all parishes. The decision meant that every parish was expected to pay for their pupils' accommodation in Stockholm.

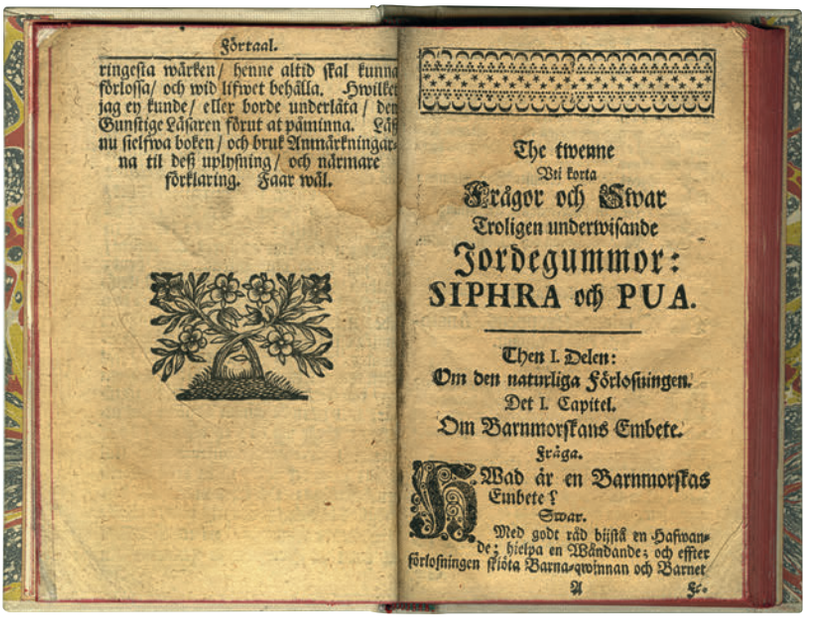
In 1761 David von Schulzenheim was named as the country's first professor of obstetrics and fourteen years later the country's first maternity hospital was opened in Stockholm – the General Maternity Hospital. It was established to support poor and unmarried women and was part of the work to prevent the great child mortality rate. The spirit of enlightenment gave a greater emphasis on humanitarian motives and in the prevalent societal ideology, mercantilism, the nation's riches were defined by the number of its citizens. In 1775 Gustav III wrote about the General Maternity Hospital:

> With a lying-in hospital here in the city under the supervision of the Collegium Medicum, we have even extended our areas of help to such an extent that children born of mothers living in poverty and wretchedness do not perish and therefore be lost to society.

In the labour ward the destitute were allowed to stay free of charge for nine days to recover after delivery. As an element in the fight against infanticide, the right of women to give birth without disclosing their identity was introduced. The General Maternity Hospital became the teaching institute for doctors and midwives.

A MIDWIFE IN EVERY PARISH

The line of the authorities was, however, clear about training midwives who could assist at home births. Instead of building midwifery institutions in the towns, as in the more densely populated and affluent countries of Europe, Parliament emphasized that "through the care of the provincial doctors at least one midwife in every parish should be trained. Furthermore, suitable people from every district should be sent to Stockholm to receive guidance in the art of midwifery."



Förtaal.

ringesta wärken/ henne altid skal kunna förlossa/ och wid lifwet behålla. Hwilket jag ey kunde/ eller borde underlåta/ den Gunstige Läsaren förut at päminna. Läs nu sielfwa boken/ och bruk Anmärkningarna til dess uplysning/ och närmare förklaring. Faar wäl.

The twenne
Wti korta
Frågor och Swar
Troligen underwisande
Jordegummor:
SIPHRA och PUA.

Then I. Delen:
Om den naturliga Förlossningen.
Det I. Capitel.
Om Barnmorskans Embete.
Fråga.
Wad är en Barnmorskas Embete?
Swar.
Med godt råd bijstå en Hafwande; hielpa en Wändande; och effter förlossningen sköta Barna-qwinnan och Barnet

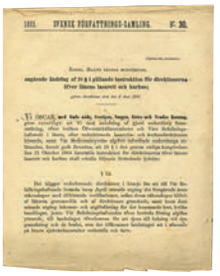
A Fr.

In 1780 the peasantry forced through a resolution stating that the provincial doctors should train midwives locally, which happened to a lesser extent. In 1819 The Health Collegiate (previously Collegium Medicum) again pushed through the requirement that all midwives should be trained in Stockholm.

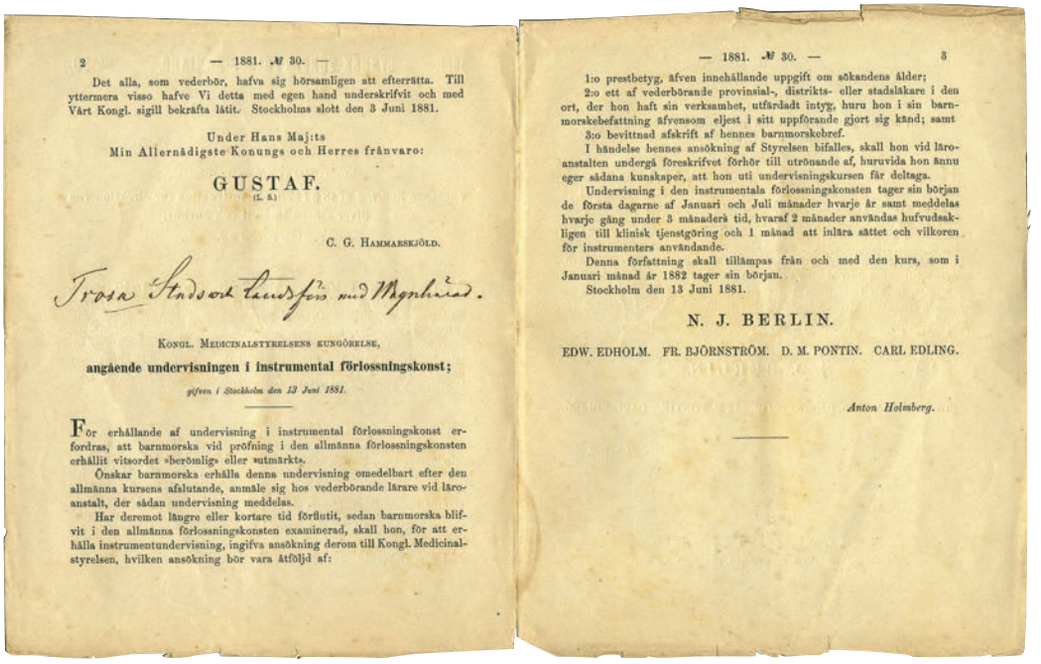
A parish that wanted a midwife had to select a suitable woman in the district, pay for her living expenses as well as travel expenses to and from the training institute in Stockholm and finally be responsible for her upkeep in her home district.

Collegium Medicum pointed out in repeated communications during the 18th century to the county governors the importance of sending suitable women for midwifery training in the capital. The regulations for midwives for the year 1777 stated that no one other than midwives who were bound by oath could be employed except in dire necessity. If either the mother or child died, the untrained assistant was obliged to pay all or half a wergild (an old form of legal reparation paid to the family of the victim under Salic Law).

The result of this was that the number of certified midwives increased manifold. At the same time, however, the peasantry complained that the regulations meant that many women were without help as the distance between midwives was great and other women were afraid of punishment.



The Swedish midwife's right and ability to use instruments was unique in Europe but well suited to our sparsely populated, elongated country. Home delivery midwives were obliged to keep clinical notes about all their patients.



2 — 1881. № 30. —

Det alla, som vederbör, hafva sig hörsamligen att efterrätta. Till yttermera visso hafve Vi detta med egen hand underskrifvit och med Vårt Kongl. sigill bekräfta låtit. Stockholms slott den 3 Juni 1881.

Under Hans Majits
Min Allernådigste Konungs och Herres frånvaro:

GUSTAF.
(L. S.)

C. G. HAMMARSKJÖLD.

Trosa Stadsoch Landsförs med Mynbråd.

KONGL. MEDICINALSTYRELSENS KUNGÖRELSE,

angående undervisningen i instrumental förlossningskonst;

gifven i Stockholm den 13 Juni 1881.

För erhållande af undervisning i instrumental förlossningskonst erfordras, att barnmorska vid pröfning i den allmänna förlossningskonsten erhållit vitsordet »berömlig» eller »utmärkt».

Önskar barnmorska erhålla denna undervisning omedelbart efter den allmänna kursens afslutande, anmäle sig hos vederbörande lärare vid läroanstalt, der sådan undervisning meddelas.

Har deremot längre eller kortare tid förflutit, sedan barnmorska blifvit i den allmänna förlossningskonsten examinerad, skall hon, för att erhålla instrumentundervisning, ingifva ansökning derom till Kongl. Medicinalstyrelsen, hvilken ansökning bör vara åtföljd af:

— 1881. № 30. — 3

1:o prestbetyg, äfven innehållande uppgift om sökandens ålder;

2:o ett af vederbörande provinsial-, distrikts- eller stadsläkare i den ort, der hon haft sin verksamhet, utfärdadt intyg, huru hon i sin barnmorskebefattning äfvensom eljest i sitt uppförande gjort sig känd; samt

3:o bevittnad afskrift af hennes barnmorskebref.

I händelse hennes ansökning af Styrelsen bifalles, skall hon vid läroanstalten undergå föreskrifvet förhör till utrönande af, huruvida hon ännu eger sådana kunskaper, att hon uti undervisningskursen får deltaga.

Undervisning i den instrumentala förlossningskonsten tager sin början de första dagarne af Januari och Juli månader hvarje år samt meddelas hvarje gång under 3 månaders tid, hvaraf 2 månader användas hufvudsakligen till klinisk tjenstgöring och 1 månad att inlära sättet och vilkoren för instrumenters användande.

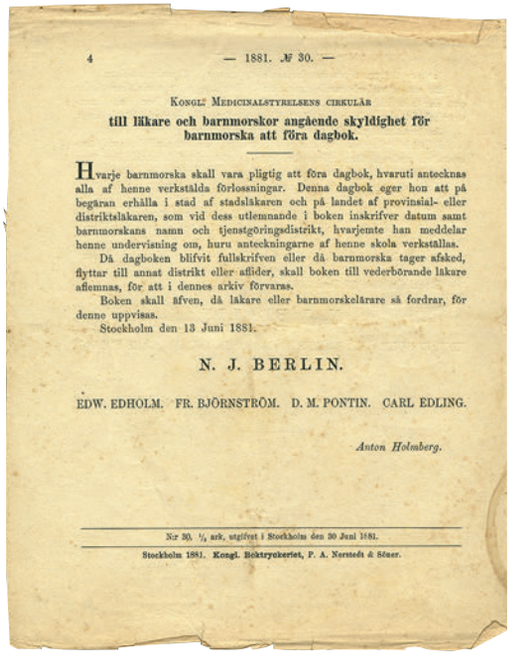
Denna författning skall tillämpas från och med den kurs, som i Januari månad år 1882 tager sin början.

Stockholm den 13 Juni 1881.

N. J. BERLIN.

EDW. EDHOLM. FR. BJÖRNSTRÖM. D. M. PONTIN. CARL EDLING.

Anton Holmberg.



4 — 1881. № 30. —

KONGL. MEDICINALSTYRELSENS CIRKULÄR

till läkare och barnmorskor angående skyldighet för barnmorska att föra dagbok.

Hvarje barnmorska skall vara pligtig att föra dagbok, hvaruti antecknas alla af henne verkställda förlossningar. Denna dagbok eger hon att på begäran erhålla i stad af stadsläkaren och på landet af provinsial- eller distriktsläkaren, som vid dess utlemnande i boken inskrifver datum samt barnmorskans namn och tjenstgöringsdistrikt, hvarjemte han meddelar henne undervisning om, huru anteckningarne af henne skola verkställas.

Då dagboken blifvit fullskrifven eller då barnmorska tager afsked, flyttar till annat distrikt eller afflider, skall boken till vederbörande läkare aflemnas, för att i dennes arkiv förvaras.

Boken skall äfven, då läkare eller barnmorskelärare så fordrar, för denne uppvisas.

Stockholm den 13 Juni 1881.

N. J. BERLIN.

EDW. EDHOLM. FR. BJÖRNSTRÖM. D. M. PONTIN. CARL EDLING.

Anton Holmberg.

Nr 30. ½ ark, utgifvet i Stockholm den 30 Juni 1881.

Stockholm 1881. Kongl. Boktryckeriet, P. A. Norstedt & Söner.

Under pressure, His Majesty removed the paragraph which led to the number of certified midwives suddenly decreasing. Not until 1819 was it again decreed that every parish was obliged to install a certified midwife.

The midwife's formal training was extended to six months in addition to their practical experience with the government paying the wages for twelve pupils per year. This opened the profession up to any women who were interested, instead of restricting the training to those who were sent by the communities.

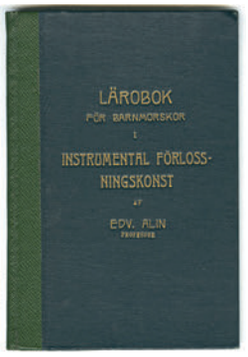
COMPETENCE IN INSTRUMENTAL DELIVERY

The Karolinska Institute was founded in 1810 with the obstetrician Pehr Gustaf Cederschjöld (1782–1848) as one of the first professors. He was one of the leading lights of midwifery training during the nineteenth century. Cederschjöld requested the Health College to provide training and certification in the art of instrumental delivery to particularly competent midwives who were expected to be on duty in areas where there was no doctor within a reasonable distance. His Royal Majesty granted his second request in 1829 and the regulation that forbade the midwife from using delivery forceps other than in exceptional circumstances was rescinded to allow them the authority to do so. Cederschjöld even gave special training in the use of delivery forceps and sharp instruments for foetuses which had died in the womb; 'Draft of the Handbook in the Art of Instrumental Delivery', (1830) and 'Handbook for Midwives in the Art of Instrumental Delivery' (1843). The Swedish midwives' right and ability to use instruments was unique in Europe, but well adapted to our sparsely populated and long country.

A forceps delivery was a risky intervention which was used in approximately 0.5–0.8 percent of deliveries. For 2–3 percent of the women it led to the 'unhappy outcome', that is to say the mother died. In every third case there was a description of an 'unlucky outcome for the child'. The indication for the use of sharp instruments was if the foetus had become stuck and then died. This happened in one case in every 3,000 to 4,000 deliveries, and 13–20 percent of the mothers died after these types of delivery.

PUERPERAL FEVER

During the nineteenth century puerperal fever was the great scourge of the maternity hospitals. The Scottish doctor, Alexander Gordon, described as long ago as 1795 that puerperal fever was infectious, which means that infection was transferred from doctors and midwives as they passed between patients. At the General Maternity Hospital, maternal



mortality caused primarily by puerperal fever, was 4–5 percent. When severe epidemics raged puerperal fever could lead to the death of every fifth woman admitted. Women who had midwife-assisted home deliveries were less often affected by puerperal fever. Cederschjöld described puerperal fever thus:

> ... if the pulse remains frequent, with 112 or 120 beats a minute and the woman has a burning thirst, then the fear becomes a reality. And if the woman in addition is tormented by gnawing pains in the lower abdomen with great tenderness when touched : then one can no longer doubt that she is definitely suffering from puerperal fever.

Cederschjöld recommended hand washing, airing and washing of the floors and walls. He also thought that the mattresses should be boiled and that every woman giving birth should have her own wash flannel. The delivery wards were steamed with chlorine but it was only after the publications by Oliver Wendell Holmes (1843) and Ignaz Semmelweiss (1844) that it was proved that contagion could be prevented by asepsis. Hand washing for doctors and midwives with carbolic acid became obligatory in the General Maternity Hospital in 1878 and three years later the country's midwives received a circular from the Medical Board with careful instructions for hand hygiene and instructions for the dilution of carbolic acid.

DEVELOPMENTS IN MATERNITY CARE

Maternity care which had taken its first steps in the eighteenth century now gradually started to spread into country areas although this had been slow during the first half of the nineteenth century. In 1860 only two in five of the country's deliveries were attended by certified midwives. The greatest increase would take place during the second half of the nineteenth century. Towards the end of the century, nine out of ten women were attended by a midwife during home deliveries, whilst barely three in a hundred were delivered in a maternity hospital. The midwives were part of a chain of care in the county which included the provincial doctors.

Towards the end of the century maternity hospitals were opened even in the large towns. The midwives attending home deliveries were expected to keep detailed clinical notes (midwives' records) on all their patients. In general the midwife attended 37 deliveries a year. If the midwife intervened with instruments a special journal was kept. The provincial doctors were obliged to take responsibility for the midwives and supervise their work continuously. If particular complications such as puerperal fever were noted, the provincial doctor could temporarily take the midwife out of service. The home delivery midwife's significance for the woman's

and child's survival should not only be interpreted in terms of asepsis and competence in instrumental delivery but also in general terms of continual support for the woman giving birth; to be able to give morphine and other pain relief when necessary, to empty the bladder and to assist in the removal of the afterbirth.

MATERNAL MORTALITY HALVED

In 1800 maternal mortality was still 896 per 100,000 live births. During the nineteenth century two thirds of maternal deaths were caused by direct obstetric causes such as haemorrhage, obstructed labour, severe pre-eclampsia with convulsions and puerperal fever. The remaining third had indirect causes such as other infections.

Maternal mortality fell from the beginning of the nineteenth century but rose during the years 1850–1880 because of an increase in deaths from puerperal fever. This increase happened in parallel with the increase in deaths caused by contagious infections. The increased number of deaths from puerperal fever could have been connected to a lack of suitable use of asepsis practices during deliveries by midwifery assistants, but could also have been caused by epidemics of streptococci with increased pathogenic properties. The introduction of asepsis in maternity hospitals from the 1870s lowered the risk of mortality from puerperal fever twenty-five fold. Without the use of asepsis the number of deaths from puerperal fever would have been nearly doubled in maternity hospitals during the years 1861–1900. Aseptic techniques used by midwifery assistants during home deliveries led to a 2.7 fold decrease in deaths from puerperal fever. Calculated over the entire childbearing population the deaths from puerperal fever were halved during the latter half of the nineteenth century.

At the same time that the proportion of midwifery assistant deliveries increased from thirty to seventy percent, maternal mortality declined from 414 to 122 per 100,000 live births. The instances of puerperal fever were not included in the calculations. The risk of maternal death decreased fivefold if a midwife attended a home delivery. Calculated over the entire childbearing population, maternal mortality would have been nearly double without trained midwives.

With nearly one midwife in every parish at the beginning of the twentieth century, Sweden had succeeded in halving maternal mortality over a period of nearly 50 years and attained the level of approximately 200 which Collegium Medicum had predicted 150 years earlier. But the improved obstetric care in the country also lessened the number of still births and the number of babies dying during the neonatal period.

The midwife's box of instruments that she carried with her when attending the woman in labour.
Photo: Birgit Jansson
SOURCE: Jamtli Bildbyrå

GOD'S HELP AND POWERLESSNESS

The historic fall in maternal deaths during the latter part of the nineteenth century can best be illustrated at parish level. Tuna community, 20 kilometres west of Sundsvall, trebled its population during the nineteenth century at the same time that infectious diseases, such as tuberculosis and pneumonia, claimed many victims. Epidemics of typhus, cholera, scarlet fever, smallpox, diphtheria and whooping cough raged and during the years 1800–1849, 400 women per 100,000 deliveries died.

In 1847, the 25-year-old, recently qualified midwife, Christina Elisabeth Morström Holmgren was installed in Tuna. Originally from Falun she was trained as a midwife at the General Maternity Hospital in Stockholm under the tutelage of Pehr Gustaf Cederschjöld. She worked as a midwife in this parish for nearly 50 years.

She soon gained the people's trust in the district and travelled tirelessly between farms. The work she carried out during home deliveries is

detailed in her diary. During the period 1881–1891 Elisabeth Holmgren attended 995 deliveries of which 18 were twins. During these years she noted that 15 women had severe bleeding, four had severe puerperal fever and two had pre-eclampsia one of whom died. In five cases she freed the placenta and the provincial doctor Söderbaum had to be called from Sundsvall on six occasions because of haemorrhage, puerperal fever, convulsions, inflammation and difficult forceps deliveries.

In 1885 the midwives were called to a meeting in Sundsvall to learn about the new asepsis. After suitable training they were instructed to use carbolic acid as a disinfectant. Despite this there were still occasional cases of puerperal fever even in Tuna parish. On one occasion the provincial doctor in Sundsvall, Söderbaum, wrote that he took Elisabeth Holmgren out of service for a few months as there had been a couple of cases of puerperal fever in the community.

Elizabeth Holmgren needed to use forceps on 14 occasions and in her 'Account of a forceps delivery' in 1886 she wrote about the 26 year old primagravida Johanna Öhlen:

> On my arrival at 10.30 in the morning on the 11 August … I found the pelvis well formed, the cervix fully dilated and the membranes broken. The position of the foetus was the right occipital anterior presentation … and as the contractions were strong and frequent and the foetus had been for 6 hours without descending down into the lower pelvis, I realised that I ought to help nature with instruments and therefore used … the forceps and after half an hour's work produced a live child which weighed 9 pounds (3.6 kg). The woman was returned to full health.

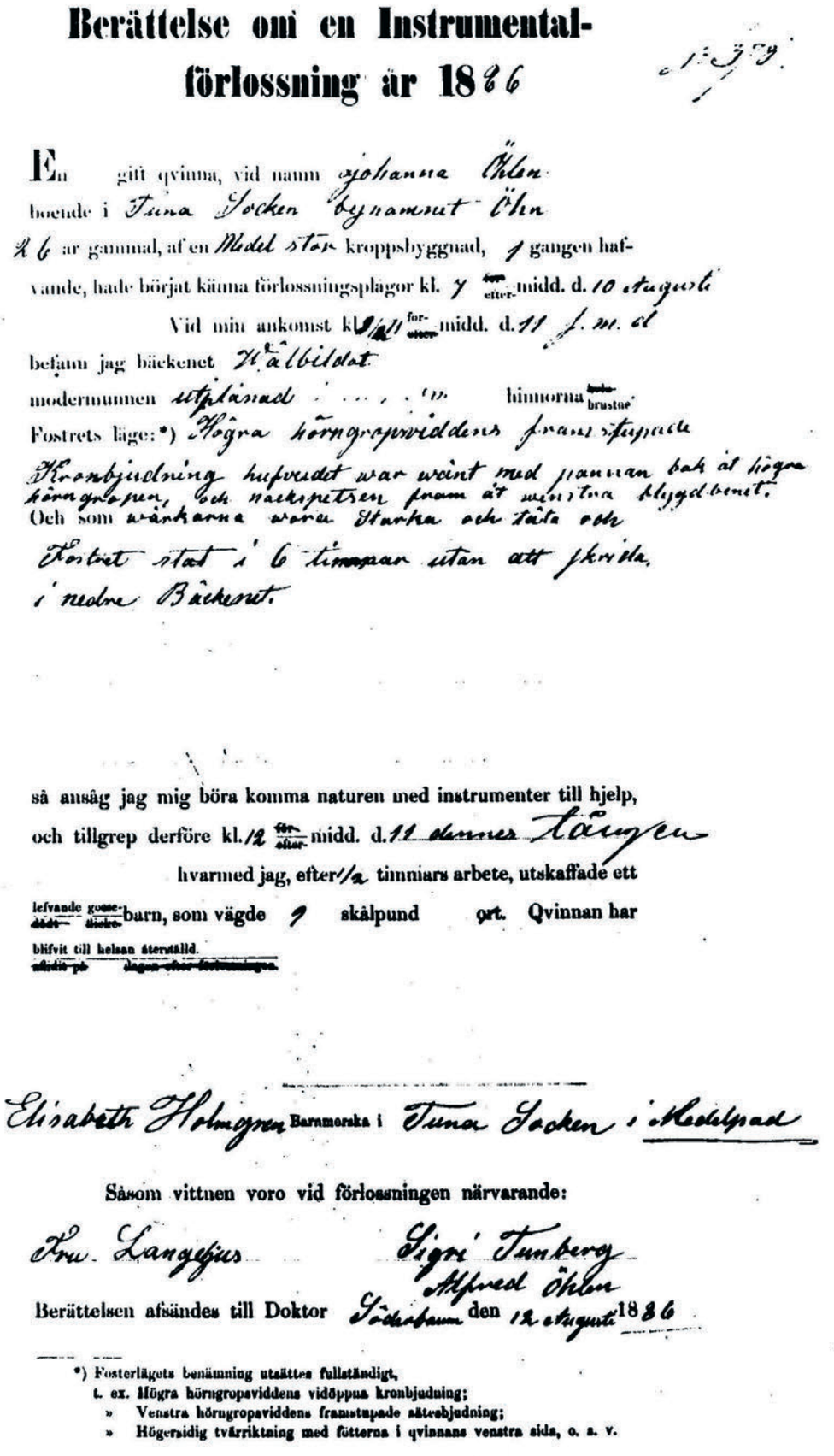
Elisabeth Holmgren's own comments in the journal showed how difficult her work was. At a delivery of twins she wrote: "severe haemorrhage, with God's help she survived and lives."

Maternal death is the most difficult event a midwife can face during her obstetric duties. Fourteen women died during delivery or lying-in during Elisabeth Holmgren's period of duty.

In the parish register of deaths and burials it was often only noted: "died in childbirth" or "died from puerperal fever."

1856	42 year old multigravida died during delivery
1857	21 year old prima gravida died 2 days after delivery
1860	39 year old prima gravida
1864	21 year old prima gravida died 5 weeks after delivery from puerperal fever
1871	25 year old maid
1872	31 year old multi gravida
1875	21 year old "loose woman" NN died one day after delivery

In 1882, when writing about the death of a 43-year-old mother of eight,



Berättelse om en Instrumental-förlossning år 1886

En gift qvinna, vid namn Johanna Öhlen
boende i Tuna Socken Bygnamnet Öhn
26 år gammal, af en Medel stor kroppsbyggnad, 1 gangen haf-
vande, hade börjat känna förlossningsplågor kl. 7 för/efter midd. d. 10 augusti
Vid min ankomst kl. 8/11 för/efter midd. d. 11 f. m. 6
befann jag bäckenet Normalbildat
modermunnen utplånad . . . . . himmorna hela/brustne
Fostrets läge:*) Högra hörngropsviddens framstupade
Kronbjudning hufvudet var vänt med pannan bak åt högra
hörngropen, och nackspetsen fram åt mörstra blygdbenet.
Och som värkarna voro starka och täta och
Fostret stod i 6 timmar utan att skrida,
i nedre Bäckenet.

så ansåg jag mig böra komma naturen med instrumenter till hjelp,
och tillgrep derföre kl. 12 för/efter midd. d. 11 dennes Tången
hvarmed jag, efter 1/2 timmars arbete, utskaffade ett
lefvande gosse-barn/dödt flicke-barn, som vägde 9 skålpund ort. Qvinnan har
blifvit till helsan återställd.
~~aflidit på dagen efter förlossningen.~~

Elisabeth Holmgren Barnmorska i Tuna Socken i Medelpad

Såsom vittnen voro vid förlossningen närvarande:

Fru. Langefjes Sigri Tunberg
Alfred Öhlen

Berättelsen afsändes till Doktor Södersbaum den 12 augusti 1886

*) Fosterlägets benämning utsättes fullständigt,
t. ex. Högra hörngropsviddens vidöppna kronbjudning;
» Venstra hörngropsviddens framstupade sätesbjudning;
» Högersidig tvärriktning med fötterna i qvinnans venstra sida, o. s. v.

"Official Report to the National Swedish Board of Health and Welfare from the Licensed Midwife Elisabeth Holmgren about a forceps delivery on 11th August 1886. "... after a complete dilatation of the cervix the labour was prolonged for 6 hours in left occipital anterior presentation despite frequent pains, therefore I considered it a necessity to help nature with instruments, and delivered the woman with forceps, extracting a live male child of 9 pounds. The woman was recovered."

who probably presented with a placenta praevia, Elisabeth Holmgren wrote in her diary:

> During the last month, several haemorrhages. One part of the placenta in front of the head, died 9 hours after delivery, severe haemorrhage before contractions. Powerless to help.

Elisabeth Holmgren.

In the Sundsvall district infant mortality related to birth was a third lower if a midwife was present at a home birth (35 per 1,000 births). Maternal mortality declined during the latter part of her professional working life in the community to 1.5 per 1,000 births. Two cases of death not included in these calculations are assumed to be unwanted pregnancies: a 25-year-old servant who died of "suicide by drowning" and a 23-year-old unmarried servant who died of "phosphorus poisoning".

Elisabeth Holmgren's tireless work saved many women and children from death and her contribution was invaluable to the community. Her skill and obliging manner were also commented on and she received a medal for long and faithful service. After her death on 3rd June 1897, the community had a memorial erected on her grave in Tuna churchyard.

SWEDEN THE LEADING COUNTRY

That which the Collegium Medicum foresaw as being possible in 1751 was realised at the beginning of the twentieth century. At that time maternal mortality in Sweden was 230 per 100,000 live births, compared with 470 in England and 850 in the USA. Even Norway and Denmark had a low mortality rate, but not as low as Sweden. Sweden also had significantly more midwives per doctor (3:1) than its Nordic neighbours (1.4:1). The low rate of maternal mortality – for that time – was also noticed internationally, and was seen worth noting as Sweden had only half the GDP of the USA and England. George W. Komack, professor and editor of the American Journal of Obstetrics and Gynaecology, visited Scandinavia in 1926 and reported enthusiastically to a meeting of the American Medical Association:

> To begin with the midwife is not regarded as a pariah ... One sees, therefore in the training school for midwives, bright, healthy looking, intelligent young women of the type from our best class of trained nurses recruited in this country, who are proud of being associated with an important community work, and whose profession is recognized by medical men as an important factor in the art of obstetrics, with which they have no quarrel … The results of this midwifery training are evidently excellent because the mortality rates of these countries are remarkably low and likewise, the morbidity following childbirth.

Swedish obstetric care developed during the eighteenth and nineteenth centuries was built on the priorities of society. The aim was to offer equal care to all women irrespective of where they lived. The following was to be provided: national obstetric guidance, development of obstetrics as an academic discipline, well trained midwives who assisted at home births, task shifting with transfer of competence from doctors to the midwives, division of responsibility, and cooperation between provincial doctors and midwives as well as the introduction of asepsis. All of this was decisive in the decline of maternal mortality during the last half of the nineteenth century.

THE INCREASE IN MATERNAL MORTALITY AT THE BEGINNING OF THE TWENTIETH CENTURY

During the first decade of the 20th century maternal mortality increased instead of decreased and Spanish influenza was the cause of many deaths of pregnant women. Influenza pneumonia caused half of all the cases of maternal mortality in hospitals during the years of the epidemic 1918–1919 and during the 1920s there was an increase in the number of women who died from 'childbirth fever'. This was often because of infections following abortion.

Hjalmar Forssner, consultant at the General Maternity Hospital, wrote in 1920 that: "Criminal abortion has spread to an extraordinarily large extent in Stockholm and claims many young women's lives depriving children of their mothers." It was only in 1931 when the cases of death were divided into full term or early pregnancy that one could prove statistically that the increase was due to deaths after criminal abortion. Every fourth case of maternal mortality occurred in connection to illegal abortion. During the 1930s legal abortions were carried out only if the mother's life was in danger as in cases of severe illness such as tuberculosis and cardiac insufficiency. The intervention was not without risk.

Tuberculosis and lack of vitamin D during early childhood meant a risk of pelvic malformation and a third of pregnant women in the 1930s were severely anaemic. Damage to the cardiac valves after streptococcal infection was not uncommon. Both congenital and acquired heart failure meant a great risk for the woman during pregnancy and mainly after delivery with the risk of lung oedema. One in a hundred pregnant women had lung tuberculosis with a death rate of over 20 percent after long-term follow up. The widespread lack of vitamin A increased mortality from infections. Attempts were made to prevent the dreaded puerperal fever with strict asepsis. Strict bed rest was thought to increase a woman's power of

Midwife with forceps Margareta Johanna Skog. Djurö Parish stationed in Runmarö 1860–1901. Photo: Copyright Nordiska Museum

resistance and she was told therefore to stay in bed for one to two weeks after delivery. A midwife from the coastal area of Västerbotten recounted:

> The women had to lie still in their beds and not get up until the day before discharge. So every morning when we wanted to make the beds we carefully lifted the woman over onto a trolley which we placed next to the bed.

Outwardly healthy women, without any previous symptoms, could fall down dead the first time they got out of bed or could be found lifeless in their beds because of blood clots. Even at the end of the 1920s every tenth woman still died following a caesarean section. The primary causes of death were bleeding, infection, intestinal obstruction and blood clots.

At the beginning of the 1930s maternal mortality was still 280 per 100,000. The five predominant causes of death were puerperal fever, illegal abortions, severe pre-eclampsia with cramps, haemorrhage and complications in connection with prolonged delivery.

SUCCESSES FROM THE 1930S

The decline in maternal mortality from the latter part of the 1930s was due to the advances in medicine, the organisation of health and medical care, societal prioritisation and socio-economic development.

The development and advances in modern medicine started in earnest at the beginning of the nineteenth century. The professionalisation of obstetrics was developed by gynaecologists and surgeons. The Swedish Union for Obstetrics and Gynaecology was founded in 1904 and is the oldest union for specialists in the Medical Society. In Stockholm as long ago as 1905 deliveries mainly took place in an institution, whilst in 1920 ninety percent of all Swedish women gave birth at home. The proportion of deliveries in institutions such as maternity homes, cottage hospitals, surgical maternity hospitals and women's clinics, increased rapidly to 75% in 1940. The home was no longer seen as a suitable place for very complicated deliveries. In 1916, Doctor Helge Rödén of the General Hospital in Sundsvall, pleaded for a maternity hospital to be established. He cited as an example a midwife who sent a woman with a retained placenta to the general hospital instead of calling the doctor to the home because "the conditions in the poor home with its dirt and rags would be such ...".

The new midwifery regulations of 1919 restricted the right of the midwives to use instruments – they could use obstetric forceps only so "they are freed from the heavy responsibility of using cutting instruments in desperate situations."

THE DECLINE IN MATERNAL MORTALITY DURING THE TWENTIETH CENTURY

The fact that home deliveries disappeared in Sweden faster than in any other Nordic country could be due to a more rapid industrialisation with significant movement of the population to suburbs and towns; a stronger professionalisation as well as active local authority policies. From 1938 state subsidies were issued for antenatal and obstetric care, which made it free for pregnant women. The Population Commission, the State Health Care Committee and the 1941 midwifery report maintained that the "development of maternity hospitals ought to be in the best interest of the mothers and children, which, as experience has shown, required an extension of the closed maternity wards". The midwives' independent professional position to assist women during normal pregnancy and delivery was upheld when the home births disappeared. The animosity between doctors and midwives which existed in the USA during the twentieth century had few parallels in Sweden.

The instances of maternal mortality decreased exponentially from the beginning of the 1940s from 160 per 100,000 live births to 6–7 during the latter part of the 1970s, to today's figure of 4–5 per 100,000. This was due to a decrease in deaths from abortion, pre-eclampsia, blood clots (thromboembolism), infections and bleeding. The decreasing mortality rate is first and foremost connected to the growth of modern medicine: uterotonics (methergin, oxytocin, prostaglandins); blood transfusions; antibiotics (first sulphur and then penicillin); the discovery of heparin for the treatment of thromboembolism and prevention of blood clots; treatment of oedema; haematology's ability to overcome coagulopathies; treatment of high blood pressure; and effective treatment of eclampsia.

In order for the new research discoveries to be implemented quickly, the organisation of maternal and obstetric health care was significant together with safe and earlier abortions; obstetric care which reached everyone at the beginning of the 1960s and contributed to early discovery of pre-eclampsia and anaemia; improved operation techniques during caesarean sections; and the introduction of intensive care. Other factors that benefited the development were the documentation, reporting and discussion of each maternal mortality in order to improve obstetric care. The Swedish Association for Obstetrics and Gynaecology has, since the 1950s, reported annually and followed up cases of maternal mortality.

In a wider perspective the decline in maternal mortality was due not only to early discovery of complications and better treatment but also to health promotion factors. Improved nutrition and less vitamin D deficiency with fewer growth disorders in the pelvis simplified the delivery of the baby. Better opportunity for contraception, access to safe abortions with fewer multiple pregnancies also contributed to the decline in maternal mortality.

The decline in maternal mortality in Sweden over 300 years illustrates the significance of societal prioritisation of safe abortions and deliveries, the advances in modern medicine, professionalisation of delivery assistance, for every time period the optimisation of the organisation of obstetric care, the task shifting of competence from doctors to midwives, responsibility sharing and team work between midwives and obstetricians as well as a general improvement in women's health.

ULF HÖGBERG, *Consultant at the Akademiska Hospital, and Professor in obstetrics & gynaecology at Uppsala University. Chairman (2009–2010) of the Swedish Association of Obstetricians and Gynaecologists (SFOG). His dissertation is called: Maternal Mortality in Sweden, Umeå University (1985)*

Kontrakt

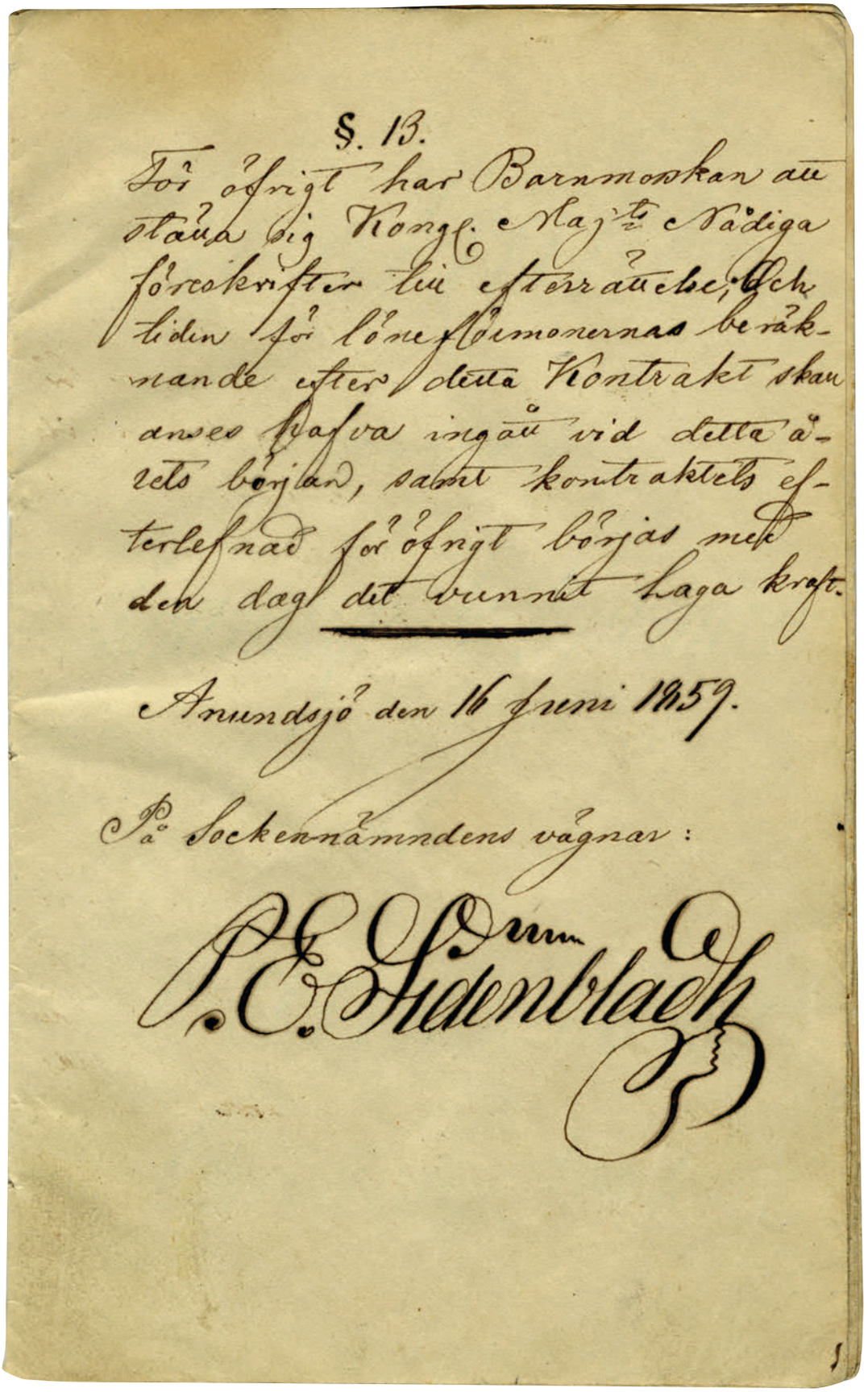
emellan

Amundsjö Socknemän

och

Barnmorskan

Christina Norlén.



§. 13.

För öfrigt har Barnmorskan att
rätta sig Kongl. Maj:ts Nådiga
förordningar i efterrättelse, och
tiden för löneförmånernas be-
räk-
nande efter detta Kontrakt skall
anses hafva ingått vid detta å-
rets början, samt kontraktets ef-
terlefnad för öfrigt börjas med
den dag det vunnit laga kraft.

Anundsjö den 16 Juni 1859.

På Socknenämndens vägnar:

P. E. Sidenbladh

Contract between Anundsjö Parish Council and the midwife Christina Norlén. Anundsjö, the 16th June 1859.

WITH AN EYE TO THE FUTURE

TRADITIONAL OR MODERN? Nostalgic or far-sighted? Having an eye to the future often seems to be the key to success and as a historian I wonder how a characteristic such as foresight arises.

Can certain people have an inkling of the direction in which development will unfold and how do they convince others? I do not have the answer to these questions but in my research it has often occurred to me that, in tricky situations, the Swedish Association of Midwives have often chosen the far-sighted alternative, the modern way.

On important occasions the Association has stressed the consistent and basically unchanging character of the profession. At the same time the daily practice and knowledge-generating work of the midwife has more often been marked by modernism than tradition.

The Swedish Association of Midwives is not only a long lasting professional alliance but also a trade union and seen historically is a uniquely early women's organisation. The roots can be found in social liberalism in which people from the educated, wealthy middle class began a discussion with a woman's professional group which socially and economically was in flux at a time when society which had previously been based on the guild system was being replaced by industrialisation.

The outcome of this discussion was the foundation of the Swedish Association of Midwives. From the beginning the leadership understood what a winning strategy doctors, lawyers and priests had employed to reach to the top of the power elite. The scientific term for this strategy is 'occupational closure'. This means that a professional body claims an area of competence and defends it. The midwives' organisation decided, not without internal debate, that their area of competence encompassed healthy pregnancy and normal delivery. Within this area they would not accept any interference.

At that time the midwives' professional field was threatened on two fronts. Firstly, untrained delivery assistants were common in the country areas and could even be found in towns. Many still believed that the outcome of delivery was predestined and could only be influenced by

magical rites. There was widespread distrust of trained midwives. Many households economized on the cost of professional assistance when a woman was to give birth.

Secondly, the greatest threat came from the doctors' organisation. It became clear that competition for the same area of work arose after the foundation of the Association of Midwives in 1886. No one at that time could imagine that the Swedish midwives would succeed in defending normal deliveries as their professional field, at a time when an increasing number of doctors had won the privilege of having influence in one issue in society after another.

In my opinion there were three decisive reasons for the Association of Midwives finally succeeding in standing up for their professional area of competence.

Firstly, the politicians concentrated on publicly financed, hierarchically organised and nationally uniform health care. In this organisation the doctors were assigned the task of leading and supervising the midwives from a distance. On the other hand, the midwives, who outnumbered them, received only a fraction of their salary. The midwives were also obliged to be on call 24 hours a day, year round. This proved to be a cost-effective solution and to the taste of the doctors' organisation and also the taxpayers. But should the midwives accept this development? Yes, the Association accepted the change in the system as it was the only alternative which in the long run gave the midwifery profession continued independence – although with limitations.

Secondly, the Association had adopted the new research developments from the beginning. Distinguished obstetricians wrote in the midwives journal Jordemodern, gave lectures at congresses, and were invited to Association meetings. Through their male chairman the Midwives Association had a direct channel to the Medical Council and thus also to Parliament. The Association demanded more qualifications and more professional development courses.

Thirdly the Association wanted midwives to stop carrying out all duties that were not part of their core professional area. In the 19th century midwives were still carrying out duties that during the 20th century were taken over by nurses, veterinarians and funeral directors. Such wide-ranging duties were not acceptable to the Association.

But success was not easily gained. Sweden could instead have had a system where the doctors incorporated the complete care of the woman during pregnancy and delivery within their professional field, with the midwife as an assistant. Sweden could also have had a market-dominated health care system in which midwives and doctors competed for the same professional tasks.

Södra Maternity Hospital.

A consequence of this would probably have been that doctors, as in the USA, would have influenced the legislators by dividing up the midwives' area of professional competence.

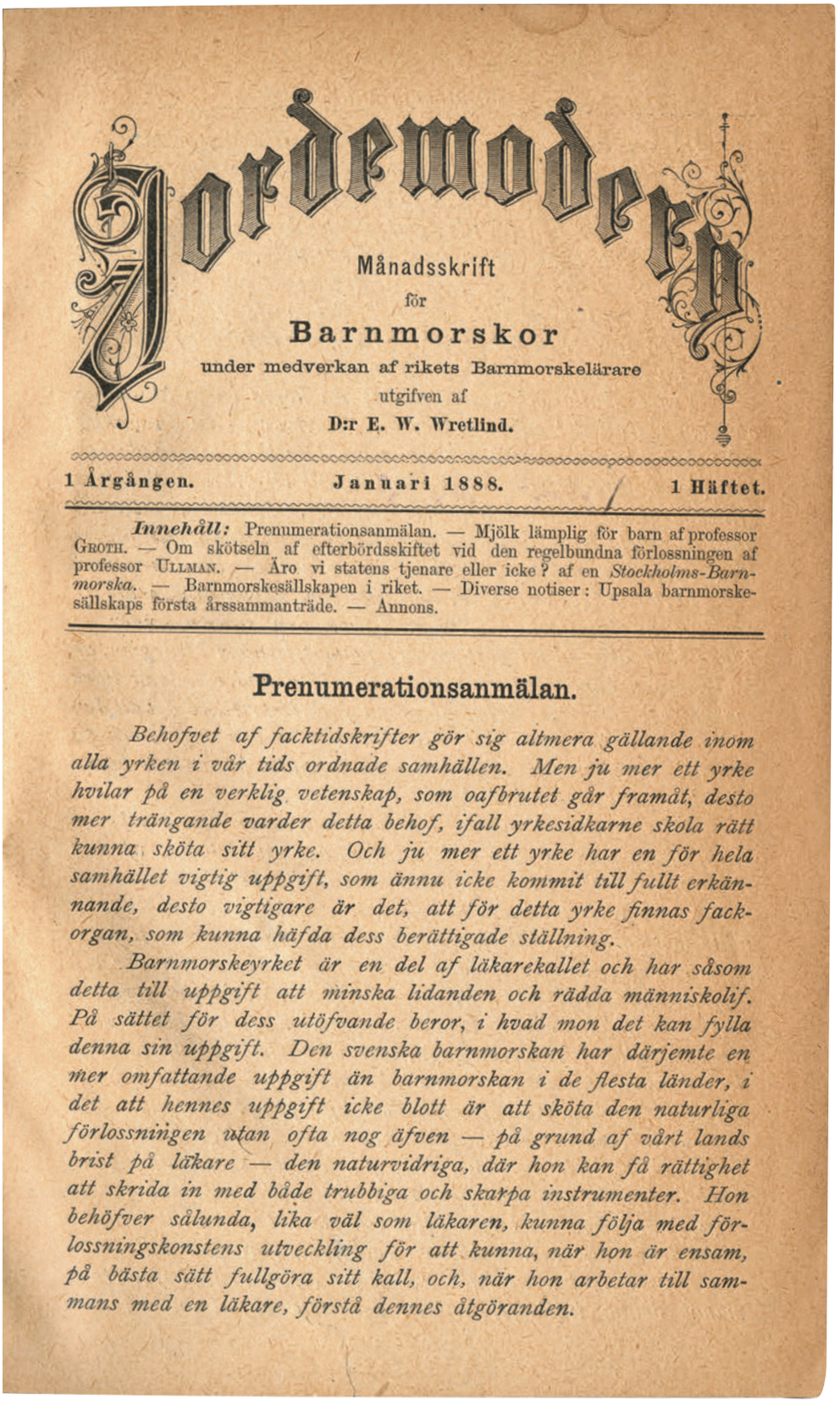
The Swedish Association of Midwives' professional and trade union strategy was contested, but obtained support within influential circles. The first female Member of Parliament chose the midwifery issue as the subject of her maiden speech, and a plea for the increase in a midwife's annual salary of 50 kronor. The argument was based on medical reasons. Scrubbing floors led to dry, chapped hands on which bacteria thrived (with the subsequent risks involved in an age before surgical gloves). The addition of 50 kronor would give the midwife the means to pay for cleaning assistance which in the long term would improve the health of the people! The government allowed itself to be persuaded.

The Welfare Society created new threats and opportunities for the profession. There was a crisis in population growth and a free rein for contraceptive advertising. The Association of Midwives took on the challenge of giving family planning advice. In other countries midwives were obstinate – fewer pregnancies meant less demand for their services! Research shows that the midwives' negative position to family planning in Norway preserved the profession's field of competence there, whilst the Swedish midwives' area of competence was broadened by their greater foresight.

The world changes and new demands are placed on trade union and professional activity. Movement increases over borders, many women still die daily during or after pregnancy; gender differences are tightened in certain areas and loosened in others. The homosexual, bisexual and transsexual issues (HBT) challenge the western world's traditions and so on.

Will the Swedish Association of Midwives be able to keep and maintain its far-sightedness? No one can be certain. But it could be worth reminding oneself that openness to present tendencies and to questions regarding research, seen in retrospect, have often been the key to success.

LISA ÖBERG, *Reader in history, Södertörns högskola.*
Lisa Öberg defended her thesis in 1996 on
"The midwife and the Doctor: Competence and conflict
in Swedish maternity care 1870–1920"
Ordfront publishing (1996).



Jordemodern

Månadsskrift
för
Barnmorskor
under medverkan af rikets Barnmorskelärare
utgifven af
D:r E. W. Wretlind.

1 Årgången. **Januari 1888.** **1 Häftet.**

Innehåll: Prenumerationsanmälan. — Mjölk lämplig för barn af professor Groth. — Om skötseln af efterbördsskiftet vid den regelbundna förlossningen af professor Ullman. — Äro vi statens tjenare eller icke? af en *Stockholms-Barnmorska.* — Barnmorskesällskapen i riket. — Diverse notiser: Upsala barnmorskesällskaps första årssammanträde. — Annons.

Prenumerationsanmälan.

Behofvet af facktidskrifter gör sig altmera gällande inom alla yrken i vår tids ordnade samhällen. Men ju mer ett yrke hvilar på en verklig vetenskap, som oafbrutet går framåt, desto mer trängande varder detta behof, ifall yrkesidkarne skola rätt kunna sköta sitt yrke. Och ju mer ett yrke har en för hela samhället vigtig uppgift, som ännu icke kommit till fullt erkännande, desto vigtigare är det, att för detta yrke finnas fackorgan, som kunna häfda dess berättigade ställning.

Barnmorskeyrket är en del af läkarekallet och har såsom detta till uppgift att minska lidanden och rädda människolif. På sättet för dess utöfvande beror, i hvad mon det kan fylla denna sin uppgift. Den svenska barnmorskan har därjemte en mer omfattande uppgift än barnmorskan i de flesta länder, i det att hennes uppgift icke blott är att sköta den naturliga förlossningen utan ofta nog äfven — på grund af vårt lands brist på läkare — den naturvidriga, där hon kan få rättighet att skrida in med både trubbiga och skarpa instrumenter. Hon behöfver sålunda, lika väl som läkaren, kunna följa med förlossningskonstens utveckling för att kunna, när hon är ensam, på bästa sätt fullgöra sitt kall, och, när hon arbetar till sammans med en läkare, förstå dennes åtgöranden.

The first number of the journal Jordemodern (The Midwife) was published in January 1888.

The need for professional journals is becoming more relevant within all professions in the settled communities of our time. The more a profession is based on real science, which moves inexorably forwards, the more urgently the professionals need a journal to be able to carry out their job effectively. The more important a profession is to the community (even though its importance is not completely recognised) the more it needs to have a trade union to maintain its standing.

Då nu den svenska barnmorskan emellertid icke har tillgång till eller kan göra sig till godo medicinsk literatur, ej heller — enligt regel — kan studera främmande länders barnmorsketidningar, så har hon hittills varit aldeles beröfvad möjligheten att genom studier gå vidare framåt i sitt yrke, sedan hon tagit sin examen. Detta måste verka nedtryckande på den, som vill framåt och vill göra sitt bästa; ja, det måste ofta verka förslöande på sinnet, så att yrket varder mera enformigt och tröttande, än det annars behöfde blifva.

Yrket skulle också komma att stå högre i den allmänna opinionen, ifall det erkändes vara hvad det är — en på verklig vetenskap grundad konst. Äfven mera teoretiskt begåfvade och anlagda naturer skulle då vända sig till ett yrke, hvilket icke syntes dem vara endast handtverksmessigt. Detta vore åter till vinst för hela kåren, ty denna skulle genom sådana mer öfverlägsna personer erhålla god lyftning i både inre och yttre hänseende.

Förlossningskonsten är, lika litet som någon annan del af medicinen, stillastående. Särskildt har den samma under de bägge sista årtiondena gått mycket framåt likasom kirurgien, af hvilken den kan sägas vara en gren. Men under sådana tider märkes bäst det stora behofvet af en facktidskrift, på det att den äldre delen af kåren icke måtte blifva efter den yngre, och på det att barnmorskan inom sitt område måtte kunna väl häfda sin plats gent emot allmänheten.

Men barnmorskekåren har också, likasom hvarje yrke — synnerligen sådana som till staten intaga en ställning af dess tjenare — icke blott att häfda sina skyldigheter utan ock att värna sina rättigheter. Ty skyldigheter måste i ett ordnadt samhälle motsvaras af rättigheter. För detta behöfves ock ett fackorgan, hvarigenom de spridda medlemmarna kunna förenas och sammanhållas till ett helt, och hvarigenom de kunna göra sin röst i samhället hörd. Härigenom skall icke blott kåren utan ock samhället sjelft hafva gagn, ty samhällets bästa är, att inga dess lemmar kränkas i sin rätt, synnerligen när dessa lemmar hafva en mer än vanligt samhällsviktig uppgift att fylla.

Den svenska barnmorskekåren har — enligt vårt förmenande — obestridligen en i vissa hänseenden skef ställning uti samhället, i det att skyldigheter och rättigheter icke kunna sägas väga jemt. För att belysa detta och för att verka till missförhållandenas utjemnande kan ett fackorgan göra god nytta.

Dessa nu här uttalade tankar och erfarenheter hafva frammanat denna tidskrift, hvilken dock icke blifvit satt i verket,

förrän de nu i tjenst varande barnmorskelärarne i riket benäget lofvat sin medverkan till företaget. Först härigenom har tidskriften fått så att säga fast mark under sig. Men sedan företaget kommit i gång, hoppas utgifvaren på bidrag också från vårt lands barnmorskor, i det att de framlägga sina praktiska rön och erfarenheter till kamraters undervisning och uppmuntran.

"Jordemodern" skall således — i mon af utrymme — komma att innehålla: uppsatser på förlossningskonstens, barnsängs- och dibarnsvårdens områden; artiklar och meddelanden om den svenska barnmorskekårens sociala ställning förr och nu; notiser rörande barnmorskeundervisningen och barnmorskeyrket i Sverige samt andra länder; meddelanden från de barnmorskesällskap, som nu finnas eller komma att bildas i vårt land; meddelanden om barnmorsketjensterna i riket och deras löneförmoner; utdrag ur embetsläkarnes berättelser till medicinalstyrelsen rörande barnmorskornas verksamhet i riket och mera dylikt.

Ämnen för tidskriften behöfva sålunda icke fattas. Men huruvida den kan blifva beståndande beror dock helt och hållet på, med hvilket intresse den kommer att omfattas af barnmorskekåren. För att underlätta en allmän prenumeration har priset blifvit satt så lågt som möjligt och vida lägre än för dylika tidskrifter i andra länder. Måtte ett allmänt intresse nu ock komma tidskriften till del. Endast härigenom kan den komma att fylla sin bestämmelse.

"Jordemodern" utkommer med ett tryckark i stor oktav omkring d. 15 i hvarje månad.

***Prenumeration** sker i Sverige (utom Stockholm), Norge och Danmark å närmaste postkontor, i Stockholm hos redaktionen eller å Stadspostens kontor; alt med 2 kr. 50 öre för helt år och 1 kr. 50 öre för halft år. I Finland är priset å postkontoren 4 mark 12 penni för helt år och 2 mark 50 penni för halft år. Från Amerika göres prenumeration direkt hos redaktionen med 1 dollars för helt år och 75 cents för halfår. Vid prenumeration i bokhandeln, höjes priset med bokhandelsprovision.*

***Annonser** mottagas endast för såvidt deras innehåll kan anses för barnmorskor ha specielt intresse; priset är 30 öre för finstilsrad.*

Professor Herbert Swanberg and Professor Emeritus Emil Bovin. Both were tutors in Midwifery Training in Stockholm.

"MISTER MIDWIFE"

—A WOMAN'S PROFESSION IN A MAN'S WORLD

IN A NEWS item in the Swedish Midwives' Association Journal Jordemodern from 1919 is a story of an old man living near the village of Vitträsk in Lapland who was seeking a literate person to help him to write a letter to the previous district midwife. During her time there she had been responsible for both obstetric and medical care as the doctor was seldom on hand. In the letter he wanted the following words included: "all of us – Lapps, Swedes and Finns love you and want to thank you." This was to be sent to 'Mister Midwife'.

Where did the title 'Mister' come from? Since time immemorial, the profession of midwife had always been an all female profession. By the same token nearly all doctors were men. Was it then quite right that a midwife could be included in a doctor's territory if she shared his male title 'mister'? Was this to her advantage or not? And what did it signify for the professional relationship between doctors and midwives?

The Swedish Midwifery body is in a strong position. That is due to the investment in the health and preventive care of the population. Midwives have been a resource since the 19th century, when a countrywide network of trained childbirth assistants was started. It was at that time that the sciences – represented by men – began to advance, but the fact that the midwives were already considered to have a place in this male world, begs the question of how they and their work were actually seen.

For a long time the population of Sweden was small and widespread and doctors were few and far between. The midwives' districts could therefore cover a wide area and they often had to handle more just than obstetric care. They worked independently outside the home and with their own responsibilities – that is to say in quite a male way. Their superior, the provincial doctor, seldom met the midwife, but he was the only authority she could turn to for advice. For her part she was the only person who could ensure the smooth function of the obstetric care that was his sole responsibility.

A RURAL BACKGROUND GAVE A PROFESSIONAL ADVANTAGE.

Many midwives, right up until the 1950s had their roots in rural areas. They came from the countryside or small communities. This is an explanation for the social barrier between them and the 'finer' nurses. But a farming background did not necessarily mean low status. The profession of midwife was respected and perhaps it was precisely this position in the local community that characterised the professional ideal and gave it weight. Such status was not relevant in a middle class world, but well into the 20th century the majority of the population lived in rural areas and were quite likely to have ideals based on a world where women also needed to be strong and able to work hard. Society has changed since then but the old image of the midwife – knowledgeable, independent and with authority – is still today the basis of the midwifery profession's self-image.

A typical image was presented in the journal Jordemodern which contained subjects of interest the profession: working conditions, trade union issues, news and biographical data. Under the latter headline emerged an interesting image of "midwives". At a time when male midwives were unthinkable, it is true that typically female traits were emphasised such as empathy and patience, but the duties themselves and the authority were described in a male way. Midwives were called "scientists," the same as doctors, and in obituaries words such as "veteran" and "fighter" were used. "The work you did was a man-sized effort" was written about one midwife and about another who died young it was written that she never managed to "show what she was capable of as a self-sufficient member of society." Here, therefore they were striving for something other than being a dependent housewife. On the other hand there was no disadvantage in being a wife – or unmarried for that matter. In contrast to most other contexts the marital status was not thought to make any difference to the status of midwife.

In photographs of recent pensioners and people celebrating anniversaries the subjects are sitting surrounded by their gifts, often decorated with the long-service medal (another male symbol), presented to many of them by the Royal Patriotic Society. Midwives also wore uniform (naturally during deliveries) but from the 1940s there was also a travel variation which they wore during journeys within the district and which were given the military sounding title of 'field uniform'. Some midwives also drove cars, which few women did at that time. Out on official duties, it was the midwife who took command and she could give both orders and reprimands even to men. She was also the representative of the authorities who acted in paternity suits, against charlatans.

How did men and women manage to work together? A lot depended on the professional efforts of the Midwifery Corps. When the Swedish Association of Midwives was founded in 1886, raising the status was an important issue. But it was also a question of making the correct alliances. To start with several feelers were sent out to the women's movement, but obviously alliances with the doctors appeared more interesting. Despite everything it was they who had the influence in the world of medicine, which with the modern scientists' establishment became ever more of a power base. Several obstetricians also became involved on the Association's behalf both within the work environment and at a political level. Cooperation meant advantages for both parties. There were few doctors and those with specialist training even fewer, so, in order for the scientific obstetric expertise to be spread, the midwives were necessary. For their part the midwives wanted to have part of the medical school status and opportunities, something that was only possible with the help of the doctors.

Before any potential competition with the doctors could take place it was logical to state how unique the occupation of female midwife was and how important the womanly qualities were. The restless masculine gender was said to be too immature to learn the difficult art of 'being expectant' and would therefore never be able to take over the task. At the same time the profession should not be so female that an alliance carried with it a loss of prestige for the doctors. The medical school's greatest competitor, folk medicine was often carried out in homes and was traditionally a female domain. Being female in that case meant superstition, poor hygiene and lack of training, and doctors had to distance themselves from such things. It was therefore important that the midwives should be relatively like them in both activity and behaviour. Furthermore, the midwives wanted to distance themselves from the traditional local women on whom a section of women in childbirth still relied. The midwives were also 'scientists' and wished to be included in the ever stronger power base that constitutes the national obstetric care.

WOMANLY MILD AND MANLY MASTERFUL

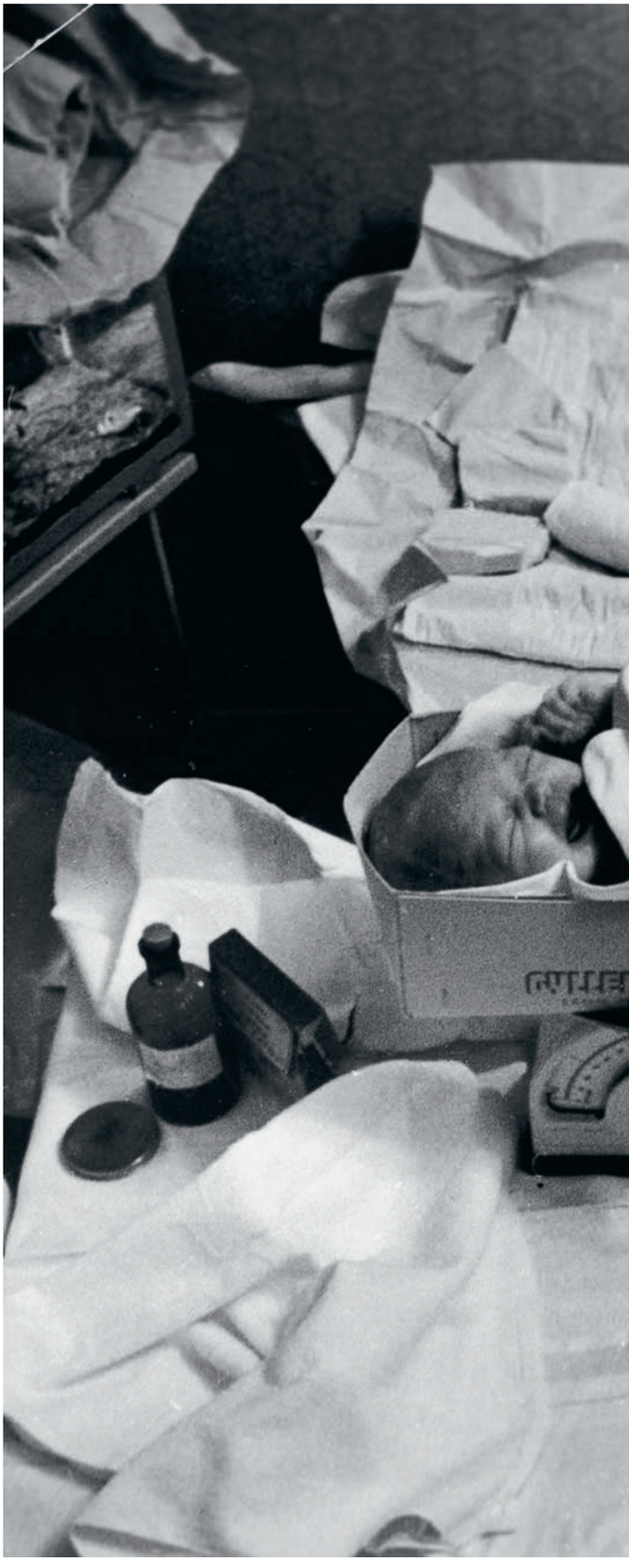
In the midwifery profession's position and practice, one can also trace a connection with the farming society's gender-based division of work, where the rules for how tasks should be carried out were important, and different occupations often were designated as men's work or women's work. But male and female work did not necessarily fall into the categories men/women: more important than the gender of the person who carried out the work was perhaps the distinction itself as well as the

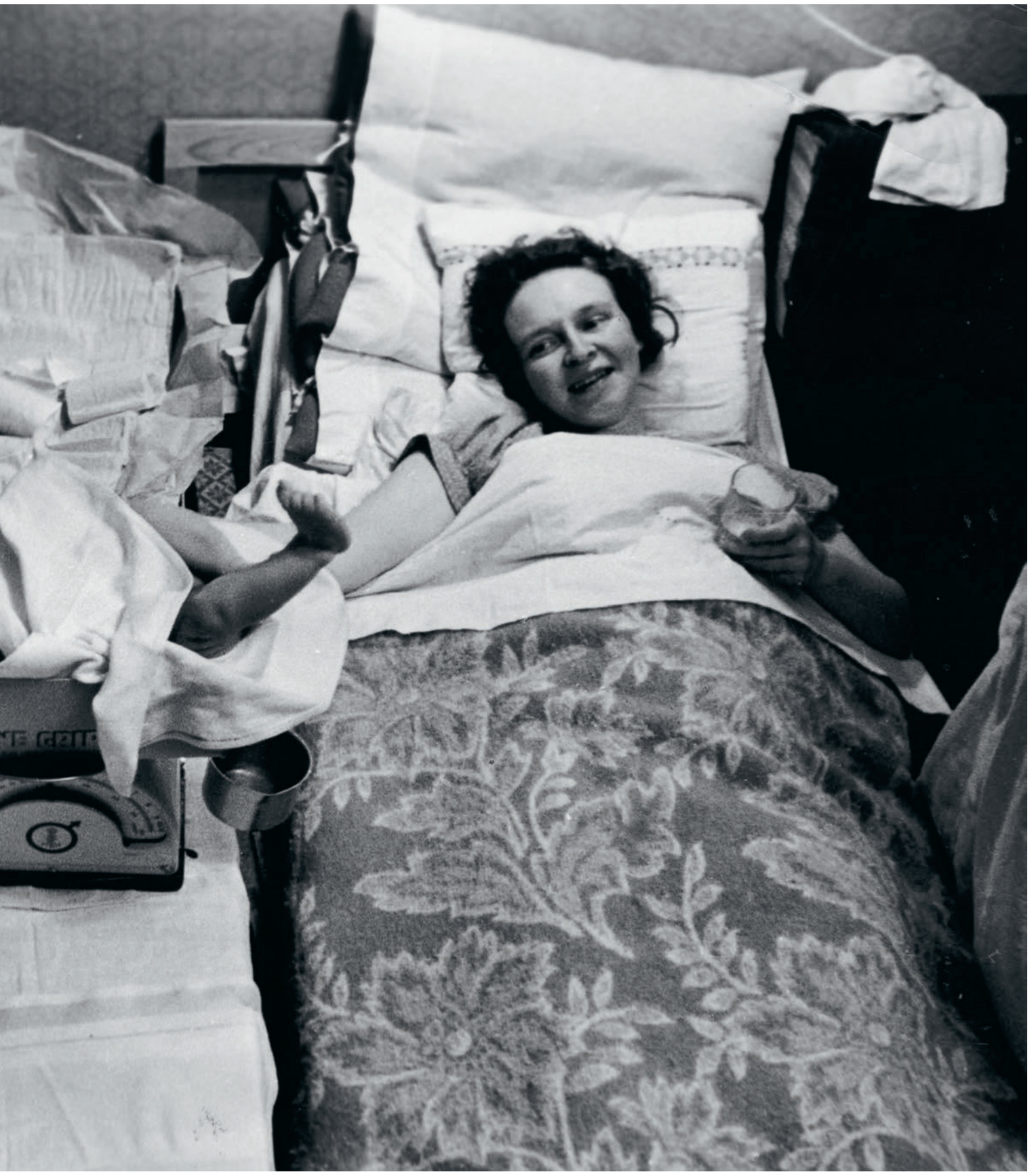
associations attributed to the respective activities. The difference was also clear within obstetric care, but even there the labels male/female probably referred more to the task and position than to men or women. Medicine-making "medicine men" and quacks could also be referred to as "old women" – and midwives could act with male authority.

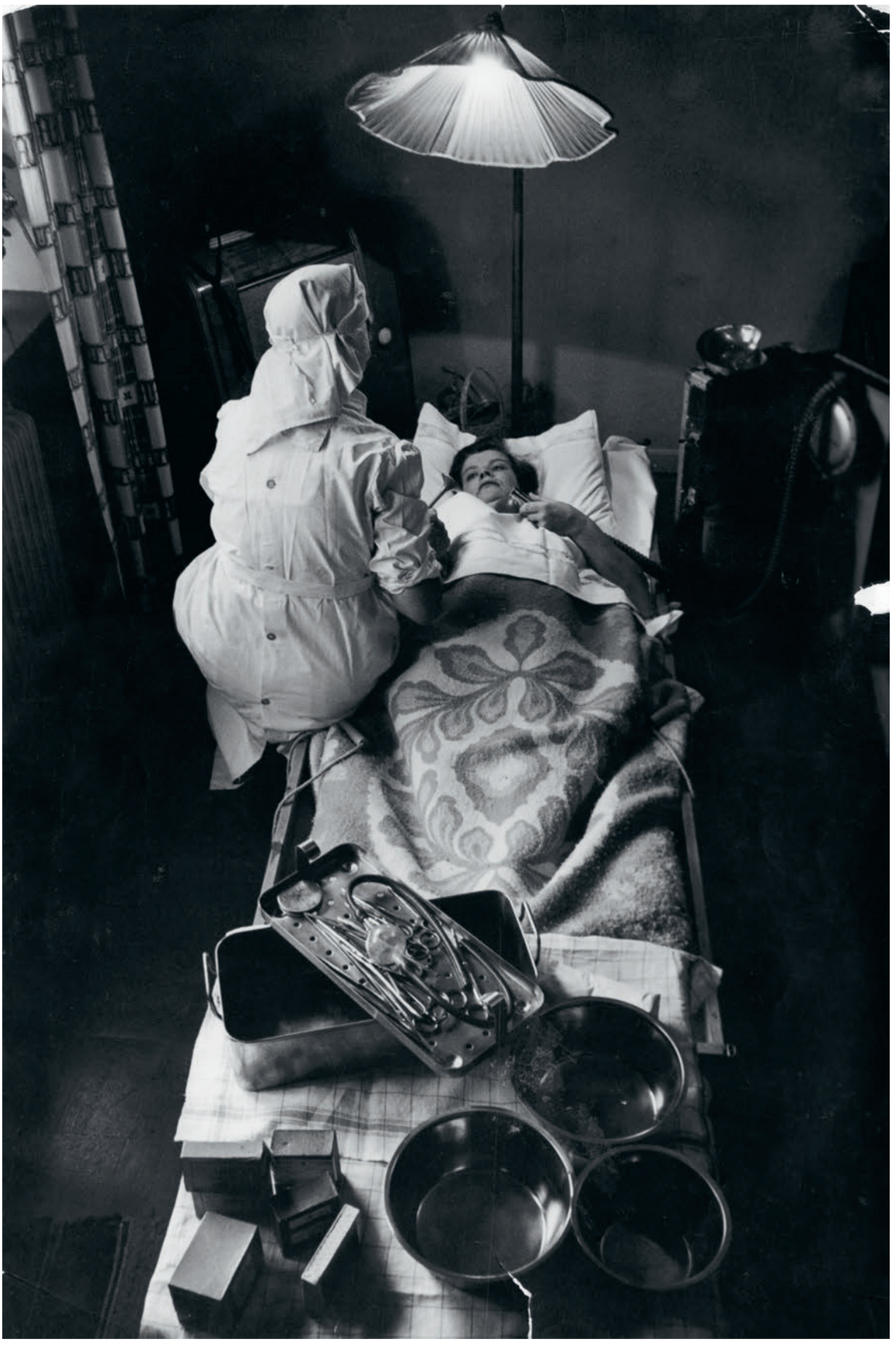
It is also easier to disregard norms if there are important outcomes in view. In that case a flexible boundary is an advantage. For the resource-straitened nation it was practical that the midwife could support and completely replace the doctor if necessary and for the doctors and obstetricians, the competent midwife became a way of reaching the remote areas of the country. She was the channel for a communal endeavour which aimed to persuade people to choose trained obstetric help rather than folk remedies. At the same time the midwife gained professional influence and good reputation if she became competent in crossing the boundaries of expertise. It was therefore essential that the midwife could represent the scientific obstetric care in both norms and practice. A practice that was not greatly contrary to the farming community's ideals and traditions of women. In that way midwives took a place in a male world.

LENA MILTON, *PhD, Editor of the Swedish Lexicon of Biography at the Government Archives in Stockholm.*

Midwifery Examination Stockholm 1932.

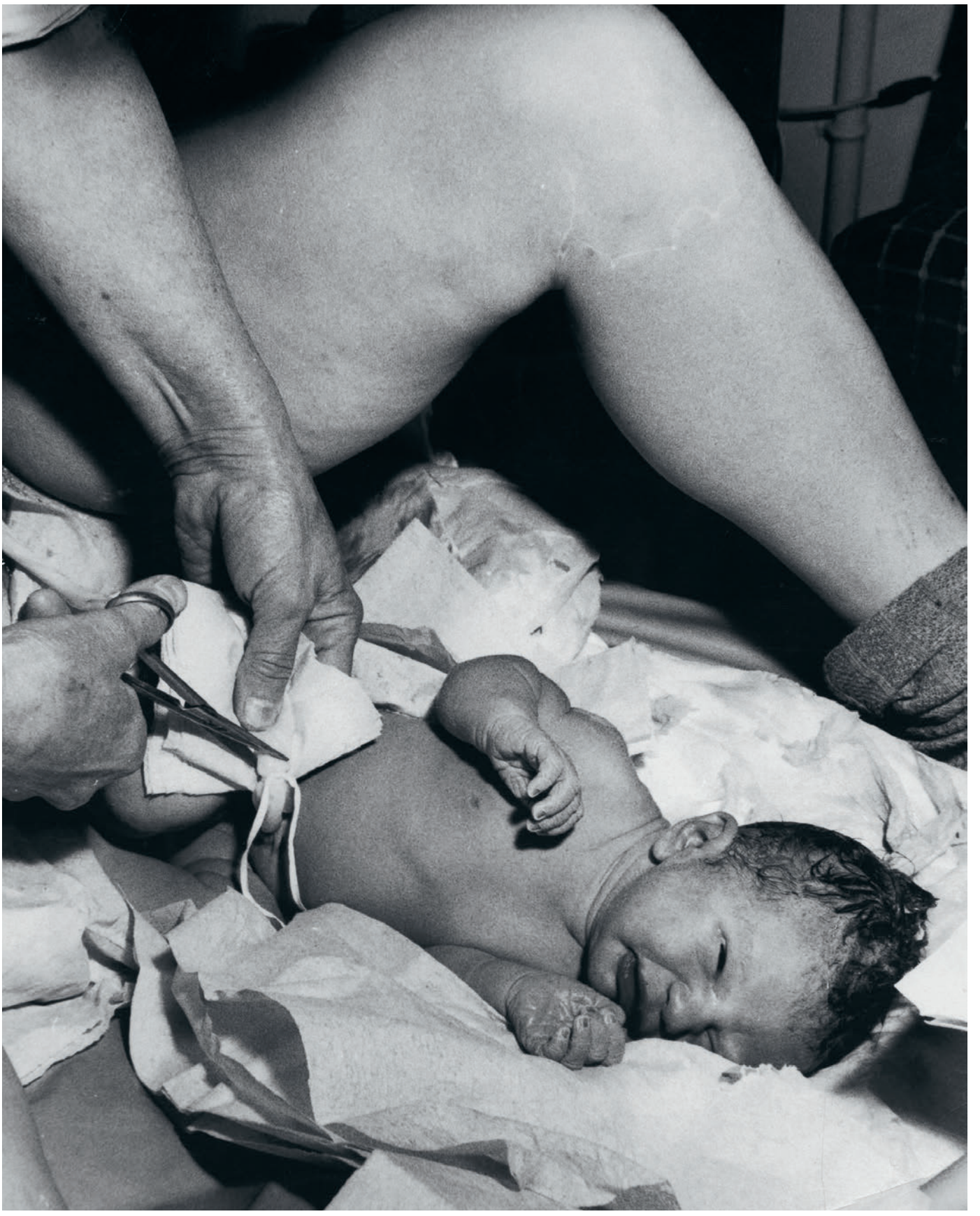






When Anna Johansson took the midwifery examination most babies were delivered at home. When she finished practising as a midwife in the 1960s deliveries were mostly at a maternity hospital. The pictures of Anna Johansson at work were taken in 1954.

Free labour and maternal healthcare were introduced in 1937. Antenatal classes and exercises were introduced in the 1950s.



Midwives' Meeting in Luleå 1961.

MIDWIVES OF THE WELFARE STATE

THE MIDWIVES AND THE GREAT HEALTH PROJECT

"TESTING URINE SAMPLES and talking to expectant mothers" W ill this be the extent of our duties?" This was the rather far-fetched question that Sweden's midwives asked themselves when they were drawn into the planning of a new area of responsibility in the 1920s: Preventative medicine. It was obvious that the scope of their professional duties was soon to be altered. Over several years the number of district midwives, who were responsible for home labour care, had seen their duties reduced. Pregnant women increasingly registered themselves at clinics and the birth figures fell to what was considered an alarmingly low level. The intake for training decreased and the shrinking midwives' corps began to fear that it was about to become 'obsolete'. So of course they hoped that something would break the trend. But was that enough? It was natural to keep an eye on the pregnant women in the district and then step in if complications arose, as well as supporting mothers and new-born babies with advice and help, but these duties were subordinate to the main task: the delivery. Most of them found it difficult to believe that testing samples and giving advice were to be their main duties.

How did the idea of preventative care arise? The most important reason was, of course, not concern about underemployed midwives but rather a range of factors from concrete social policies to eugenics ideology, where the aim was nothing less than a new modern society populated by healthy people.

'HYGIENISM' AND SOCIAL REFORMS

As long ago as the early 1900s socially engaged politicians, doctors and others started to push forward a social hygiene project that mainly centred on body, health and family life. They were inspired by debates on birth control and on improving the health of the people – which at that time was quite poor. One important factor was the housing conditions. As midwives visited patients mostly at home, they were asked, during

Midwives' Meeting Luleå 1961. Ellen Erup at the Polar Circle.

the period of the First World War, to help investigate the living conditions of the average person. They were horror struck at the results.

Many people lived among rats and lice in draughty shacks. They suffered from tuberculosis and malnutrition, and poverty was widespread. What this meant for the obstetric care of mothers was not difficult to imagine. The investigations led to proposals for maternity allowance. Just as important was the health of the individual women because without healthy mothers there would be no healthy children. In 1921 the midwifery training was extended from one year to two and right from the start the midwives were seen as necessary to the work of reform. In parliament they spoke of the midwife as a 'walking college of hygiene in country districts'.

Hygienism contained a clear element of eugenics, something that was not unique to the later Nazi ideology but was a widespread theory and a feature of the population policy in many countries, but it was not taken to such extremes as later occurred in Germany. Along with the great

advances in the sciences during the first half of the 1900s, the idea arose that through planning and carefully considered measures, it was in fact possible to solve social problems and create a healthier and stronger individual – and who would not wish to contribute to that? The midwives, worried about the lack of work and at the same time strengthened in their identity through more qualified training, realised new opportunities and declared through their association that they were ready to do their duty as civil servants.

THE WELFARE SOCIETY TAKES SHAPE

In the 1930s when the transformation of society was taken up to the highest political level, the dream of the good society developed a clearer outline. In 1935 a population commission was set up which drew-up guidelines for an extensive programme of reforms. The same year The Swedish Medical Society obtained a new head – Axel Höjer, a paediatrician with radical visions whose aim was the effective development of preventative care. The previous year Gunnar and Alva Myrdal had published the book 'Crisis in the Population Question' which caused an enormous stir when they not only described the demographic development in pure doomsday-laden terms – but also the solution to the problem in terms of equal conviction. During the years that followed, contemporary society was able to witness a debate on social policy without historical equivalent.

Now the hitherto fairly modest maternity and child welfare care was made permanent. Regular centres started to appear where the risk of pre-eclampsia, anaemia, tuberculosis and much more would be recorded. The midwives were considered able to establish particularly good contact with the patients and could therefore more easily influence them by informing them about the importance of hygiene and nutrition. Consequently this became another important duty. Some form of family planning for married women was possibly also carried out even if this subject was not mentioned in so many words. Eventually all of these areas were incorporated within the midwifery training, but for a long time articles in the Swedish Association of Midwives' journal Jordemodern had to serve as further professional education.

The children's feeding was an urgent question and breast feeding was warmly encouraged. The then secretary of the Swedish Association of Midwives even wrote a little book on the subject, and the midwives considered themselves quite naturally experts on health and fitness in the care of healthy newly delivered mothers and newborn babies.

EXPERT KNOWLEDGE AND EXPERT STATUS

It also became increasingly important to be an expert. The idea of the welfare state and the emphasis on scientific scholarship gave rise to the so called art of social engineering which would be the lode star in the building of society. The "engineers" were experts in several subjects, especially the doctors. By association with the obstetricians the midwives also indirectly became experts as they built their competence on the same knowledge base. The most important aspect was the scientific art of delivery, but now this basis needed to be widened. And if risks were to be eliminated it was logical to demand that something as subtle as the interpretation of symptoms and the appearance of complications also required specialist knowledge. Many doubted that being engaged in preventative care could compensate for under employment of midwives and that those who had chosen the midwifery profession for its independence and the often exciting nature of the work would hardly be attracted to the tranquil nature of maternal care.

But the fact remained that if the state authorities wanted to prioritise preventative care, it lay in the midwives' interest to do the same. Since it was stressed so strongly with time it gained a value that brought with it great ideological advantages. It was particularly emphasized that the prospect of good health must be a democratic right which should be available to all. By being awarded a unique competence the midwives (and nurses) were granted an automatic position as experts, who performed important work based on modern scientific observations and methods. Axel Höjer regarded them as "hand picked troops" within health care, and a professional group which wanted to make itself relevant, could hardly have a better starting point when new times arrived. But in order to succeed, it was important to be constantly responsive to whatever demands the new times craved.

PROFESSIONAL ENDEAVOURS AND STRATEGIES

As the implementation of a new type of health care was exacting, no group of personnel could be dispensed with and therefore the corps of midwives had actually never been threatened. But when the hospital deliveries increased rapidly and the district nurses, the midwives' competitors in matters of child welfare, became more numerous, it was quite obvious that the care of home deliveries and the former old fashioned type of midwife with a specialised training was "obsolete".

THE SWEDISH ASSOCIATION of Midwives and especially its first female chairman, Ellen Erup, appointed in 1944, had realised this early on. She had previously worked for many years on the Board of the Association,

Ellen Erup takes over from Professor Birger Lundqvist as Chairman of the Swedish Association of Midwives at the Midwives' Meeting in Sundsvall 1944.

within the area of midwifery training and also in various government investigations.

Ellen Erup, who was herself both nurse and midwife, stated categorically that a dual training was necessary for all practitioners if the midwifery corps was not to be marginalised. Not only complicated deliveries in a hospital, but also preventative care, demanded knowledge of diverse illnesses. She also reserved the right to be responsible for certain medications, an idea which initially was not shared by all midwives. The difference between illness and health had for a long time been an important way of marking professional boundaries between the midwives and the doctors who were expected to step in if there was an emergency, but not to interfere in normal deliveries. The midwives felt that it was important to set clear boundaries regarding professional duties also between themselves and nurses. Many midwives also wondered what would happen to the profession's independent character and if their certification might be withdrawn. The nurses did not have certification and they could still not work independently as their training was not completely regulated.

The Swedish Association of Midwives plays host for the ICM's XI International Congress in Stockholm 1957. Ellen Erup elected as ICM's president.

Ellen Erup and famous Swedish actress Hjördis Pettersson discussing the pageant "Jordemodern" (the midwife) in Lund 1950.

Ellen Erup suggested that giving contraceptive advice should be added to the duties of the midwives but even here she got a half-hearted response. Preventing the creation of life was obviously against the whole ethos of the profession, according to some. Furthermore a lot of taboos about traditional morality stood in the way.

But the Board of the Association, which also had distinguished doctors behind it, had set the course and forced the questions indefatigably forward. There was an awareness of what a positive reputation the contraceptive service would get, especially as the Myrdals and many other 'social engineers' had emphasized how important private life was for a functioning society. Well-organised family planning would, at an individual level, mean a better economy and good developmental conditions for any future children, and, at a society level, a healthy 'human resource' and competent citizens.

MIDWIFE OF THE WELFARE STATE

The population began to rise during the Second World War which in itself was positive, but the threat of war gave the population rise renewed significance. Further investigations were carried out and one of them specifically discussed the organisation of midwives. Trials with dual midwifery and nurse training were introduced in 1944 and made permanent ten years later. Midwives started to be employed full time within obstetric care. Part of the work for equal welfare and better public health was accomplished and the midwifery corps had been given a position in this project. They would have been indispensable but the corps' own foresight and ambition in getting a position for themselves had great significance. As the work for public health contained strong elements of 'hygienism' and scientific scholarship, it gave the midwives' task a different framework than in many other countries. The Swedish midwives, the public health midwives, became communicators both of a new idea of health and a democratic project. Thus they also gained considerable status.

LENA MILTON, *PhD, Editor of the Swedish Lexicon of Biography at the Riksarkivet in Stockholm. Her dissertation is called 'Midwives in the Swedish Folkhem. Professionalisation of Swedish midwifery during the interwar and postwar period.' The Historical Institute, Uppsala University (2001).*

"Knowledgeable and dutiful, with a gentle, pleasant female demeanour but with an iron will." Ellen Erup (1893–1988) was Head Midwife and Principal of the Midwifery Institute at Södra Maternity Hospital, Stockholm.

Midwife's letter, Anna Gustafson Green, Stockholm.

År 1879 den 23 Juni i Kongl. Medicinal-Styrelsen företr., dervid Anna Gustafva Gren aflade prof, skickar Barnmorske Ed. Stockholm, som ofvan. Lösen En Krona Ex officio O. J. Broomé

Jag Fredrik August Cederschjöld,

Medicine Doctor, Chirurgie Magister, Professor och Lärare vid Barnmorske undervisningsanstalten i Stockholm, Riddare af Kongl. Nordstjerne Orden, **gör härmed veterligt:**

Att som Anna Gustafva Gren

vid den, med henne inför Deputerad af Kongl. Medicinal-Styrelsen i dag anstälda Examen, ådagalagt Berömlig

insigt och skicklighet i de stycken, som till Barnmorske-yrket höra; så varder hon, genom detta öppna bref, till *Barnmorska* antagen, samt iklädd alla de rättigheter och skyldigheter, som gällande Lagar och författningar utstaka.

Till yttermera visso varder detta egenhändigt underskrifvit och med mitt Sigill bekräftadt.

Stockholm den 21 Juni **1879**

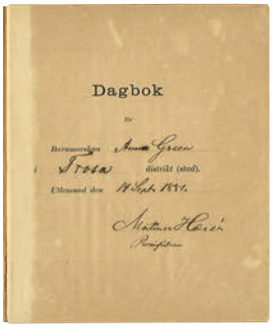
C. A. Cederschjöld

Inför Deputerad af Kongl. Medicinal-Styrelsen hon Anna Gustafva Gren i dag genomgått examen uti den Barnmorskekonsten. Stockholm den 27 September 1879.

C. A. Cederschjöld.

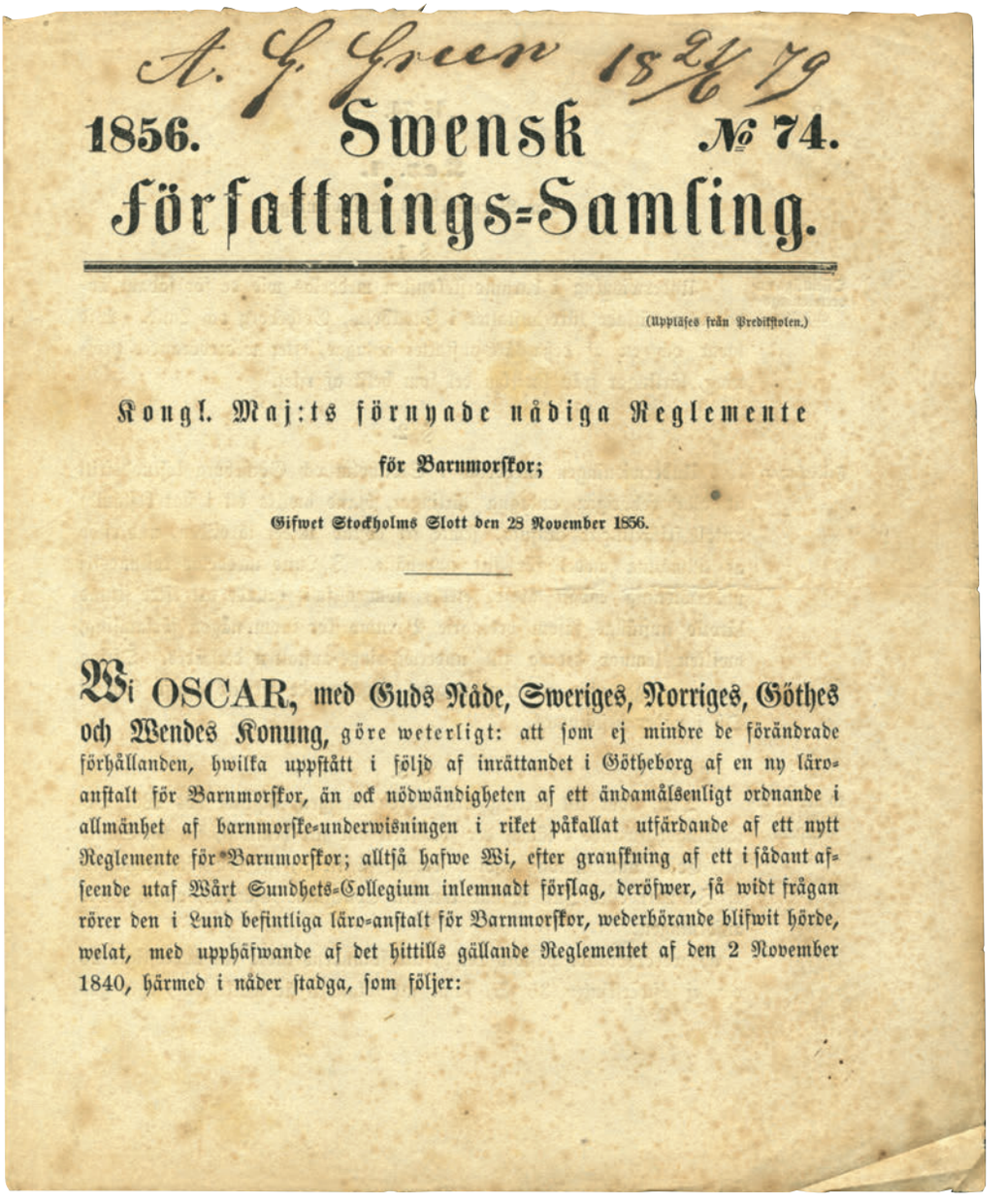
Lösen: 3 Kr.

Examination certificate 1879.



Diary 1881

Handbook for vaccinators


A. G. Green 18/6 79

1856. Swensk № 74.

Författnings-Samling.

(Uppläses från Predikstolen.)

Kongl. Maj:ts förnyade nådiga Reglemente

för Barnmorskor;

Gifwet Stockholms Slott den 28 November 1856.

Wi OSCAR, med Guds Nåde, Sweriges, Norriges, Göthes och Wendes Konung, göre weterligt: att som ej mindre de förändrade förhållanden, hwilka uppstått i följd af inrättandet i Götheborg af en ny läro-anstalt för Barnmorskor, än ock nödwändigheten af ett ändamålsenligt ordnande i allmänhet af barnmorske-underwisningen i riket påkallat utfärdande af ett nytt Reglemente för Barnmorskor; alltså hafwe Wi, efter granskning af ett i sådant af-seende utaf Wårt Sundhets-Collegium inlemnadt förslag, deröfwer, så widt frågan rörer den i Lund befintliga läro-anstalt för Barnmorskor, wederbörande blifwit hörde, welat, med upphäfwande af det hittills gällande Reglementet af den 2 November 1840, härmed i nåder stadga, som följer:

Swedish Statute Book 1856.

Nr:o

År 1879

Barnbördstyg medföljer

Förlossningsberättelse

af Eleven Anna Sofia Charlotta Nordblom

Den 1sta Juni kl. 7 f. m. inkom en barnaföderska, som uppgaf sig vara 35 år gammal, gift ~~ogift~~ och heta Anna Sophia Andersson till lefnadsyrke Mannen Fjenarbetare, bo Ytterstätorängränd 52 sednast kyrkoskrifven uti Adolfia församling med adress denna samma vistats i Stockholm 1 år

Vidare: att hon före hafvandeskapet varit frisk ~~lidit af~~

att hon under d:o 3 varit frisk ~~lidit af~~

att hon genomgått 3 hafvandeskap och varit naturligen ~~med konst~~ förlöst från 3 lefvande ~~dödt~~ foster.

att hon förut varit ~~ej varit~~ här intagen sednast d. 31sta Oktober 1874 1/11 74

att sista reningen inträffat d. i början af Oktober

att hon känt fosterrörelse första gången d. i slutet af 28 Januari

och att hon börjat känna förlossningsvärkar d. 2 Juni kl. 10 f. m.

Vid anställd yttre undersökning befanns

Lifmodern äggformig

Moderbotten mellan naflen och moggropen

Urinblåsan ej uppdrifven

Fosterljud hördes till höger om medlinien

Lifmoderljud hördes på flera ställen

och vid inre undersökning

Bäckenet tillbörligt Moderhalsen försvunnen

Modermunnen öppen för flere fingrar Himnorna brusto före inkomsten

Den föreliggande fosterdelen hufvudet

Under fortgången af förlossningen iakttogs:

Modermunnen utplånades d. ej fullkomligt ~~kl.~~ ~~f. m. e. m.~~

Himnorna ~~brusto~~ ~~bräcktes~~ ~~kl.~~ ~~f. m. e. m.~~

Fostret bjöd sig på det sätt att man kände lilla fontanellen till höger å framåt

och förlossningen utfördes ~~af naturen~~ ~~med vändning~~ ~~tång — skurja instr.~~ uti ventra hörngrops videns framskridande

Kronbjudning den 3 Juni kl. 1 f. m.

Efterbörden ~~afgick~~ ~~utlöste~~ i anledning af värkar genast ~~kl.~~ ~~f. m. e. m.~~

Fostret, en ~~lefvande~~ ~~gosse~~, ~~död flicka~~, vägde 8 ℔ ~~var~~ ~~lång~~

Under förlossningen användes ej loftvensonge

Barnet tog bröstet kl. ~~f. m. e. m.~~

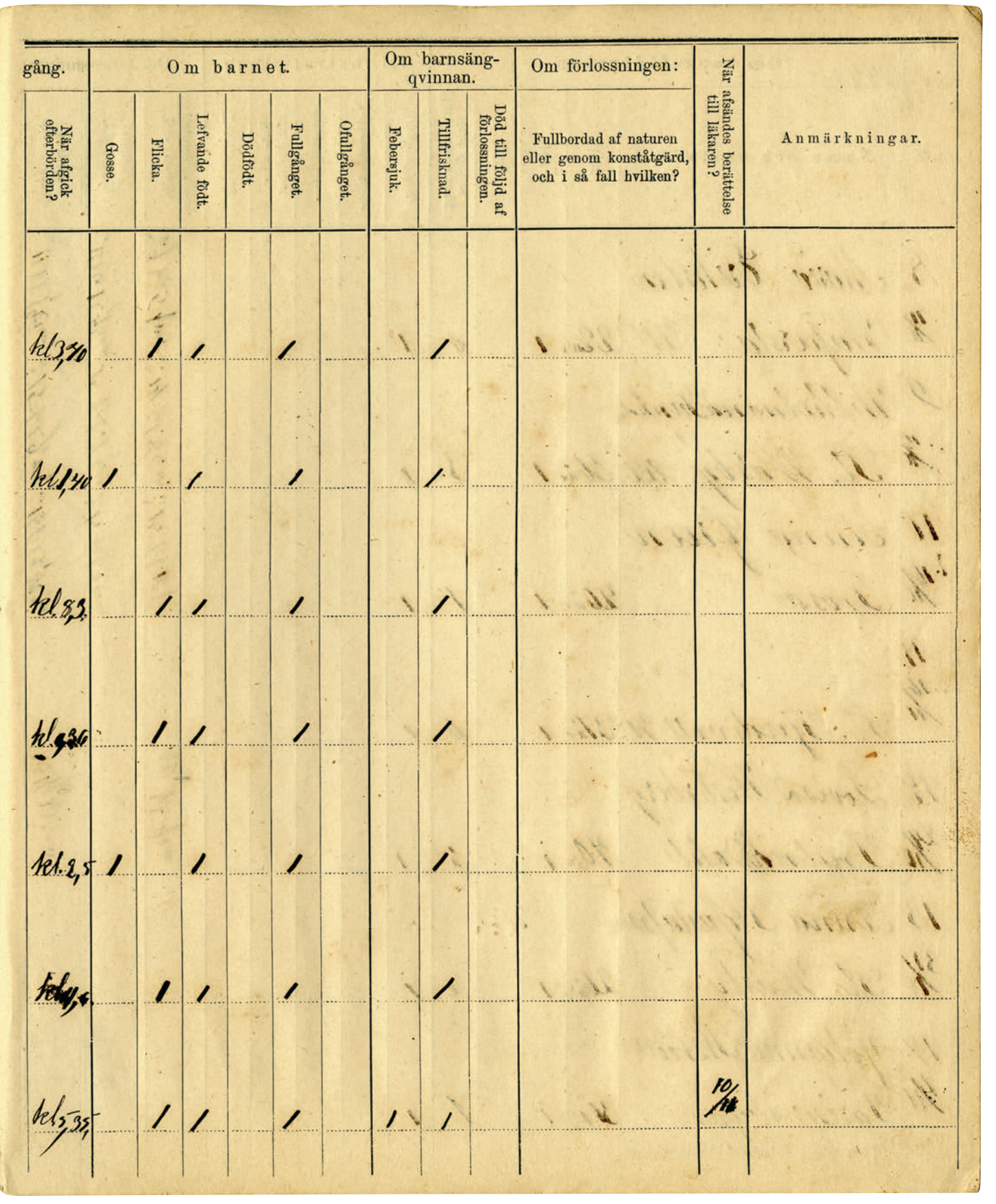
Ovanliga omständigheter vid förlossningen.

Barnet döptes d. och kallades: Tyra Matilda

Account of instrumental delivery 1879.

År 1881	Om barnaföderskan.					Om fostrets läge.					Om förlossningens		
№	Namn och bostad*).	Ålder.	Gift.	Ogift.	Huru många gånger förut förlöst.	Kronbjudning.	Ansigtsbjudning.	Sätesbjudning.	Fot- eller knäbjudning.	Tvärrigtning.	När började förlossningsarbetet?	När afgick vattnet?	När föddes barnet?
1. d. 22/9	Anna L. Karlsson Hopalot. V.	26 år	1		1	1					d. 21 e.m. kl. 6	d. 22 f.m. kl. 3.	d. 22 f.m. kl. 3,30
2. d. 23/9	Maria Pettersson Åda V.	19 år	1		1	1					d. 23. kl. 10 f.m.	kl. 11,30 e.m.	kl. 1,35 e.m.
3 d. 29/9	Lovisa Pettersson Lundbyst. W.	30	1		4	1					d. 28 kl. 8 f.m.	d. 28 kl. 8 e.m.	d. 29. kl. 8. 1 kl. 30 f.m.
4 d. 1/10	Sofia Jansson Sättra W.	17		1	0	1					d. 30 kl. 11 f.m.	d. 30. kl. 11 e.m.	d. 29. kl. 11 f.m.
5 d. 1/10	Kristina Eriksson Åda W	24	1		1	1					d. 29 e.m.	d. 30 kl. 5 f.m.	d. 1 kl. 9 f.m.
6 d. 1/10	Okänd	23			0	1							kl. 5,25 f.m.
7 d. 1/10	Matilda Sandelius Nora Bålsmanstorp	27	1		3	1							

*) Vid hemlig förlossning tecknas »okänd».



gång.	Om barnet.						Om barnsäng-qvinnan.			Om förlossningen:	När afsändes berättelse till läkaren?	Anmärkningar.
När afgick efterbörden?	Gosse.	Flicka.	Lefvande född.	Dödfödt.	Fullgånget.	Ofullgånget.	Febersjuk.	Tillfrisknad.	Död till följd af förlossningen.	Fullbordad af naturen eller genom konståtgärd, och i så fall hvilken?		
kl 3,10		1	1		1			1				
kl 1,10	1		1		1			1				
kl 8,3		1	1		1			1				
kl 9,30		1	1		1			1				
kl 2,5	1		1		1			1				
kl 4,5		1	1		1			1				
kl 5,35		1	1		1		1	1			10/11	

Notes in the Midwife's Diary, 1881.

DRIVING OUT DEVILS WITH BEELZEBUB

THREE MIDWIVES WHO WENT ASTRAY

With shame and grief midwives occasionally witness, how some unworthy members, within the ranks of their corps, draw dishonour and disdain not only on their honourable colleagues but also on the entire profession. It is a particularly serious and dishonourable type of crime, namely abortion, which since time immemorial, has tempted midwives and has caused many of them to break the law of both God and man.

THIS TEXT, JUST over a hundred years old, is taken from an article in Jordemodern, the journal of the Swedish Association of Midwives, in 1909 with the telling title Three Midwives went astray. Here one can read of three midwives who were sentenced to hard labour and "loss of public confidence" for carrying out illegal abortions which meant they lost the right to practise their profession. Jordemodern had investigated whether there were any mitigating circumstances for the actions of the three midwives, but came to the conclusion that they were driven by greed and were unaware that abortion is murder.

Edward Alin, Professor of Obstetrics and Gynaecology and editor of Jordemodern, returned to the subject some years later. The corps had been tarnished by a few midwives who had succumbed to temptation. Now it was time to silence once and for all the old accusation that midwives lent themselves to take part in abortions. The abortions brought shame. But to prevent them with contraceptives was, according to Alin, no solution "for it would mean driving out devils with Beelzebub".

Contributions to Jordemodern indicate society's viewpoint at the beginning of the twentieth century: Abortion was equivalent to murder and the use of contraceptives condemned as immoral. How common it was for midwives to carry out or assist at abortions is difficult to judge. The midwife had the opportunity and a certain amount of knowledge but at the same time, all eyes were on her. Furthermore, she had sworn an oath to do everything in her power to prevent miscarriage.

Throughout the ages women have carried out or have tried to carry out abortions. Herbs such as juniperus sabina, citrullus colocynthis,

parsley camphor and quinine, are well-known abortifacients from history – albeit with uncertain effects. Abortion by massage was a method already used in Antiquity. During the nineteenth century people called it instead "belly squeezing". Hundreds of women died in the 1890s after taking phosphorus which they scraped from matches. In the twentieth century it was more usual for women to use probes, catheters or vaginal sprays to bring on a miscarriage. These instruments could be bought from medical suppliers. The methods for carrying out an abortion probably became more effective, but perhaps also more dangerous if one did not have sufficient knowledge. As a rule, abortion using instruments needed an assistant, an abortionist.

All types of women had illegal abortions: married and unmarried, old and young, with children or childless, from different social and economic backgrounds. According to the court proceedings they were waitresses, teachers, housewives, shop assistants and students. The abortionists were also drawn from a variety of backgrounds. They could be seamstresses or ladies' hairdressers who wished to help or to earn some extra money. They could be factory workers or office workers, a woman friend or a husband. Or they could also be midwives or doctors.

The number of illegal abortions was reckoned to be between 10,000 and 24,000 a year during the 1930s and 1940s. In 1940 on average one woman a week died after an illegal abortion. This meant that a woman could risk life and health if she had the forbidden operation. But this also meant that a large number of illegal abortions were carried out safely.

Until 1938 abortion was forbidden – except if there was a danger to the woman's life and health. The death penalty of former times was replaced at the beginning of the twentieth century with the relatively mild sentences for women who had abortions, whilst the abortionists could be sentenced to several years' imprisonment. In 1938 a law was brought in allowing women to have an abortion on medical, eugenic or humanitarian grounds. That is to say if she was seriously ill, carried a serious hereditary condition or became pregnant as a result of rape.

The 1938 abortion law permitted abortions only in exceptional cases. At that time motherhood was described as a woman's natural and foremost function. Thus abortion appears to be something that a woman would only choose as an emergency solution in a particularly difficult situation. The idea was that with social reforms and health education the need for abortion would decrease. At the beginning, legal abortions were several hundred a year, whilst illegal abortions could be counted in the thousands. In 1946 a socio-medical indication was included in the law and the number of legal abortions rose. In 1951 there were 6,000 abortions.

Ten years later legal abortions barely amounted to 3,000. Society in the 1950s was characterised by a strict restriction in the question of abortions.

The political battle for a woman's right to abortion has been carried out since the 1920s. Doctors, lawyers, feminists, politicians and, from 1933, even the Swedish National Association for Sexual Education (RFSU), pushed through the demand for the right to abortion on medical or social grounds. A woman's right to choose started in the 1960s, or to be exact, 1963.

Young Liberal and Social Democrat student and youth organisations then led the way and a woman's right to abortion was pushed through both as a matter of freedom of choice and a social issue. It touched on the ability of women to make decisions about their own lives as well as a child's right to be wanted. The demand was radical. It meant abolishing the application procedure and placing the decision in the hands of women. For the young activists everything else was paternalism.

The reaction was keen and parties and organisations distanced themselves from these demands. But the support for free abortion grew gradually. An important occurrence was the so called Poland Affair in 1965 when Swedish prosecutors had discovered that women travelled to Communist Poland for abortion as it was legal there. A prosecution was planned against the women, a media storm took hold and an increasing number of opinion-formers asked themselves why Swedish women could not obtain abortions in their own country. No prosecution was ever brought. Instead a government investigation was started with the task of carrying out an overhaul of the legislation in a liberal direction.

When the demand for free abortion was first made it stemmed from a belief in a woman's freedom and self determination. Women's organisations at the time were, however, critical or biding their time, with the exception of the Swedish Women's Left Wing Association. The National Federation of Social Democrat Women in Sweden and the Fredrika Bremer Association did not make a decision on free abortion until the 1970s. Even the RFSU were ambivalent to begin with. One cause can be found in the general view of women. Ideas on motherhood as the goal and meaning of a woman's life were still widespread and the conclusion was reached that free abortion did not always benefit women. The RFSU made a decision on free abortion in 1968. Two years later, in 1970, Group 8 was formed, a Swedish example of the second wave of a women's movement. The first occurred around the turn of the twentieth century. Under the slogan "A woman's right to decide over her own body", they fought for free abortion, free contraceptives and painless labour. Free abortion was introduced in Sweden in 1975.

The abortion issue carries within it a multitude of questions. It touches

on the attitude to women and the foetus, ideas about the body, power, sexuality and health. And it has consequences for how we perceive the task of doctors and midwives. One hundred years ago Jordemodern described midwives who carried out abortions as deviant; they had deviated from the profession's correct path. Today, now that Swedish women have the right to abortion, the midwives have a key role in giving contraceptive advice and prescribing contraceptive pills. Furthermore, at some places in Sweden it is midwives who handle medicinal abortions.

LENA LENNERHED, *Professor of the History of Ideas at Södertörn College, Chairman of the Swedish Association for Sexuality Education (RFSU) (2005–2011). She is the author of Historier om ett brott: illegala aborter i Sverige på 1900-talet (Atlas 2008).*

THE PAIN RELIEF DEBATE

ON THE BOUNDARY BETWEEN MEDICINE AND POLITICS

ACCORDING TO THE Editor of the Swedish Medical Journal 1973, the pain relief debate was in a state of war. In an editorial he wrote indignantly, referring to women's demands in recent years as, "the veritable war-like demands for analgesia in obstetrics." This was in reference to the demand that all women should have the right to effective, up-to-date pain relief. Such demands first appeared during the 1960s and 1970s within the growing women's movement in both Parliament and the media. The editor was not alone in his position. The sometimes fierce criticism of the conditions during childbirth gave rise to strong reactions among doctors and midwives who maintained that the debate was irrelevant and alarmed the women giving birth.

The prelude to the debate took place at the end of 1966 when the media reported that the Västervik doctor, Gustav Hedberg, used Para-Cervical Block (PCB). He claimed that nitrous oxide (laughing gas) and ante natal preparation for labour were not sufficient. The Västervik Method, as it was popularly called, gave complete pain relief and, according to Hedberg, was risk free. He wanted it spread rapidly to all the clinics in the country within the next month. In a communication to the Medical Board he expressed his wish that midwives should be trained in the method and be granted permission to use it. In the media smiling women during labour and astonished journalists testify on the amazing advantages of the method.

Hedberg's hopes were a long way from being realised. The real possibilities of using new methods of pain relief such as PCB or epidural block (EDB) increased slowly. In 1973 only about 1% of women in labour received PCB or EDB, a figure which climbed to just over 5 percent in 1975. In 1980 on average 10% of women received EDB and 9%, PCB and by 1985 the figures had risen to 16% for EDB and 12% for PCB. The variations were significant: in some parts of Sweden this kind of pain relief was common whilst in other parts only a few, or no women at all were given this opportunity. The differences suggest that

routines, risk assessment and the choices that individual clinics made, differed largely.

The media depiction of the doctor as medical pioneer and the liberator of women changed during the 1970s whilst at the same time the contented woman in confinement changed her guise to one of indignant political activist. Under headlines such as, "Why must women give birth in pain?" and "Demonstrate mothers!" the media discussed how the interests of women in childbirth were in opposition to the interests of the doctors. In articles such as these the access to pain relief became a political issue about who had the power and whose knowledge was considered most important. The changed media attitude went hand in hand with the debate in general. In 1971 parliament took a principled stand that pain relief was a reasonable demand which should be granted to those women who wanted it. As its usage slowly increased the representatives of several parties continued to place demands.

The criticism had its most vociferous form within the women's movement. The journal of the Social Democrat Women's Association, Morgonbris (Morning Breeze) demanded pain-free labour and immediate training for midwives in PCB. The magazine wrote how "the reactionary gentlemen" made decisions about deliveries. One writer criticised the National Board of Health and Welfare which, in its notes on pain relief, stated that the sensory impressions, mood and fatigue level of the woman, influenced the degree of her pain. She did not mince her words when she wrote: "What a load of rubbish! They would never dream of writing such things about a man undergoing an appendix operation." Group 8, the largest group within the new women's movement, gave out flyers demanding pain-free labour. They organised a meeting in 1971 with the theme, "Giving birth – a time of anxiety or joy?" Doctors and representatives of the Social Services were invited to answer questions. One of the gynaecologists was taken to task after answering one of the women in the audience who wanted pain relief, with the words: "The pain is natural."

From the end of the 1960s the women's movement therefore maintained that women must become politically engaged to bring about a change in the conditions of women in confinement. Women's movements across the whole political spectrum made a case that it was the fact that it was men, doctors, heads of clinics, and the authorities who, because of their positions as medical experts, had the power to make decisions about the births and not the women who actually gave birth. Women argued that medical knowledge and practice were built on myths about the happiness of motherhood and that doctors used

the idea of the naturalness of birth to be able to neglect the political demands. The women's movements fought to highlight the fact that it was women's experience of birth and their social and political daily lives that should be considered important knowledge and affect the decision about care. Thus the women's movements questioned the existing boundaries between medicine and politics. They fought to have questions about pain relief, and other questions influencing women's bodies, to be made political questions about knowledge and power.

Doctors and midwives were generally critical of such politicization. They considered the debate skewed and unsubtle and that the demand for pain relief created fear and anxiety among the women. Both groups maintained that the psychological aspects of giving birth, the opportunities for natural childbirth and obstetric care were pushed into the background of the debate, but that it was these aspects that were most important. Such a position must be seen against the background of the medical developments of the period regarding labour pains, which arose from a strong notion regarding the connection between pain and the psyche of the woman in labour.

Pain studies of the period ascertained that approximately 30 percent of women in labour experienced an almost intolerable pain. A common notion among the authorities was that those women who could, or would not, adapt to the role of wife and mother were those who had the most pain during labour. Pharmacological pain relief was not the solution to the problems of these women, according to doctors and midwives who instead considered that obstetric care should help these women to prepare themselves for labour and adapt to their roles. In the light of the equality debates of the 1970s and women's entry into the job market, such a medical idea of motherhood was built on a conservative or traditional understanding that a woman's correct place was at home with the children.

Another prominent attitude among doctors was an emphasis on the risks of analgesia to the foetus, which meant that doctors and the National Board of Health and Welfare could maintain that pain relief was an issue exclusively for medical experts – that is to say – themselves. They could thus uphold the boundaries between medicine and politics that the actions of the women's movements had brought into question. The issues regarding the relationship between medical knowledge and power could thus be marginalised. Doctors spoke about pain relief as a choice between a mother's comfort and the risks to the foetus. Risk was therefore a concept that could be used to depict the woman as a threat to the foetus and the relationship between foetus and the woman as full of

conflict. The doctors could take the position of defenders of the foetus against the demands of the ignorant women for pain relief.

The knowledge that permeates obstetric care today and that can stand out as an obvious result of an increase in medical knowledge and technical advances, came as a result of an integrated historical progress. A progress especially involving the actions of the women's movement and its questioning of the positions of doctors and midwives as childbirth experts.

Where does the boundary between power, knowledge, medicine and politics go today and who now questions it?

CHRISTINA JANSSON, *PhD.*
Chriština Jansson's dissertation is called 'Maktfyllda möten i medicinska rum. Debatt, kunskap och praktik i svensk förlossingsvård1960–1985'. Sekel Bokförlag (2008)."Medical Meetings That Matter. Debates, Knowledge and Practices in Swedish Maternity Care, 1960 to 1985 "

THE STRUGGLE FOR NATURAL CHILDBIRTH

I FIND IT easy to commit myself to a cause. In my youth it was the fight for socialism, then women's issues such as the right to work and childcare and, when I retrained from behavioural scientist to midwife, it was the woman's fight for the right to give birth as she wished and without unnecessary medical intervention. When I eventually became a researcher it was the impartial search for truth that was the great challenge, but still within the area of reproduction and childbirth.

I qualified as a midwife in 1981. Modern obstetric care had at that time been in place for more than a decade. Before this one spoke of the art of midwifery which meant patience and waiting, not intervening in labour unnecessarily but letting nature take its course. During the 1960s a range of new methods were developed which were successively introduced into Sweden and thus made a more active method of conduct possible. By using CTG machines (cardiotachiography) the foetus's heartbeat could be monitored electronically in parallel with the contractions of the uterus. In effect this meant that the mother had a band around her abdomen with a button which reacted to the abdominal contractions and a band with a monitor which registered signals from the baby's heart. The abdominal monitor could be replaced by an internal foetal scalp electrode which was passed through the woman's vagina via a catheter into the womb, and the end of this electrode was then attached to the baby's head.

In the wake of a lively media debate about a woman's right to pain-free delivery came the debate regarding epidural anaesthesia – a nerve block also called spinal block, which was gradually being introduced into all labour clinics/wards. The method means that an anaesthetist is called to inject the anaesthetic into the woman's spinal canal. It also became more and more common to hasten the labour pains by infusion of the hormone oxytocin. The proportion of deliveries which ended with a ventouse (suction bell) or caesarean section also increased.

I became a midwife during the transition period between the technical medical development and the period in modern health care when the

demand for so called 'evidence' (i.e. a proved benefit for the patient), was being developed. The spread of a particular method had until this time primarily relied on the conviction and enthusiasm of the doctors rather than on solid scientific knowledge. The enthusiasm for the new methods was easy to understand as reliance on nature's powers alone could lead to complications. At the same time there was some anxiety that the fast development of new techniques could lead to an unnecessary use of them and thus turn all births into high risk deliveries.

The protest began in the USA. With the shift from home births to hospital births, the entrance of doctors (in the USA mostly male) into the labour ward and the increase in medical intervention, it was thought that the male medical establishment removed the woman's power over her own body and delivery of the baby. It therefore transformed one of life's most natural processes into an illness. From being an event taking place in the midst of the family, where the woman could move about freely and adapt herself to the character of the labour pains, she now lay tethered by hands and feet with tubes and wires coming from all directions.

I immediately identified with this protest movement which later spread to several countries, including Sweden. Ideologically the values coincided with the women's movements of the 1970s. When Group 8 formulated its demands for a woman's right over her own body, the focus was directed against the commercialisation and sexualisation of women, which did not engage me at that time. However, I felt strongly about a woman's control over her own body during pregnancy and birth. One reason for this could have been my own experiences. I experienced my pregnancies as important periods which allowed me to be introvert, sensitive and thoughtful – so different from today's pregnant woman who surfs the net, chats with others, compares, checks and looks in on the foetus via ultrasound equipment. My deliveries were normal measured against the standards of that time. Today the first one would have been considered prolonged. I did not want pain relief out of fear of damaging the babies, but was persuaded the first time to take a sleeping tablet. The feeling I carry with me is one of having lived through a very great effort, great pain and having tried to protect my child. I believe that the experience made me stronger. And I would like to share this experience with others.

I also think that I identified with those who criticised the medicalization of childbirth in order to oppose the established methods, the authorities and 'the system'. In this way I found a parallel to my previous political opposition. And in so doing I did not betray my old ideals. I just moved the focus of my commitment. The medicalization of childbirth could be placed in a greater socio-political context, in which authors

such as Ivan Illich described health care in the western world as a new power statement. His book "Inhumane health care" was published in Swedish in 1977 with the sub-title, "The medical establishment is a threat to our health and interferes in an individual's right to make decisions for himself." In his opinion it was undeserving to abandon oneself body and soul to an institutionalised health care system which could lead to as much damage as benefit, and which took away an individual's right to decide over birth and death.

At this time I was not as dogmatic as before, which meant that my belief in natural birth was not categorical. I did not question the value of medical intervention in general but realised that the development had made it possible to improve the outcome of obstetric care. Thanks to medical developments the number of maternal deaths in Sweden per year could be counted on the fingers of one hand and many children survived without disability. My criticism came to be about the overuse of medical technology – an overuse which we critics, as well as Illich, believed gave rise to iatrogenic damages (that is to say, those that the health care itself created). My fundamental ideological position was then, as now, that nature is the starting point. Before we intervene it is incumbent on us as human beings to prove that the outcome will be improved by the intervention in question. The development within obstetrics turned the burden of proof around. New methods such as CTG, epidural anaesthesia and later on, routine ultrasound investigations during pregnancy were introduced with relatively limited basis in research and only when the methods had become integrated parts of the care did the research into the advantages and disadvantages start. The issue was then if it was dangerous not to use the current methods.

At around this time nature started to take an important place in my life. In a discussion on the significance of religion in a person's life someone said that a human being, in order to experience wellbeing, needs to believe in something that is greater than themselves. I believe that this is correct. To some extent my respect for nature came to replace my childhood belief in God and my youthful belief in communism.

In December 1985 I had an article printed on the debate page of Dagens Nyheter under the title Pregnancy – an illness? In it I developed my idea of childbirth as a natural part of life and possible source of power:

> Giving birth is, for most women, the most revolutionary and personality developing event in her life. It is an experience on the border of the incomprehensible which inspires humility before nature and life. During an uncomplicated pregnancy nothing can be controlled or directed: Will it be a boy or a girl? What will the child look like? Is it healthy or sick? What will the labour be like? Uncertainty is a part of the delivery. It sets

thoughts, imagination and expectations in motion. She wavers between joy and happiness, fear and anxiety. Women describe how they shield themselves from the outside world during pregnancy and turn inwards. The most important thing is the child growing inside her. Her body is changing and this arouses new thoughts. The pregnancy is succeeded by labour.

The strenuous and difficult work during the opening and birth phase contrast with the relaxation and joy after the delivery. It definitely has great significance for the woman to undergo pregnancy and delivery in a natural way. Even the uncertainty of pregnancy, its anxiety and the effort and pain of labour are important parts of the process. The effort leads to maturity and growth and makes the woman better equipped to meet her new role as the parent of her child.

I continued to discuss the woman's need of support, a support which was previously given by the family and other people close to her, but which is now to a greater extent given by society's institutionalised support structures, in the form of the health care system.

My understanding is that today's obstetric care works against self-reliance and instead encourages reliance on experts. Pregnancy is treated more and more as an illness and delivery as an operation. The thought of risk and illness dominates. A delivery can be considered normal but only in hindsight. The health system takes over all responsibility already in the ante natal clinic. Whether the woman feels well or not, if her child is healthy or sick, she finds this out from the midwife or doctor. Investigations and tests with ever more refined methods give figures, curves and images. The woman's own body signals, notions and feelings carry little weight against this tangible, precise information. Routine ultrasound monitoring has become more common during pregnancy: Sound waves are beamed towards the foetus, bounce back and become an image on a screen. The weak signals in a woman's own body are only able to give a vague idea of what the foetus is like – the doctor on the other hand can show a clear, detailed image with the aid of a machine. The medical value of the investigation has still not been confirmed in normal cases. Many parents feel that it is a positive experience to see their child in this way. The pregnancy seems more tangible, the child a reality. In some places the parents are even allowed to take home a photograph of the foetus. But what are the short and long term effects? Is something lost in sensitivity, imagination, expectations and the experience of pregnancy? During antenatal classes the parents receive information on the course of a natural birth but also on deviations from the norm and possible complications. The problem is that the knowledge of complications, methods and equipment always increases and the space to pass on information about the normal delivery and the psychology of giving birth is therefore squeezed out. The message that parents are given during pregnancy is often twofold: pregnancy is normal, delivery is normal and the labour pains can be controlled by relaxation, massage and other natural methods. But one can always count on the fact that pregnancy can be complicated, the delivery full of risk and the pain unbearable. The other side of the message takes a greater space and everything points to the fact that this development will continue. This gives parents the feeling that

> they can never be sure; never rely on their own impressions and feelings. Security can only be found with the experts at the hospital – not with themselves. Reliance on health care and its resources is increasing.

The idea of risk is primarily developed in the labour ward. Even women with a normal course of events are treated like risk patients. In over 85% of all deliveries today operative or other interventions are made, such as stimulation of labour with hormones, rupture of the membrane, administration of narcotic anaesthesia and nerve blocks. Less than 15% give birth completely naturally. The centralisation of the labour ward to large units is another expression of the way in which childbirth is made into an illness. Women's demand to be close to the place of delivery to feel secure has to retreat before the demand for a perfect medical outcome – a goal which in normal cases is not proved to have any connection with centralisation and production.

> Naturally we all want to give birth under safe and secure conditions and have healthy children. The support services which have been developed to facilitate this are valuable. But when support services intended for cases of risk and complications are spread to everyone and when the woman's own control over birth is threatened, then we must react.

Then follows a description of how equivalent developments in the USA, England and Denmark have created an opinion that criticises high risk care for uncomplicated pregnancies and deliveries and women's lack of influence, and how this opinion has stimulated the growth of new forms of care, for example ambulant delivery where the mother and child go home several hours after the birth and ABC units (Alternative Birth Centres) with small-scale, homely care in connection with a hospital.

Despite this critical analysis there is great latitude to work in accordance with one's own conviction, especially if one worked within a medium sized labour ward and preferred the night shift as I did. Then the tempo was calmer than during the day and there was the opportunity to give more continuous care and spend more time with the woman giving birth. The greatest challenge was to support the women who were terrified of labour, but the most enjoyable was to follow women who relied on their own ability to give birth and who were aware that it would be painful but at the same time understood that the pain would not be for ever. Once in a while I received a letter which confirmed my attitude to birth as a possible source of power. This is what one woman wrote:

> The overwhelming, almost ecstatic feeling during the happy event starts to recede but I still remember it as if in a haze of splendour/magnificence. I want to thank you for letting me decide completely for myself (respect!), for your calmness and above all for your encouragement. I still feel so proud of myself. It is probably the only time in my life that I have really been

satisfied with my own achievement (and so frightened before). Lars, my husband, is also happy, when you consider the thought that he was able to receive her himself.

Even if few are granted such an experience of giving birth, I have kept the letter as a source of inspiration, and as a goal that I want to work towards in my profession as a midwife and researcher.

ULLA WALDENSTRÖM, *Midwife, Professor of Nursing at the Department of Women's and Children's Health, Karolinska Institute, Stockholm. Chapter from her book: Brinna och Brännas. Om mina engagemang. (Carlsson 2011).*

HELENA MALHEIM'S THEORY OF MIDWIFERY 1756

In 1758 Helena Malheim sent her manuscript on the theory of midwifery to the Collegium Medicum to have it printed. We know this from a note in the Collegium minutes. It was also noted that the book was rejected. But no one knew that it was preserved. In 1993 historian Lisa Öberg rang me and with her colleague, Göran Samuelsson, I waited with pounding heart to withdraw the manuscript from the National Archive. Both of the historians asked: "Who should open it first?", when the little ninety eight page handwritten book lay on the table in front of us.

"I should because I am a midwife!" I said.

To discover a text written by an eighteenth century woman is not an everyday event even at the National Archives so one by one people got up from the reading room chairs and came over to us. The text was impossible for me to decipher but I had help and decided to publish Helena's book 200 years after her death (1995) together with a text analysis and a biography.

So Helena finally had her book published!

PIA HÖJEBERG, *Midwife and author.*
She is the author of the book:
Helena Malmheims Barnmorskelära år 1756
(Hälsopedagogik. HB 1995).

FROM ONE TO A HUNDRED IN 30 YEARS

MORE AND MORE MIDWIVES CHOOSE TO DO RESEARCH

DURING THE PAST 30 years over one hundred midwives have completed their doctoral studies in Sweden. It began with my own thesis on *Credé's prophylaxis – The application of silver nitrate to neonates' eyes 1982,* which was the first midwifery thesis in the Nordic countries.

The fast development of the medico-technical side of health care had given it a 'conveyor-belt character'. Obstetric care was in a period of medicalisation where different types of intervention had been introduced, among them, monitoring of the foetus (CTG), drip-regulated oxytocin infusion to hasten the course of labour, as well as pain relief with pethidine, para-cervical and pudendal blocks. Moreover, many old routines were used year after year without being evaluated in line with new types of treatment. One such routine was the application of 1% silver nitrate solution drops to the eyes of a newborn infant as a prophylactic against gonococcal infection. It had been introduced one hundred years previously by the German gynaecologist and obstetrician, Credé, long before the discovery of penicillin and long before the introduction of many preventative measures during pregnancy and labour, which then lessened the justification for the method.

As long ago as the 1960s people started to question the use of this method to treat the eyes of all neonates with silver nitrate solution which at that time, was an obligatory requirement for the midwife in accordance with medical paragraph MF 38:66 . The debate, "To treat or not to treat with silver nitrate" then intensified among parents, midwives and doctors, both in Sweden and abroad. Research, primarily in the USA and France had shown the significance of 'a soft approach' to the infant at birth and early close contact between the parents and the child. They had also stated that skin-to-skin contact as well as eye contact played an essential role during the first hours of life and could have significance for the continued emotional, social and language development of the infant.

BACKGROUND TO MY OWN RESEARCH

After many years as a midwife, followed by administrative work within health care, I got married and had a family. Directly after the birth of our first child I became completely convinced that I should be a "stay-at-home" mother for a long time. We then had another child, so in total I was away from health care for seven years. Towards the end of that period I started to study Social Science part-time (two evenings a week) at Stockholm University.

When I had presented my thesis in Sociology at a seminar and was about to take my Bachelor of Arts degree, one of the professors asked to speak to me in private. He then encouraged me to apply for their doctoral studies and asked for suggestions of several possible areas of research. My reply was an immediate: "I would like a 'care-related' project" whereupon he spontaneously replied: "Yes, I know that you are a qualified nurse and midwife, but making beds, washing and feeding patients – you can't make anything scientific out of that!"

Yes, that was the response I got. His reply was, however, a disappointment, and, slightly offended, I replied with the following explanation, which I later used many times in my lectures:

> If I am to spend a further four years studying it must take place within the field of health care. There is experience around life and death in the field of health care that needs to be brought to the fore and researched in the same way as life within society. The hospital is, after all, a mini-world. The great difference between these worlds is that we within health care often deal with anxious, traumatised people – after a traffic accident, a heart attack, a cancer diagnosis – in pain and crisis, but who, nevertheless have duties and connections to the everyday world.

The professor thought for a moment – he had never thought about that before and he agreed with me. Yes, of course the care of patients should also be researched. At the same time he did not consider that he could supervise such research and advised me to contact the Karolinska Institute (KI) in Solna.

I went home with my appetite whetted. I had never thought of following a research path – or being able to study for a PhD degree. Would it be possible? My mother had already prevented my stubborn attempts to try to get in to further education, her reason being: "You will never manage to cope with it." But now... yes, a professor had indeed thought that I could do it. No one in my family had even passed their school certificate at an advanced level but my husband had a Master of Arts (MA) degree in mathematics and physics and he gave me his full support.

I started to plan my research. I was advised by the Karolinska Institute's study tutor to seek out Professor Jan Winberg of the Paediatric Institute who could be a possible supervisor. He received me with great interest and enquired in detail about my ideas and future research plans within child care, maternity and obstetric care. I suggested several ideas such as: respect for the pregnant woman during childbirth and the newborn child, the effect of certain routines at the birth, the baby's experience of pain, for example silver nitrate eye treatment, routines during incubator care such as the child's experience of separation from its mother and the feeling of abandonment and the absence of the mother's closeness and tenderness. Many of these routines can influence the early development of the personality and even give rise to physiological effects.

I also suggested three specific projects:

- Credé's Prophylaxis – preventative application of antiseptic to neonates' eyes (against gonoccocal infection) using a solution of silver nitrate
- Care of premature babies – the medico-technical care of the premature infant
- Pregnant immigrant women and their new lives and situation in Sweden.

We immediately agreed that the current issue regarding the application of silver nitrate to a newborn's eyes in a country as developed as Sweden ought to be reassessed and scientifically evaluated. The problem was that the National Board of Health and Welfare did not wish to grant a dispensation from the medical paragraph which imposed a mandatory directive for the use of silver nitrate as an antiseptic for the eyes directly after birth – despite repeated applications from paediatricians and professors to the contrary.

I tentatively asked Professor Winberg if I could request a new meeting with the head of the then Legal Office of the National Board of Health and Welfare myself to try to obtain a dispensation. Slightly hesitantly he replied, "Fine, you are welcome to try, but the question is, if it is worth the effort?" However, after one week there I was, face to face with the Head of the Legal Office Börje Langton. I explained the midwives' daily experience of the cries of a newborn child and the after effect of irritated eyes and the mothers' disgust at the festering eyes and the absence of eye contact.

His immediate reply was: "I had never understood this before – we must of course give a dispensation for research and evaluation of this method."

I went back to Professor Winberg with great joy. He could hardly believe it was true. When we received a written confirmation of the dispensation after about a week we could begin to outline the project. We discussed which modules should be included and I was given the task of writing a research plan and then told to get back to him. The plan of the project was approved and within ten days I was taken on as a doctoral student at the Karolinska Institute within the academic field Paediatrics/Obstetrics.

During my four years as a doctoral student (1978–1982) I did my research at the Karolinska Institute, with two supervisors, Professor Jan Winberg at the Children's Clinic and Professor Ulf Borell at the Women's Clinic. Both gave me their complete support.

One problem was that the Ophthalmic Clinic and its chief physician had absolutely no desire to cooperate or sanction my studies. In his opinion it was unnecessary and claimed that eyes were their department and research into them could not be assigned to a midwife – despite the fact that it was part of a midwife's daily routine to administer silver nitrate eye drops to the eyes of newborn babies.

Of course, I also met other doctors who questioned the presence of a nurse doing research. But I argued for the need to reassess our numerous care routines and when I pointed out that the midwives' great experience was an underused resource which could improve patient care, I met with overwhelming understanding and respect from both doctors and other care personnel.

The University College Reform (H77), which was the result of an investigation in 1968 (U68), gave many the opportunity to study and carry out research at universities and technical colleges. The reform also led to the so-called medium-term health care courses becoming university education which would be founded on a scientific basis. The research into health care was soon put into motion with influences from the USA and England and we discussed its contents: Was it a case of "what nurses/midwives do?" or "what patients/parents need?" It appeared to be both. Many midwives were convinced that several of the health care routines needed to be reviewed and reassessed.

EFFECTS OF MIDWIFERY RESEARCH

My thesis showed clearly that administration of silver nitrate did more harm than good and a short time after my defence of my thesis in 1982 Credé's Prophylaxis was abolished in Sweden and the other Nordic countries. The following year I was invited to be Visiting Professor at Calgary University in Canada. The use of silver nitrate had for a long time been debated in the Province of Alberta and they had heard that a midwife in

Sweden had written a thesis on Credé's Prophylaxis. I was thrown into a great many debates on radio and TV and was then present when the use of silver nitrate was also abolished there. Several years later I was asked by CIDA (The Canadian International Development Agency), Canada's equivalent of SIDA (The Swedish International Development Agency), to lead an ophthalmic project in South America where, in the city of Bogotá, Colombia, there were great problems of blind and sight-damaged children among the millions of inhabitants who really needed ophthalmic prophylaxis.

The following year I was once again invited to Canada – this time to receive an award – an honorary doctorate, LL Dr, from the University of Calgary. During my month-long visit to Bogotá I came into close contact with the so-called Kangaroo method with skin-to-skin contact as a complement to incubator care for premature babies. After that, I had the good fortune, via TV and other media, to communicate this knowledge to the Nordic countries as well as to many countries in what was then Eastern Europe as well as Russia, China, Chile, Easter Island and others.

In spring 1986 I was offered a one-term appointment in International Professorship at the University of San Francisco, UCSF. Besides research and teaching in the faculty I was also given the task of planning new and better maternity and obstetric care through frequent visits to the various islands in the State of Hawaii together with Professor Dyanne Affonso.

During my periods at home I was able to take part in a long line of important midwifery research projects around Sweden. And today, spring 2011, over one hundred midwives have consequently defended their theses. Our scientific studies have been decisive and many routines have thus been changed.

Credé was abolished, 'cuts' (episiotomy) during delivery decreased significantly, we began routinely laying the baby immediately onto the mother's breast or abdomen after delivery, the infants were allowed to breastfeed freely and stay together with their mother/father skin-to-skin around the clock and were permitted to go home early.

The routines after a stillbirth were changed so that the mother and father could see their dead child and say goodbye.

Below is just a small selection of theses and some notes about what they signified for the clinical treatments.

ULLA WALDENSTRÖM's thesis (1987) *Early discharge from the Maternity Ward* and the study of ABC health care, had both contributed to more natural childbirth – the norm has been transferred from medico-technical care/treatment to more natural and humane obstetric care.

ANNA-KARIN DYKE's thesis (1988) comprised both preclinical and clinical research on *Group B streptococcus (GBS) during pregnancy,* and how colonisation of the infant can be prevented. The results show, among other things, that a vaginal douche using Chlorhexidine significantly reduces transfer of GBS to the child.

ANN-MARIE WIDSTRÖM's thesis (1988) *Studies on breast-feeding and peptide hormones* shows that the newborn infant has an inbuilt biological programme which prompts the child itself to seek out the breast and begin to suckle spontaneously approximately one hour after birth. The thesis has, among other things; led to the World Health Organisation reinterpreting its guidelines on how and when the first breast-feed should take place.

GUNNY RÖCKNER's thesis (1991) on the then routine intervention *Episiotomy* had such an impact that there were headlines in the major daily newspapers the day after the dissertation! Within only a few years her research had led to a significant reduction in incisions. As an example there was a 90 % reduction in the number of episiotomies at Huddinge Obstetric Clinic.

KYLLIKE CHRISTENSSON's thesis *Care of the infant – satisfying the need for comfort and energy conservation* (1994) aimed, among other things, at studying how one can best prevent the newborn baby suffering from hypothermia. The results show the significance of skin-to-skin contact directly after birth, so that the infant saves more of its energy deposits, and that metabolic adaptation is hastened and the child cries less.

INGELA RÅDESTAD shows through her thesis *Giving birth to a dead child* (1998) how important it is to help and care for these parents throughout the birth and in the meeting with the dead child – that a photo and a footprint of the child can have great significance for them when working through their grief.

MARIE BERG's and INGELA LUNDGREN's doctoral theses (2002) at Uppsala University show clearly the value of qualitative methods – in these cases primarily phenomenology/hermeneutics – in studies of, for example, meetings between patients and care professionals.

Some other important theses on the subject of sex and relationships must also be mentioned: for example: Vivi-Anne Rahm's thesis on *Chlamydia trichomatis* (1991), and Tanya Tydén's on *STD-prevention* (1996). Several theses have also contained studies in developing countries such as Anna-Berit Ransjö Arvidson's thesis *Childbirth care in affluence and poverty – in Sweden and Zambia* (1998). Furthermore, through contact with our research, many midwives in China, Russia, India and Africa have had the opportunity to come to Sweden for further education and research.

BESIDES THE DOCTORAL theses mentioned above there are another ninety to date – theses therefore are of great significance for development and progress within the field of midwifery. And the research continues with the intention of achieving optimal goals in the work with our young people, our pregnant women, future parents and the new family.

VIVIAN WAHLBERG, *Emeritus Professor of Caring Science, Midwife /Qualified Nurse, B.A. Doctor of Medical Science, LL. Dr. (Hons)*

WOMEN'S HEALTH WORLDWIDE

THERE IS A long tradition of Swedish midwives becoming involved in low income countries. When I did my midwifery training in the late 1960s nearly half of the students on my course had applied for midwifery training so they would be better able to work in missionary service in the future. Some years later the then newly established aid organisation SIDA recruited a great many midwives for what was then a voluntary service. When this was replaced by so called expert services many nurse and midwifery services primarily in countries south of the Sahara, had their teaching staffs complemented by Swedish midwives. SIDA's activities continued until the middle of the 1980s, whilst at the same time we in Sweden started to develop our expertise through courses in research methods.

I worked within midwifery training in Stockholm. Together with my colleagues Anna-Berit Ransjö-Arvidson and Ann-Marie Widström, I commenced a study whose aim was to evaluate stomach evacuation which at that time was routine care during delivery. This work meant that we saw our role as midwifery tutors from a completely different angle. Can we really state, in every situation, what is right and wrong regarding obstetric care in every different context and culture?

Together with fifteen newly qualified midwives we travelled to Zambia on a study trip, where Anna-Berit had previously worked as a midwifery tutor. There it was natural to discuss obstetric care and its shortcomings with our Zambian colleagues at the University Hospital. I started to focus on the care of the baby immediately after the delivery.

In Sweden, the problem of 'hypothermic' babies in the maternity unit came down to a lack of appropriate care, as the baby's low temperature meant that the mother and infant were separated whilst the baby was 'warmed up' in its plastic bed under a heat lamp. This precaution naturally made the mother anxious whilst also preventing the baby from suckling spontaneously when it showed signs of wanting to do so.

In Zambia, as in most other low income countries, the low temperature of neonates correlates to high neonatal sickliness and death. I was

completely taken aback when it became clear that my Zambian colleagues, on the whole, either did not know or did not care that it was the midwife's responsibility to prevent cooling of the newborn child.

Together we did an observation study of the midwife's actions and care of the birthing woman and the newborn infant. When the result, which showed a marked lack of care, was presented in the clinic, the reactions were not those we had expected. Both the obstetric midwives and the clinic supervisors were very upset that we, both Zambian and Swedish tutors, should come and criticise their work which was carried out in the absence of every conceivable staff and material resource.

How could we proceed so that our results would not create chaos – but to stimulate change? Who owns the problems and who owns the solutions?

By asking the obstetric midwives to write down what they knew about the best way of preventing hypothermia of the newborn, together we developed a new observation routine. In order to transfer the research process to those who owned the problem, all midwives had to act as observers during one shift and be observed during another. After the first round of observations the results were analysed together and then followed by a group discussion where everyone could air their opinions regarding why no one 'had done what they should have done or what they had learnt'. Everyone also had the opportunity to offer suggestions on how they could rectify the observed discrepancies in care. It took three rounds of observations before everyone was satisfied with the results – the best possible care.

With this experience behind us we carried out a similar doctoral project with colleagues in Mozambique and Angola in order to understand why care routines during delivery do not always follow the evidence we have. By intensive interviews we discovered that the hierarchical structure found in most healthcare systems hinder rather than enable midwives to take responsibility for care. This in its turn leads to the midwives easily blaming the observed shortcomings on others, that is to say, everyone from political authorities to 'uneducated mothers'. It became obvious that unwelcome results must be highlighted if our research was to be of advantage to women; not only as scientific articles but also at a policy level.

One such example was that midwives as well as doctors accepted illicit payments 'under the table'. This in its turn carried with it the consequence that women avoided care in an institution. In our studies which aimed to introduce the partogram developed by WHO (the World Health Organisation), it was thought primarily that the intervention had succeeded, but on further analysis it became clear that the input perhaps

had contributed to clever 'doers' – but not to analysts. The intervention had not led to more correct referrals, or to fewer incorrect ones. Once again one should ask, for whose sake was the research being carried out and how was the result transferred to the health care and, in the final phase, to the birthing woman and her newborn child?

The midwife's responsibility to understand the mechanisms that control why she does not always work for the woman's, and especially the young woman's, right to her own body and her sexual rights, is a subject that has been researched by midwives in several countries. At present a research project is underway in Uganda, Kenya and India on midwives as responsible for 'post abortion care' and medical abortion. The results of this are likely to have great significance for women's sexual health.

CREATING A STRONG AND CRITICAL BODY

Networks are not only useful for lobbying activities such as breast feeding, but also for research-based and breast feeding promotional safeguards. Africa Midwives Research Network (AMRN) was founded in the early 1990s with the aim, through communal research, to strengthen the competence development of midwives, regionally as well as nationally. Through the network, which now includes several African midwives who have finished their doctoral studies, a large critical body has evolved. At the same time as the network has stimulated demand for regionally adequate midwifery research, it has also developed various tools for facilitating the implementation of evidence-based midwifery practice in cities as well as country districts. Similar networks are being built up in Asia.

The humanitarian care which ought to permeate all midwifery practice is absolutely the most important competence that we Swedish midwifery researchers can contribute to the improvement of international women's health. If we want women's health to improve, and, above all, maternal mortality to decline, much of our research ought to aim at understanding a woman's desire when it comes to optimum healthcare. A healthcare which means that they consider it worth coming to the professional midwife, instead of giving birth at home without professional help or choosing the other extreme – the non-medically induced caesarean section. Our great challenge is to find ways and research methods which show how best we can implement the healthcare and midwifery practice we have evidence for.

KYLLIKE CHRISTENSSON, *Midwife, Professor of Reproductive and Perinatal Health, Department of Women's and Children's Health, Karolinska Institute, Stockholm.*

WHY DO YOU WANT TO BE A MIDWIFE?

TEN FUTURE MIDWIVES TELL THEIR STORIES

TO WORK WITH healthy women and take part in the most important moment of most people's lives. Sorrow sometimes, but above all, joy. Think of being able to experience a miracle at work every day! The Swedish midwife is already independent and in the forefront internationally. I hope that our competence continues to increase and that the salary increments improve.
Marie, aged 31

I WANT TO work with something that feels so positive – preferably with contraceptive advice for young people and care of the maternal health. The profession of midwife will always be there and I believe that it will quickly develop into something even more specialised. I also believe that we will be able to work more in the private sector.
Hedvig, aged 24

I WANT TO work with young people and inform them about sexually transferred diseases and contraception – preferably in Africa where I have met many high school pupils who are keen to learn, but unfortunately do not have the opportunity. I would also like to assist at deliveries and support young mothers in these areas. With so many varied duties, I believe that the profession will never be out of date!
Nathalie, aged 25

I AM LOOKING forward with excitement to the first time I will be present at a delivery. I would also be interested in working with contraception for young people. At the beginning I will probably work in a maternity unit, but can also imagine working in maternal healthcare or a youth clinic. I believe that midwives will always be a strong and established professional body.
Maria, aged 24

PREGNANCY, LABOUR AND women's health interest me a great deal. I want to work with maternal healthcare or in a youth clinic. Hopefully midwives' status will rise in society even more, considering what a responsibility the profession has.
Anna, aged 26

MIDWIFERY SEEMS TO be a very positive profession with opportunities within many fields. I would preferably like to start working in the labour ward and then realize my great dream of starting my own midwifery clinic. I believe that we will become proud midwives who realise what broad skills we have (and receive a commensurate rise in salary).
Klara Johanna, aged 28

IT IS SO exciting to be a midwife because one can work with sexuality and young people, but also because one often works with healthy people. There is a lot of energy and a positive working environment. It will be a privilege to be able to work with issues that touch women and children worldwide! Furthermore I would like to improve the contact with HBT individuals. I want preferably to work in a youth clinic, or labour ward – or start my own clinic for HBT individuals, alternatively, within RFSL or RFSU.
Sofia, aged 27

MIDWIFE. IT SEEMS like the most important work I can imagine doing – being there at the start of life. I want to work in the labour ward and possibly also the youth clinic. Our field of responsibility will be greater in future and our professional competence even more specialised.
Bodil, aged 27

I WANT TO be a midwife because it is a multi-faceted profession. I like working with children and young people and also with preventative work. I want to work in outpatient care; in the maternity and youth clinic. The future looks bright with the thought of all the midwives born in the 1940s now reaching retirement age.
Anna, aged 28

I WANT TO be a midwife to fulfil a dream that I have had since I was 7–8 years old. I want an independent profession with my own responsibility. At the beginning I want to work in the labour ward/maternity ward. In the future we will get more responsibility and receive greater demands from the parents.
Katia, aged 43

ALLMÄNNA SVENSKA BARNMORSKEFÖRBUNDET

TILL SVERIGES BARNMORSKOR!

Hvarför hvarje barnmorska bör vara med.

Hvad är Svenska Barnmorskeförbundet?

En sammanslutning af alla barnmorskeföreningar i vårt vidsträckta land. Det vill arbeta för att barnmorskekåren må växa sig stark både utåt och inåt; det vill medverka till att hvarje enskild barnmorska allt mer måtte i socialt och ekonomiskt afseende erhålla den ställning i samhället, som hennes viktiga och oumbärliga kall berättigar henne till. Tag reda på dess stadgar: Förbundets sekreterare, fru Anna Nordal, Molinsgatan 7, Göteborg, sänder på begäran dylika.

Hvarför är en centralisering mer verksam än de enskilda lokalföreningarne?

Det kan ofta vara så, att lokalföreningarne bära på förslag och önskningar, men, spridda som de äro öfver hela vårt vidsträckta land, komma dessa förslag ofta ej till utförande, om ej en stor enhetlig sammanslutning upptager, undersöker, sammanfattar och bär dem vidare.

Har förbundet lyckats föra barnmorskefrågan något framåt?

Genom sina hvart tredje år återkommande allmänna möten, å hvilka endast föreningar, anslutna till förbundet hafva rätt att genom valda ombud deltaga i mötesbesluten — äfven om alla

To Sweden's midwives!

landets barnmorskor ha rättighet att bevista mötena och medverka i diskussionen — har förbundet icke allenast genom petitioner till högre myndigheter lyckats förbättra barnmorskornas förhållanden i allmänhet utan äfven genom påverkan af den lagstiftande riksdagen vunnit åtskilliga fördelar. Så t. ex. år 1904, då pensionsfrågan gick igenom, och år 1908, då en minimilön, ehuru ännu så länge otillräcklig, men ur principiell synpunkt betydelsefull, i lag fastställdes. Då det nya reglementet utkom, var det nära att barnmorskorna frånhändts bestämmanderätten öfver sin understödskassa. Men Stockholms Barnmorskesällskap, lokalförening till förbundet och stödt af detta, lyckades genom skrifvelse till Kungl. Maj:t få reglementet i denna punkt att bibehållas oförändradt tills vidare. Nu nyligen har samma sällskap, Stockholms Barnmorskeförening med anslutning af Förbundet genom skrifvelse till Kungl. Maj:t och Kungl. Medicinalstyrelsen anhållit att Svenska Barnmorske*förbundet* måtte tillerkännas rätt att på sina möten välja föreståndarinnor för understödskassan. Kungl. Maj:t har beslutat i enlighet med sagda skrifvelse. Svenska Barnmorskeförbundet har genom denna lag blifvit erkändt som organisation. Vidare har förbundet flera gånger utverkat hos Kungl. Maj:t resestipendier för barnmorskor till internationella kongresser och för närvarande har förbundet en skrifvelse till Kungl. Maj:t angående lönefrågan. Med anledning af denna skrifvelse har uttalanden af förste provinsialläkarne och K. Befallningshafvande i länen begärts och ha så godt som alla lifligt tillstyrkt de uttalade önskemålen.

Har barnmorskan såsom enskild någon fördel af att tillhöra förbundet?

Ja, hon får del af de beslut och framsteg kåren gör; hennes intresse för sammanslutningstanken växer; hennes blick blir mera vidsynt och förstående gentemot kamraterna; hennes soli-

daritetskänsla väckes och fördjupas och hon börjar själf verka för kårsammanslutningsidén såsom en verklig kraftfaktor i allt organisationsarbete. Hon åtnjuter dessutom förmånen af att å föreningsmötena åhöra de mycket lärorika föredragen af de läkare, som ofta välvilligt ställa sina rika kunskaper till föreningarnes tjänst.

Hur skall barnmorskan komma in i förbundet?

Saken är enkel. Genom att anmäla sig i närmaste lokalförening. Sådana finnas i nästan hvarje län. Förbundet räknar f. n. öfver 800 medlemmar, men Sverige har nära 3,000 barnmorskor — alla böra vara med.

Är det värdt att offra årsafgiften genom att ansluta sig till en förening?

Arbetet blir mera *glädjefylldt,* när man känner att man ej står ensam, utan har kamrater, som kämpa sida vid sida. Arbetet blir mera *ansvarsfylldt,* då man betraktar sig som en del af det hela, som medansvarig i hela kårens framåtsträfvanden; arbetet blir slutligen mera *fylldt af hopp och kraft,* när många hjärtan och många armar samarbeta! Har du icke märkt att barnmorskekårens anseende växer? Allmänheten förstår oss bättre nu än för 20 år se'n, läkarne likaså, och i den lagstiftande församlingen blir det allt flere röster som höja sig till stöd åt våra sträfvanden.

Därför, kom med, kamrat! Och när du kommit med, stanna ej stilla och dådlös, utan tag din uppgift på allvar och arbeta med målet i sikte: Sveriges barnmorskekår, en af staten och kommunen stödd och omhuldad, af enskilda erkänd och afhållen, tjänstekår, det första och äldsta kvinnliga statsämbetet i Sveriges land!

I unga, som ännu stån tvekande och rådvilla, låten alla små hinder vika för den enda stora, enande tanken: Fram-

åtskridande! Sveriges barnmorskor äro sedan länge tillbaka i den lyckliga särställning att äga rättigheter i yrkets utövande, dem andra länders barnmorskor *aldrig* ägt. Men med dessa rättigheter följer förpliktelser att vårda dem så, att de ej tagas ifrån oss. Endast genom stark sammanhållning kan detta ske.

Kamrat, slut dig till vår organisation!

Kom ihåg skaldens ord:

»Du skall känna dubbel kraft
När du djärft med båda händer
— Ej med en och en i sänder —
Griper tag i hammarns skaft.
Tusendubblas skall ditt mod
När de taga vid, de många,
Att i dina fotspår gånga
Och ej stanna där du stod!»

Svenska Barnmorskeförbundet.

BRÖDERNA TÖPELS BOKTRYCKERI GÖTEBORG 1915

Colleague, join our organisation!

The Swedish Association of Midwives 1915.

MY LIFE AS A MIDWIFE 1

MY NAME IS Solveig Petersson and I was born in Motala in 1938. My mother was born in 1907 and was 31 years old when I was born. My father was born in 1901 and was 37. I was their first child.

Mother was born in Vånga, Östergötland and father in Säby, Småland. Both came from farming families and had a lot of siblings. After elementary school my mother went to a domestic science school, I do not know where, perhaps in the Norrköping area and father went to Sörängen's elementary school outside Nässjö. When I was three years old I had a sister and when I was four a brother was born.

During the first twelve years of my life my parents rented various farms and we moved several times. At the beginning of the 1950s they bought a smallholding in Vånga, which had been in my mother's family for several generations. At that time I was in the sixth class. After that it was usual to apply for secondary modern school which is what my parents wanted me to do. No one else in the class did that and I, who was a new pupil, was afraid to stand out. I therefore continued in class seven and almost immediately regretted that I had not continued to study for higher education in secondary modern school.

I worked as a child minder for about a year and then started at Lunnevad's Adult Education College where I studied for approximately three years; a fantastically positive time. I had no particular career plans as far as I remember. I planned to have a summer job between two of the courses. A school friend gave me a tip that you did not need any training to become a hospital assistant and so I applied and got a job in a hospital in Linköping. It was not until the day I was to start that I learnt that it was in the maternity hospital!

SOMEONE TOOK ME straight into a room where a woman was about to give birth. She lay on a short bed, the baby was born with its bottom first. Aha, I thought, so this is how it happens. Everything was so fantastically exciting. Somehow I knew that the baby is usually born head first but I did not think about it at the time that this was something

unusual. I believe that from that moment I was caught, I wanted to become a midwife.

After the Adult Education College in the autumn of 1958 I continued to work as a hospital assistant in the maternity hospital where I had had my summer job. I had applied for nurse's training and went as a trial pupil nurse in spring 1959. The same autumn I started the 'proper' training, which was a good three years long. After approximately half of that time you could start the specialist training that you had chosen.

At that time midwifery training was only available in Stockholm and Gothenburg and it was not taken for granted that one could get in there. It depended on how many applicants there were from all the nurse training schools in the country. I was lucky and was able to start in Stockholm in the autumn of 1961. The training was attached to Södersjukhuset (SöS) and Södra Maternity Hospital. From the very first moment I enjoyed the training and on the whole have only positive memories of the practical work in the various departments. After my training I obtained a post in the maternity hospital where I had previously worked as a nursing assistant.

Because I knew the wards and some of the staff no one, least of all me, thought that there was any necessity for a qualified midwife to work with me. My first task was to look after a mother with intra-uterine stillbirth. Number two was a multigravida who gave birth quickly. When everything was over I was so nervous that my knees shook. Then the mother says, "How wonderful that Sister is so calm. It wasn't like that last time." Those words meant a lot to me and helped and formed me in my work role.

There was a harmonious atmosphere and fine community spirit between all the categories of staff in the department. A lot of laughter and happiness. The tradition of addressing others using the familiar form of the word 'you' was not yet completely widespread. I was called 'Sister' by the doctors and patients and also introduced myself as Sister when I answered the telephone. The first doctor who addressed the midwives using the familiar form of address was a young woman doctor who later became a Member of Parliament representing the Moderate Party and county governor.

At the beginning of the 1960s fathers had been allowed access to the obstetric departments. During my training at SöS they were permitted to be in the room until the mother began to bear down. They were then allowed to come back when everything was over. Even in my first work placement the fathers were allowed to be there. As far as I was concerned they were allowed to be there the whole time if they wanted to but some of them chose to go out at the final moments. Then I think,

and I know that others did too, that the father was there for the mother's sake. I remember what an 'aha' experience it was when I realised that it was at least as important for his sake as well.

After three instructive years in the 'big' hospital where there were always at least two midwives on every shift, and we always had access to obstetricians, I got married and moved to Vimmerby where I also got a job in the combined obstetric and maternity unit.

In this hospital, there were approximately 300 deliveries a year. We worked with one, sometimes two staff nurses and a children's nurse. On-call shifts were included from the beginning and I could start a shift at 7 am on Friday morning and go off duty three days later at 7 am on Monday.

A skilful surgeon had responsibility for the maternity hospital. Patients at risk were filtered out in the ante natal clinic and referred to Västervik maternity unit for delivery, where there was also a children's clinic. But of course sometimes it happened that I had to travel in the ambulance with an emergency case, accompanying an expectant mother or a small newborn baby who needed more care than we could offer. On occasion the maternity department was so full that we had to send mothers to Västervik.

During my time in Vimmerby I gave birth to our two boys. At that time maternity leave was six months and as I had finished work four weeks before I gave birth I had to start work again when my first child was five months old. My second baby was expected in October 1969. To solve the staffing problem in Västervik, our small department in Vimmerby was closed temporarily, but when it reopened at 7 am on 15th October I was its first patient.

IN THE SUMMER of 1970 I moved with my family to Sundsvall. There were no vacancies in the maternity ward so I chose to stay at home with the small boys and did hourly-paid temporary work if I was needed at weekends.

After two years we moved again – this time to Västervik. I got work immediately in the maternity ward and remained there until autumn 1981. During that period there were a lot of changes in obstetric care. Pain relief – which previously had been medically minimal – came to the fore. We midwives who had qualified a long time before had to go on a course to learn all about pudenda, PCB, epidural block and narcosis. There were courses in CTG interpretation, training in parenting and psycho prophylaxis. Västervik was given the task by the National Board of Health and Welfare (I believe) of carrying out a pilot project

on parenting training in which I participated as the midwife. It was a fantastically enjoyable and interesting time.

The role of the father was also discussed a great deal during these years. One morning, a father was interviewed on local radio who said how much I had contributed to his positive experience of childbirth.

At this time I was also offered the post of head midwife but declined. I was not finished with maternity work and would not consider giving it up.

Once again it was time to move which made me slightly anxious as there was no maternity hospital in Tranås where we were to live. During the previous year I had worked quite a bit in the Maternity Unit and wanted to be trained in contraception so that I would be allowed to prescribe medication. I applied and was accepted on a course in Stockholm with good teaching and enthusiastic tutors.

Good rail connections between Tranås and Linköping meant however that I applied for a post at the Women's Clinic at the University Hospital in Linköping. I got a job on night duty in the maternity ward where I stayed for seven years. We were three midwives and three staff nurses on every shift, with primary on-call in place and access to anaesthetists for any epidurals.

Night duty was very tiring despite the fact that I slept well during the day. I took on a lot of extra work in the Maternity Clinic but also on day duty in the maternity ward.

After a while I felt that I was finished with maternity work as I no longer had the strength to give the parents the support that I would have liked. I then applied for, and was given, the post of assistant department head in the maternity ward combined with specialist care of mothers with diabetes. An intensive period of my professional life then followed. After a year in my new post I applied for a course as a Nurse-Trainer in Malmö. I was granted leave of absence from my job for three terms. I then continued my service which also included the further education of personnel and, as we also had student doctors as well as midwifery students, my teacher training stood me in good stead.

AT THE BEGINNING of the 1990s many babies were born at a time when the economy of the county council was not at its best. Large demands for savings and a great many comprehensive changes characterised those years and I had the privilege of starting a group therapy clinic for women who had had traumatic experiences during delivery, called Nike. The clinic is still there with the same name but with a slightly different structure. I also trained as a supervisor in care, something that came in good use in my professional duties and I was even able to work individual

hours at the midwifery training school in the subject area: "Professional approach."

It was unbelievably stimulating to be able to work in a university hospital, but also tiring. Responsibility for the staff was stimulating and I had a good working relationship with the care unit manager. We complemented each other and also received a lot of praise for our cooperation.

The psycho-social treatment of parenthood and birth has interested me since I was a student. I was voted onto the board of the Swedish Union for Psycho-social Obstetrics and Gynaecology (SFPOG) and was an active member for several years. This meant a lot both for my personal and professional development. I am now a proud honorary member of the union.

When I look back over the forty years I worked as a midwife it is unbelievable how much has happened. That the whole of society in the beginning was more authoritarian was mirrored both in the contact with patients and in the relationships between the various groups of personnel.

We cleaned with something that was called "kroll", (rolled-up wood wool moistened in soapy water), washed, mended and put talcum powder into surgical gloves, washed syringes and sharpened needles which were then sent to the central sterilisation unit. If a patient had a fever we deep-cleaned the entire room from the floor to the ceiling. When tying off the umbilical cord we first used navel bands, which were tied in a particular way. Over the years various clips made of metal or plastic were used. Some were extremely large, and I believe that the last were some small elastic bands. I have no idea what is used today.

We showed the baby to its mother but she was not allowed to take it. When I once or twice let the mother touch her baby I felt as if I was doing something wrong. But things developed and then all of a sudden the mother was allowed to take the baby straight away.

MOTHERS HAD TO lie on their backs during delivery but a lively debate began in the 1980s and 1990s on various alternative delivery positions. Squatting on the short bed was one of the first and I believe from the beginning more from consideration for the midwives' working position than for the well-being of the mother. Then came delivery chairs, stools, cushions, side position, kneeling, standing in a wheeled Zimmer frame – on the whole anything was permitted.

The environment, which from the beginning was very sterile, has become more relaxed and cosy. Before, patients had to stay a week after a normal delivery. Now, they can go home after a couple of hours. If anyone wanted to go home early before they had to sign a paper to say that they did so at their own risk. Contact with the parents in connection

with a stillbirth has also improved. But everything that we did before was not necessarily wrong. How something is experienced depended then as now on how it was carried out.

I HAVE ALWAYS understood and felt that my work has had great status and I have always been – and still am – proud of my profession.

The midwifery profession has always offered great opportunities for various career paths and directions and as there are so many different work duties there is also the opportunity to find one that you like and is suitable for you. There is also access to further education but that means taking advantage of all the offers that arise. I have also experienced how research has moved our profession forwards. Not everyone can or will study for a doctorate but we need each other. As a manager it is important to keep abreast of the developments to be able to stimulate and inform the personnel about new findings and from a quality point of view to follow up the information.

During my professionally active years I have experienced a very good working relationship with all categories of personnel and many times I have had this confirmed. Over the years it became a more companionable relationship with communal lunch and coffee breaks, but on the whole that meant no great changes.

I THINK THAT a good midwife (mostly from my own experiences in the maternity hospital) should be competent, calm, able to work under pressure, empathetic, sensitive, but of course knowledge is very, very important!

I have been a member of the Swedish Association of Midwives since my time as a student nurse. My first 'midwifery meeting' was in Växjö in spring 1964 and since then there have been a lot of meetings over the years, not forgetting the hundred year jubilee. I retired in 2001 and to begin with I worked a few hours within midwifery training. For a year I supervised a group of children's nurses and staff nurses and I was active on the board of SFPOG. Now I am no longer involved in any of these.

I loved my work and have helped many babies into the world. I have also experienced many fantastic, enjoyable as well as some sad encounters. What I think is the most fascinating part of the midwifery profession, is that for such a short moment one is able to meet another person and in that moment create trust, confidence and security.

SOLVEIG PETERSSON, *Midwife,*
born in Motala Maternity Hospital, Östergötland.

MY LIFE AS A MIDWIFE 2

MY NAME IS Eva-Marie Wenneberg and I was born in Gothenburg in 1957. My parents were born in 1920 and 1921. My father was a test driver for Volvo cars and was a heavy-goods vehicle driver as well as an assistant caretaker in the house where I grew up. My mother was a shop assistant in an exclusive lingerie shop and shared the assistant caretaker's job with my father. Both my parents only went to elementary school but took their driving tests as soon as they were 18 years old. My mother was adamant that her three daughters would also take their driving tests as soon as they were 18. She wanted us to be independent and able to take care of ourselves.

Throughout my childhood I dreamt of being an opera singer. I chose Social Studies at high school, concentrating on social issues. The discussions in my class were intense because the left wing was influential in society at that time. The first year after high school I gained experience in a nursery and studied pedagogy in the evenings to be able to get a study loan and leave home. I applied for a primary school training college and nursing school the following year.

I CHOSE NURSES' training as I very much wanted to have a lot of children of my own and thought that it would perhaps be too much to work with other people's children as well. Straight after my training at Sahlgrenska Hospital in Gothenburg I got a job in the Neonatal Department at Östra Sjukhuset (Hospital) in the same city. At that time I was 22 years old.

It was an instructive period. I was able to 'shadow' a qualified midwife for three months and after that there followed four intensive years when we nurses worked alone during evenings, holidays and nights. Being a nurse on the neonatal department meant that we were present when weak babies were expected, as well as twins and triplets, breech presentations, suction bell deliveries, babies born before term, babies born by caesarean etc. We assisted at catheterisation of the umbilical cord, cared for children in continuous positive airway pressure, helped mothers with breast feeding, talked to parents of severely ill babies, babies that had

Midwifery examination in Stockholm 1937 and 1910.

died and stillbirths. Without all the experienced midwives I would never have grown into my role and over time become competent at my work.

I loved my work and all my work colleagues – doctors, nurses, and children's nurses – but sometimes it seemed as if the various hospitals were competing with each other over which one had the pre-term baby born the earliest. In the beginning children born before pregnancy week 28 were called foetuses but as time went on we tried to save all babies that showed some sign of life. The smallest babies were so tiny that I could hold them in the palm of my hand. Our neonatal department was unique as we did not have any specific visiting hours but welcomed parents and siblings whenever they came. We also encouraged the parents to look after their own child as much as possible.

During these years I studied a five-week course in neonatology at Gothenburg University, which was a good way of gaining more expertise in the field. Nothing that I worked with in my first work placement had been learnt in the nursing school but was in 'learning by doing' which over time increased my knowledge and experience. In conjunction with this I discovered the breadth of the midwifery profession and in spring 1984 I started my midwifery training in Gothenburg.

At that time I had a six week old son and my husband took the whole paternity leave allowance whilst I did my further professional training and expressed breast milk every three hours – even during lessons. This was something that all my course colleagues and teachers accepted. It was typical of those days. As we lived in a Commune near Östra Hospital, it was convenient to get to school and then home again to breastfeed.

IN THE SUMMER of 1986 we moved to Täby, north of Stockholm, because my husband got a job he wanted. Based in Täby I could work in several municipalities and during the first summer I worked in the child welfare clinic and the maternity clinic in Täby and Vallentuna municipalities.

Our second child was born in summer 1987 and the following year I obtained a permanent position in the maternity clinic in Vallentuna. I worked there for nearly seven years. The clinic was next to the child welfare clinic and our mutual cooperation became a good basis for the expectant parents. I worked with contraceptive advice, training in parenting, midwifery controls and the other miscellaneous tasks that are carried out in a maternity clinic. (Nowadays it is called a midwifery clinic to include the whole family and not only the expectant mothers). So that children would always feel welcome I had a box with children's toys in my office.

The conversations and contact with 'my' mothers was fantastic. As midwives we dare to talk about relations, sexuality and difficult subjects.

Our profession has an accepting attitude to women from every culture and most of us are interested in protecting those who need extra care. When the clinic was to be privatised in 1995 I chose to leave and for six months I worked in a maternity clinic in Lidingö municipality. There I met my best midwifery colleague and friend, Salona. We got on with each other immediately and with her I went to the world's first Arab Congress in Sexuality in May 1996.

In 1994 I was asked if I would like to start a youth clinic in Täby. This was the beginning of a long career as supervisor at Täby Youth Clinic. The municipality had the ambition that we should be competent in our work duties and there were good opportunities for further professional development. The first year I took a half-term course in Sexology at Uppsala University Hospital's neurological institute. During the autumn term 2008 and spring term 2009 I undertook a five week course in Andrology (7.5 credits) at Ersta Sköndal University College in Stockholm.

I worked in the youth clinic until autumn 2009, that is, for 14 years. During those years I was able to work with, what for me were people from new professions such as social welfare officers, psychologists, and venereologists. I worked with the contraceptive advice service, on investigations into sexually transmitted infections, did specimen-taking for HIV, abortion counselling, school visits with information for teachers, pupils and parents, and had conversations with interested parties such as social studies graduates, to name but a few. To meet young people, both boys and girls from 13 – 23 years old, was incredibly inspiring. I keep these years in my heart and feel deeply privileged to have such a multi-faceted profession.

I AM SOMEONE who readily says 'Yes', which means that I am always eager to try new things. In June 2009 I applied on the off-chance for any vacant midwifery posts in Stockholm. As luck would have it there was a vacancy in the Fertility Clinic which turned out to be my life's work. Today I am the Unit Head at the clinic and I have reached my goal. I have gone from preventing unwanted pregnancies to helping couples to have a longed-for child. My new work with IVF (In Vitro Fertilization) is difficult, detailed and complicated but also very rewarding. I now work with embryologists, gynaecologists, receptionists, staff nurses, medical secretaries, nurses, midwives and porters and all of them are needed to achieve a fantastic outcome for our couples.

As a midwife in an IVF clinic one day I can be assisting at an egg removal operation, giving pain relief and monitoring the patient. The next day I could be preparing a couple by giving them information about injections, medication, sexuality, hormones, sperm specimens, and blood

tests. Other days I can be in telephone contact and giving advice before fertility testing or carrying out consultations.

Being unit head in a clinic with so many different professional categories creates new challenges. I take one problem at a time and have taught myself to do the best I can and be "good enough". I am also happy every day I go to work despite knowing that I cannot achieve all my work goals. Learning everything about IVF is one of the most difficult professional duties I have undertaken. I have noted that my newly qualified colleagues have a new and obvious attitude to data and quality rating work, which I have had to learn in due course.

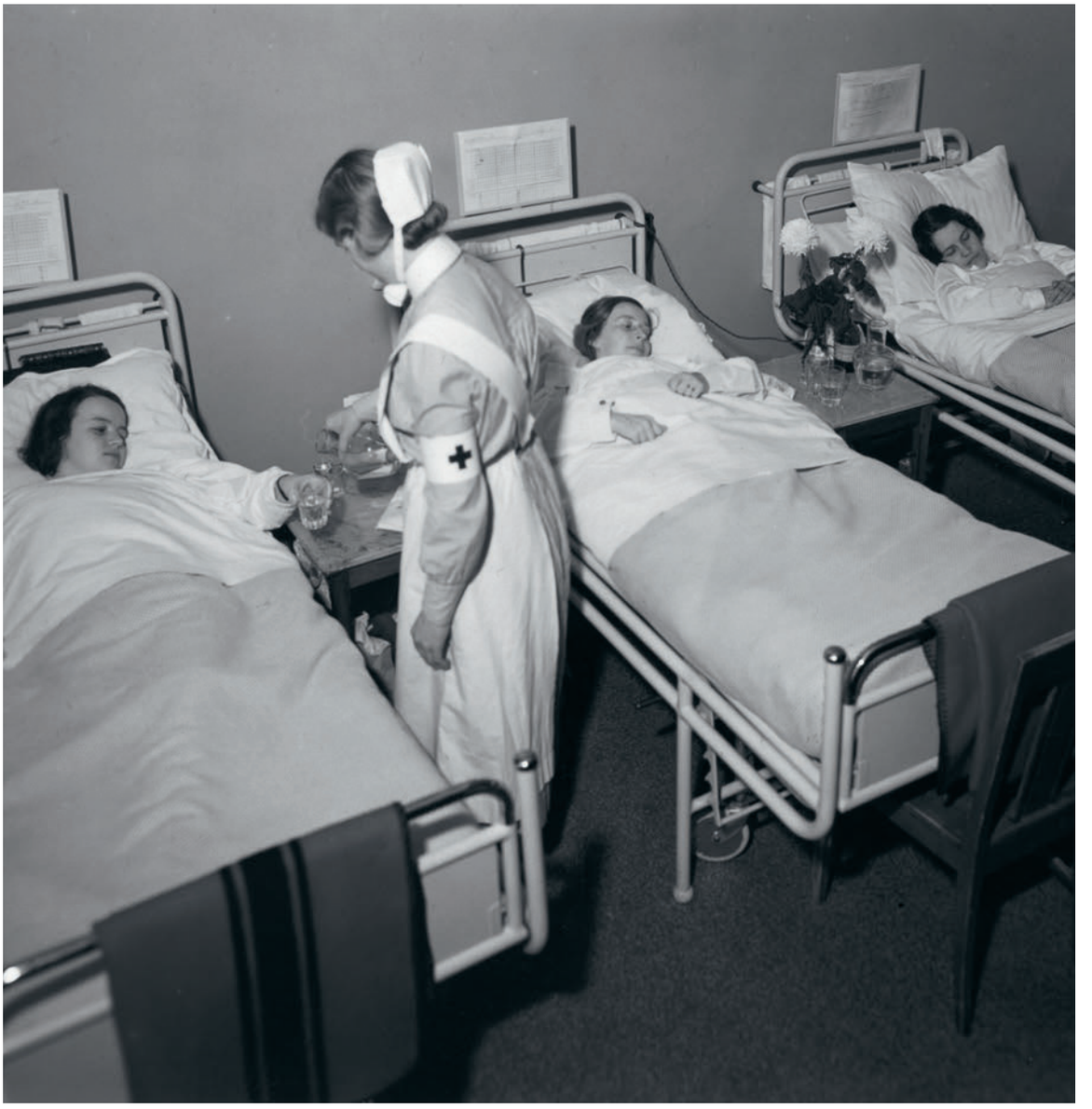
When my work day is over I am happy if my couples and patients have left the clinic with a feeling of wellbeing and if my colleagues feel satisfied with their day. I believe that the contact with other people means that I am undergoing a process where I am constantly learning something new. Every couple and person is different. A while ago I was blown a kiss by a woman who was simply happy after our conversation before her IVF treatment. It is that which makes my profession unique. One never knows what exactly that particular patient or couple needs and values. But a kiss you remember for the rest of your life. Thank you!

For the first time in my life I am the oldest person in my new workplace. Previously I have always been the youngest. But the work dynamic is built on the fact that we are all different. We must not strive to be like each other but protect our individual differences that can give all patients and couples the opportunity to feel welcome and understood.

As I see it my future as a midwife will be within IVF. For some years I have also done extra work for the "Ask the midwife" service on the internet where anyone can ask questions on contraception and get answers within seven days. It is a good way of keeping myself up to date.

Today my daughter has chosen the same basic education that I had and she says that she chose that because I have always come home feeling happy in my work. That is the best testimonial I have ever had.

EVA-MARIE WENNEBERG, *Midwife, born at Sahlgrenska Women's Clinic, Gothenburg.*



REPRODUCTIVE HEALTHCARE – PAST AND PRESENT

THE PROFESSION OF midwife is our oldest profession for women. Three hundred years ago formal training was offered for the midwives of that time who had the reputation for wisdom but also for drunkenness and witchcraft. The aim was for there to be a trained midwife in every parish. The first regulations for midwives were introduced in 1711.

This was a wise plan at a time when doctors in country districts were few and far between and also ignorant, not only about childbirth, but also about women's living conditions. In practice it was the poor 'midwives' who were the best people to help a woman in childbirth. Unfortunately it took a long time before any reforms could be carried out in earnest, as many parishes wanted to avoid paying for the training and salary of a poor country woman, for as long as possible. But eventually more and more women were sent to Stockholm for training and returned to become parish midwives. They had the right and the duty to carry out deliveries using any necessary intervention, without waiting for a doctor or giving up when the outcome seemed hopeless.

The parish midwives' art of midwifery and good aseptic techniques produced results and the number of deaths during home births declined over the whole country during the end of the nineteenth century. The midwife could also be of use during other types of women's ailments, even if she did not always dare to help those who did not want to give birth. Deaths as a result of abortion were common and did not decline until long into the twentieth century.

THE CENTRAL ROLE of the parish midwives to care for the mother and supervise during childbirth changed when the number of home births declined. In the middle of the twentieth century most babies were born in hospital and we thus had two sorts of midwife. Some of them were based in hospitals with responsibility for normal deliveries, now as trained

nurses who specialised in obstetrics (registered nurse/registered midwife). The others remained in outpatients clinics to care for pregnant women, which mostly involved measuring the blood pressure and testing for albumen in urine.

Outpatient midwives were considered by the general public at that time as being an outdated profession. But the trend reversed in the 1960s. Expectant mothers were offered antenatal exercises and information about giving birth without fear. Midwives also started to ask how the women themselves felt, and did not only measure the size of their abdomens. They were taught psycho prophylaxis as started by the midwife Signe Jansson. The fathers were also invited to practise breathing and relaxation and were expected to be there at the forthcoming birth. Political decisions on the right to pain relief and parenting education hurried the development along.

During the 1970s maternity care developed even more. The midwives had a key role in the preventative care before the liberalisation of the abortion law. They were trained to insert spirals (intrauterine device) and give information about contraceptive pills and would soon give advice about preventative measures in the maternity centres and youth clinics across the country. In 1976 midwives who had undergone this training were allowed to prescribe contraceptive pills.

Maternity health care included a list of new duties and branches of activity and the status of outpatient midwives rose. They were trained to lead parent groups, talk to young people about sex and personal relationships, give advice on contraceptive methods and offer screening for early discovery of cervical cancer. The programme for preventing unwanted pregnancies was made a permanent branch of maternity healthcare. Information on, and prevention of, sexually transmitted diseases was soon introduced

Whilst the work in maternity healthcare developed, the hospital midwives took on more and more qualified duties in maternity care. New pain relief methods and electronic monitoring were introduced and old routines and treatment methods were discontinued.

TRAINING AND DUTIES of the midwives in inpatient and outpatient care followed the traditions of the time of the parish midwives: the care and responsibility for normal pregnancies and delivery and the readiness and authority to intervene in any unusual circumstances or complications.

It can therefore be pointed out that for several decades Swedish midwives have had the primary responsibility for what we call today, reproductive healthcare. It was at the United Nations' Population Conference in Cairo in 1994, and the Women's Conference in Peking in 1995, that

the term reproductive healthcare was introduced as an alternative to the one-sided emphasis on family planning as a solution to women's health problems.

IN SWEDEN THE various sections of reproductive healthcare are well developed and usually with midwives as care providers. An exception is abortion care which has, for a long time, been the responsibility of doctors in hospitals. Recently part of the abortion provision has, however, taken place in outpatient clinics

ABORTION CARE NOW AND IN THE FUTURE

Our present abortion law of 1974 states that a woman who so wishes has the right to have an abortion carried out as general hospital treatment. The decision regarding abortion is therefore the woman's, and the hospital's task is to carry out the abortion according to science and proved experience. The legislation concerns how and by whom the abortion should be carried out. When the law was drawn up, abortion was a surgical procedure and consequently the law dictated that the abortion should be carried out in hospital by a gynaecologist. Abortion provision has since then remained a matter for the hospital, whilst most other sections of reproductive healthcare and hospital care are carried out by midwives in outpatient clinics.

For several years now there has been another method; so-called medical abortion and thus a completely new situation has arisen. Abortion no longer needs surgical intervention but can take place by starting a miscarriage by using pharmaceutical means. Medical abortions can be carried out in outpatient clinics, care centres or at home. Irrespective of the method, midwives are qualified to give support and care during the procedure and to carry out the follow up and after care – just as they would for a miscarriage. A logical development is that midwives should have the right to prescribe abortifacients just as they can prescribe contraceptives today. In other words, care during medical abortions can become a part of reproductive healthcare with the midwife as care provider.

Fewer abortions will most likely be surgical procedures. Today 80 percent of women choose medical abortions. For them, the 1970s' legislation requirement for doctors and hospital care is not relevant. The law must therefore be revised. Some changes in the directives have been made, but clearer changes in the legal text are required to adapt it to reality.

The question of who carries out the abortion must be asked. During a medical abortion it is appropriate for midwives in the outpatient clinic to start the abortion by giving the tablets and then the necessary care.

Reproductive Health Care according to WHO

- Maternity and obstetric care.
- Awareness of and access to contraception.
- Abortion care.
- Prevention of sexually transmitted infections.

Source: Kairo 1994, Beijing 1995.

But in actual fact it is, of course, the woman who swallows the tablet, who carries out the abortion. It is therefore the woman – when hopefully abortion tablets can be obtained without prescription – who not only makes the decision but also carries out the abortion. If the miscarriage necessitates care she can then turn to the women's healthcare clinic.

BIRTH CONTROL – A WOMAN'S WAY

The remaining issues for healthcare provision are important tasks, such as the development of better methods for preventing abortions. By that I do not only mean better preventative methods, something which has high priority in our women's healthcare service, but something that makes preventative methods surplus to requirements.

Since time immemorial women, when they wanted to avoid pregnancy, have demanded a method which at the right time can bring about menstruation. Everything from phosphorus matches, malaria medicine and violent physical exercise have been tried. Naturally our excellently qualified pharmaceutical industry can bring out a tablet which starts menstruation before any potentially fertilised egg has had time to be implanted. Then it is not a question of abortion, but starting off menstruation a little earlier and without knowing if it would have come anyway. The technique already exists and only needs to be further tested and developed. The obstacles are a case of lack of interest and – perhaps primarily – economic opposition from the pharmaceutical industry. Also an incomprehensible opposition from those who are most strongly opposed to abortion and claim to want to do everything to avoid a termination of the pregnancy

It is therefore not a question of "abortion pills" or "morning-after-pills" but a "once-a-month pill". This is a method which, before the fertilised egg can start to grow, prevents a pregnancy being established.

Let us use all our power to incorporate this method into reproductive healthcare and medical care as well.

KAJSA SUNDSTRÖM, *Professor, Gynaecologist, Doctor of Medical Science.*

During the 1970s Kajsa Sundström was responsible for maternity care, abortion, parent education and sex and personal relationships in the National Board of Health. She has devoted herself to research and clinical work specialising in Women's Reproductive Health and Living Conditions in Sweden and internationally.

The Björs' girls
Kari and Kesti in Djura.

FOR THE MOTHERS OF THE WORLD

TWENTY FIVE YEARS ago, in January 1986, Umeå University permitted Dr Ulf Högberg to defend his doctoral thesis: *(Maternal Mortality in Sweden"*. I had come to the disputation in cold, gloomy Umeå, direct from my post as Head of Obstetric Care in the tropical heat of Maputo, Mozambique, a city of two million inhabitants.

I came from my own reality, with responsibility for more than 50,000 deliveries and many hundreds of maternal mortalities per year, to hear about historic maternal mortality in Sweden. I realised that there were similarities between Sweden in the past and reality in Mozambique in the present.

Ulf Högberg's thesis is a masterpiece. I did not understand that then, but over the years it has become more and more apparent. It is a milestone for us in Sweden and internationally. It is a scientific monument with great relevance for today's strategies for reducing maternal mortality globally. Ulf gave scientific proof of the importance of the Swedish midwife since 1750 in the decline of the maternal mortality rate. Why is this so important for today's poor countries and their attempts to lower maternal mortality?

One of the most burning questions which will make it difficult for us to achieve the fifth millennium goal (MDG 5) of reducing maternal mortality by 75 percent from the level in 1990 to 2015 is the lack of trained healthcare workers, especially midwives and doctors. Various estimates indicate that there is an acute shortage of half a million midwives (if we can hope to come even close to MDG 5). Other estimates give even higher figures. A "brain drain" within the countries (from country districts to towns) and globally (from low income countries to high income countries) constitutes a growing problem, principally in the country districts, where the poorest groups are women. Mozambique, Malawi and Tanzania belong to those African countries which, of necessity, have been obliged to solve the problem by training "non-physician clinicians" (NPC), which can be loosely translated as 'non-doctors'. It is most often a question of "mid-level providers of care". This means a middle category

of qualified and independent care workers who are more or less equivalent to a nurse with further education. We know that nearly half of all acute surgery in the district hospitals in African countries takes place within obstetrics and gynaecology. Without access to competent (conventionally faculty trained) doctors, the midwife must refer a seriously ill woman during or after delivery to another, often distant, hospital with a great risk that the woman will die on the way.

Could the combination of midwife plus "non-physician clinician" be a solution?

When dealing with caesarean sections and other more advanced obstetric surgery (obstetric hysterectomies and laparotomies to remove ectopic pregnancies etc:), our research has shown that around 90 % of such major interventions in the district hospitals are already being carried out by one of these clinicians. In Mozambique, by *"tecnicos de cirurgia"*, in Malawi, by *"clinical officers"* and in Tanzania by *"assistant medical officers"*. None of these categories of "surgeon" has ever set foot in a medical faculty but, according to well-documented research results, are competent to carry out the greatest part of "major" surgery in hospitals, just as well as doctors. This has a decisive significance for the accessibility of life-saving surgery, especially obstetric surgery, for pregnant women in the rural areas in the poorest countries.

But this category of 'surgeons' also has to undertake other surgical procedures such as in cases of trauma, traffic accidents, abdominal surgery and burn injuries requiring skin grafts. For the past few years Mozambique has taken the step of giving selected midwives further training so they can become 'obstetric surgeons'. This four-year training, following the three-year midwifery training, has proved to be successful and points to a possible further development of the midwife's area of competence *"where there is no doctor"*.

Our future research aims to carry out a detailed investigation, not only into the practical surgical expertise ('there is no skill in cutting'), but also the diagnostic, therapeutic, pre-operative, intra-operative and post-operative expertise of both of these categories of 'non doctors'. The categories being investigated are: 'non physician clinicians', who carry out a wide range of surgical procedures, and the surgically trained midwives, (whose title in Portuguese-speaking Mozambique is *"enfermiera de saúde materna"*). The project has practical significance on several levels.

Firstly we have been able to show that nearly 90 percent of these versatile 'non-doctors' (whom we started to train in Mozambique in 1984) have, after seven years, remained at the most outlying hospitals. The equivalent figure for doctors is 0 percent. Consequently, the 'non-doctors' have great significance for the health system.

Secondly, the poorest countries will not have the means, within the foreseeable future, to train doctors to the level of expertise needed to attain the millennium goal, MDG 5. Other categories of health workers must then carry out the doctor's work, which is already a reality in a growing number of low income countries. In order to avoid a backlash because of poor training and insufficient competence, with the risk of surgical complications and even post-operative death, it is necessary to document not only the practical surgical skills, but also the quality of the decision taking itself, the diagnosis as well as the management of the patient before, during and after any operation.

Thirdly, the world is witness to what is described as 'the pandemic of caesarean sections'. That is the extremely rapid increase in caesarean sections carried out without medical indication, a phenomenon which is even happening in the urban areas of poor countries. This constitutes, according to all available documentation, a significant problem of ill health because of the increased risk to the mothers and the risk to the newborn during a caesarean section compared with a vaginal delivery. 'Surgeons' with less comprehensive training, it has been argued, can increase the risk of unnecessary caesareans being carried out in situations where other, less risky obstetric interventions have clearly been indicated (for example, vacuum extraction, craniotomy, destruction of dead foetus or symphysiotomy). Through this project we will ascertain whether this considered risk is real and create the preconditions to solve this problem with better training and other measures. The project will check these aspects by having senior obstetricians physically present for a certain time period in places where 'non-physician clinicians' carry out surgical procedures. These obstetric specialists should carry out a medical assessment of the patients independently of the 'non-physician clinicians' and evaluate the quality of their work step by step. In this way we will be able to trace the weaknesses and strengths of the training in the respective countries and establish a foundation for improvement.

Every day close to 1,200 young women die in childbirth worldwide. To this can be added nearly 10,000 stillbirths and nearly 10,000 deaths of newborns as a result of poor maternal health inadequate delivery care. Every day approximately 20,000 lives are lost as a result of poor maternal health an annual total of 7.5 million which is more deaths per day worldwide than from AIDS, Malaria and Tuberculosis together (around 5 million deaths).

WHAT HAS ALL this to do with the Swedish midwife of the past?

Just as in Sweden in the past – with its shortage of doctors and its attempts to lower maternal mortality with the help of increasingly competent and qualified midwives – many low income countries today are trying to find strategies for reducing maternal mortality despite an extreme shortage of doctors. Many doctors stubbornly claim that only they can make this reduction possible. The fixation on doctors and the notion that life-saving advanced obstetric care must be the responsibility of a doctor is a real problem in many of today's low income countries. Many doctors, mainly in West Africa, feel that the development in countries

such as Mozambique, Tanzania and Malawi are an encroachment into their territory and a union threat 'they take the bread from us...!'. But one thing is certain: the doctors' role is not threatened, they are greatly needed – but in another role.

Acute obstetrics are much more than surgery. The Swedish midwife has never carried out caesarean sections or abdominal surgery. But she successively mastered first the forceps and then sharp instruments to destroy a dead foetus. She could also stop post-partum haemorrhaging. She understood the importance of clean hands. That goes a very long way. And all this happened a long time before the role of the doctor became important for the survival of the mother. To that extent I think that the Swedish midwife came to be the 'non-physician clinician' of her time in low income Sweden.

Every day nearly 1,200 young women die in childbirth in the world. Added to this are nearly 10,000 stillbirths and nearly 10,000 deaths of newborns as a direct result of poor maternal health and inferior obstetric care. Midwives are the key professionals for radical change in today's poor countries. This must be discussed and the history of the Swedish midwife is an important tool in this dialogue.

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THE IMPORTANCE OF PERSONAL CONTACT

THE GENERAL PUBLIC, decision makers and the media have great confidence in midwives. We have earned this confidence by being a well educated, modern, courageous and independent body which has been proved to have a decisive role in the health of women and children – both historically and today. A visible body with great influence must also put up with being criticised publicly if someone is dissatisfied with their reception by staff or experience of care. We must also continually re-evaluate the "truths" with which we surround ourselves. We do this by using scientific and empirical knowledge.

I usually enjoy reading blogs to obtain some understanding of how our profession is perceived. Sometimes it makes flattering reading and sometimes less so. The thing that most often upsets the critics is poor personal contact in the clinics or wards. This indicates the importance of personal contact.

In the information and media clamour that surrounds us we need to interact with a living person who can answer questions and help us. Personal contact gives us, as midwives, the opportunity to really get to know those whom we wish to help, care for or work with. By meeting each other face to face we can also explain and convey something that would otherwise be difficult to communicate. I therefore believe that true personal interaction will still be important even in the future, both from an emotional, clinical and professional perspective.

We must all contribute to ensuring that the personal meeting with a midwife is not exclusively granted only to the few, but should be something that everyone has access to, irrespective of nationality, ethnicity, language, gender, sexual orientation, political affiliation, religion or standing in the community, wherever we live in the world.

INGELA WIKLUND, *President of The Swedish Association of Midwives*

440 YEARS WITH THE SWEDISH MIDWIFE

1571 Laurentius Petri Church order with decree for the midwives. The midwife shall assist the woman giving birth with comforting words.

1663 Collegium Medicum (present day National Board of Health and Welfare) was founded.

1663 Karl XI's Regency suggests that Collegium Medicum shall ensure that the midwives are God-fearing, honest and meticulous.

1680 Sweden gets its first medical decree.

1682 The midwife Catherina Wendt (1637–1707) comes to Stockholm from Germany to be court midwife. She assists Queen Ulrika Eleonora (1656–1693) at the birth of Karl XII.

1682 A plan for obstetric care in Sweden is drawn up and presented on the commission of Queen Ulrika Eleonora. Urban Hiarne seeks to establish a lying-in hospital for the training of midwives.

1686 Stockholm's city administration issues a decree for the city midwives. They are to be apprenticed for four years to another midwife, supervised by the City Physician and swear an oath.

1688 His Royal Majesty's Medical Decree. No one may pretend to be a midwife who has not first passed an examination by the City Physician. The midwife is obliged to attend postmortem examinations of women.

1697 Dr Johan von Hoorn publishes a text book: Then Swenska wäl-öfwade Jord-Gumman.

1700 Nine provincial doctors in the country, the greatest part of the rural areas are without doctors. Doctors have no training in the art of obstetrics.

1706 Doctor Johan von Hoorn submits a letter to the Collegium Medicum with a suggestion regarding regulations for midwives and stating that he will be responsible for the training of midwives. He already runs private training for midwives in Stockholm.

1706 Collegium Medicum submits a letter to His Royal Majesty with a plan for the introduction of a midwifery organisation and suggestions for regulations for midwives.

1708 Collegium Medicum submits a further letter to His Royal Majesty with the addition that the reform should be introduced as God has 'called home' the Queen's midwife Catharina Wenthin.

1709 Johan von Hoorn becomes City Physician in Stockholm.

1711 The first regulations for Swedish midwives which decree a two-year training for midwives followed by examination by the Collegium Medicum and that midwives should swear an oath.

1711 The Midwives' Oath in Stockholm.

1715 Dr Johan von Hoorn publishes his Midwifery book 'The twenne gudfruchtige, i sitt kall trogne och therefore af Gud wäl belönte jordgummor Siphra och Pua.'

1737–1766 The Health Commission (Sundhetskommissionen) decrees that equal access to health and hospital care should be available to all irrespective of where they live.

1734 Law on marriage in church.

1739 The Royal Swedish Academy of Sciences is founded. Publishes and distributes almanacs to disseminate knowledge about diseases, home cures and the care of children to the general public.

1749 Tabellverket (The Table Office, later The Office of Statistics SCB), is set up to collect statistics on births and deaths. More than twenty percent of all children die before one year old.

1751 Collegium Medicum, later the National Board of Health and Welfare, writes to Sweden's Parliament that of the 651 women who died in childbirth, 400 could have been saved if they had had access to adequate midwifery care.'

1752 The Seraphim Hospital in Stockholm, Sweden's first hospital, opens with beds for two maternity cases.

1757 His Royal Majesty ratifies the suggestion of the Collegium Medicum for a national training programme for midwives, which means that every parish is expected to pay for the board and lodging in Stockholm of its pupil midwives.

1758 The midwife Helena Malheim's Barnmorskelära 1756 (Learning for Midwives 1756), is rejected by Collegium Medicum.

1761 David von Schulzenheim becomes Sweden's first professor of obstetrics.

1775 Sweden's first BB Allmänna Barnbördshus (General Lying-in Hospital) opens in Stockholm.

1777 New regulations for midwives throughout the country come into force decreeing that none other than sworn midwives can be used except in cases of dire necessity.

1778 Infanticide proclamation. 'Unnamed mother'. The mother was allowed to remain anonymous.

1779 Approximately 15 percent of children between 0 and 5 years old die from smallpox.

1780 The peasant class forces through a decision that the provincial doctors shall train midwives.

1800 Maternal mortality is 896 per 100,000 live births.

1810 Karolinska Institutet (The Karolinska Institute) founded. The obstetrician Pehr Gustaf Cederschjöld becomes one of the first professors.

1816 Smallpox Vaccination Law for children under 2 years old. The priest, parish clerk or midwife to carry out the vaccinations.

1819 Sundhetscollegiet (The Health Board, formerly Collegium Medicum) once again demands that all midwives are to be trained in Stockholm.

1819 Once more it is decreed that each parish is obliged to appoint a qualified midwife.

1819 Guild statutes for Stockholm's midwives are discontinued.

1829 Midwives are granted the right to use obstetric forceps and cutting instruments.

1842 General Elementary schools are introduced.

1843 Handbook for Midwives in the Art of Instrumental Delivery is published by Professor Per Gustaf Cederschjöld.

1843 and 1844 Publications by Oliver Wendell Holmes and Ignaz Semmelweiss show that infectious diseases can be prevented by aseptic techniques which results in labour wards being steam-cleaned with chlorine.

1858 Unmarried women come of age at 25 years.

1860 Two in every five deliveries are carried out by qualified midwives.

1863 The midwife Johanna Bovall Hedén becomes the first female field doctor in Sweden.

1878 Hand washing for doctors and midwives with carbolic acid becomes obligatory at the General Lying-in hospital in Stockholm.

1881 The Swedish Medical Board distributes accurate directions for hand hygiene and instructions for mixing carbolic acid.

1881 Midwives are obliged to keep a diary (Patients' Journal).

1885 The association Göteborgs Barnmorske sällskap (Gothenburg Midwifery Society) was founded on 3 November. The meeting was held at the home of Mrs Johanna (Bovall) Hedén.

1886 Midwife Hanna Qvarzell (1844/1928) founds the Stockholm Midwifery Society.

1886 On the 10th July, 191 midwives from the whole of Sweden meet in Stockholm to lay the foundations for the Swedish Association of Midwives. The meeting was initiated by Johanna (Bovall) Hedén from Gothenburg Midwifery Society.

1887 The Midwives' Oath is abolished. The professional title becomes Qualified Midwife.

1888 The first edition of the professional journal, Jordemodern (The Midwife) is published.

1901 The first Mjölkdroppe (Milk Drop) in the Nordic countries starts its work in the Katarina parish in the Söder district of Stockholm. It distributes nourishing cow's milk substitute to poor women who cannot breastfeed.

1903 The Milk Drop Association is founded. The aim is to encourage breastfeeding.

1904 Svensk förening för Obstetrik och Gynekologi (The Swedish Association for Obstetrics and Gynaecology) is founded.

1905 Deliveries in institutions predominate in Stockholm.

1907 The Midwives Decree. Introduces the certification: Qualified Midwife.

1908 Civil marriage introduced.

1915 Women have the right to sue for divorce. The law of 'The Unnamed Mother' is abolished.

1919 New regulations for midwives restricts the midwives' right to use instruments to obstetric forceps

1918–19 Influenza causes half of all maternal deaths in hospitals.

1920 Ninety percent of all babies are born at home.

1921 Women in Sweden are granted the right to vote. Married women are declared of age.

1929 The Swedish Association of Midwives takes over publication and copyright of the journal Jordemodern.

1931 Twenty five percent of maternal deaths are a result of illegal abortions.

1933 Riksförbundet för sexuell upplysning (The Swedish Association for Sexuality Education) RFSU is formed.

1938 A new government grant makes maternal care and obstetric care free for pregnant women. Child Health Centres are established.

1938 A new law permits abortion for medical, eugenic or humanitarian reasons.

1938 The ban on contraceptive advice is lifted.

1940 One Swedish woman per week dies after an illegal abortion.

1940 75 percent of all deliveries in Sweden take place in maternity homes, cottage hospitals, surgery-lying-in maternity units and women's clinics.

1941 A new midwifery investigation stresses that lying -in hospital care should be for the betterment of the mothers and babies, which necessitates a larger number of the dedicated lying-in wards.

1944 Ellen Erup is selected as Chairman of the Swedish Association of Midwives.

1944 Experimental work with double training is introduced; two years' nursing training plus 18 months' specialised midwifery training.

1944 Homosexuality decriminalised.

1946 Addition to the Abortion Law to include socio-medical indications.

1947 Universal Child Allowance.

1949 Mothers as well as fathers considered as Guardians of children.

1950 Nordiskt Jordemoder Förbund (NJF) The Nordic Association of Midwives founded with Ellen Erup as Chairman.

1950 Maternity Allowance introduced.

1950 The Swedish National Association for Sexual Equality is founded. (RFSL).

1951 Over 600 legal abortions carried out in Sweden.

1953 New decree for midwifery training. Dual training made permanent. Two years' study at an approved nurse training school for entrance into midwifery training.

1955 Sex Education becomes obligatory in schools.

1957 The Swedish Association of Midwives plays host to the International Committee of Midwives' XI International Congresss in Stockholm. Ellen Erup elected as ICM's President.

1960 The Swedish Association for Sexuality Education (RFSU) demands free abortion.

1964 Contraceptive pills permitted as preventative method.

1965 Rape within marriage becomes a punishable offence.

1966 The Spiral (intrauterin device) permitted as a contraceptive.

1966 Doctor Gustav Hedberg uses para cervical block (PCB).

1968 Ellen Erup leaves as Chairman of the Swedish Association of Midwives.

1970 The first Youth Clinic opens.

1970 Group 8 formed.

1971 The Swedish Parliament decides that all women who wish may receive pain relief during labour.

1972 Midwives permitted to give contraceptive advice.

1974 Parental insurance of 6 months introduced. Equal care of children after divorce.

1975 Free abortion up to the 18th week introduced in Sweden (Abortion Law 1974:595)

1976 Midwives permitted to prescribe contraceptive pills.

1976 Law on free sterilisation from age 25.

1976 Swedish Association of Midwives affiliated to SHSTF Svenska Hälso- och Sjukvårdens Tjänstemanna förbund (The trade union for Swedish Health and Medical Care Workers' Association).

1977 The High School Reform (H77) is the result of an investigation in 1968 (U68) and grants the opportunity to study and undertake research at universities and colleges.

1978 Law on Parental childcare leave (the right to shorter working hours) introduced.

1978 Equal age limit (15 years) for both heterosexual and homosexual intercourse introduced.

1978 The two first women's shelters started in Gothenburg and Stockholm.

1979 Homosexuality removed from the National Board of Health and Welfare register of illnesses.

1980 Prohibition on the depiction and dissemination of child pornography.

1980 Equality Law in working life introduced.

1982 Health and Medical Care legislation (1982:763) The aim of health and medical care is good health and care on equal terms for the entire population.

1982 Abuse of women comes under public prosecution.

1982 Law against female genital mutilation.

1982 Vivian Wahlberg becomes the first Swedish midwife to defend her PhD thesis : 'Credé's Prophylaxis – Applying silver nitrate eye drops to newborns' eyes. After this, Credé's prophylaxis is discontinued in Sweden and the other Nordic countries.

1985 Insemination Law regulating how insemination may be carried out (sperm donation permitted).

1985 AIDS delegation established.

1985 Twenty eight percent of all Swedish mothers receive either epidural block (EDB) or para cervical block (PCB).

1987 The first cohabitation law (1987:232) regulates how the cohabiting partners' joint property should be divided.

1988 Equal cohabitation rights for homosexual as well as heterosexual couples.

1989 Longer parental leave introduced.

1989 Law on fertilisation outside the body which regulates fertilisation of the woman's egg outside her body.

1992 Medical abortion permitted.

1993 Emergency contraceptive pills permitted.

1993 Higher Education Reform 1993 (SFS 1993:100). Academic qualifications granted to training with previous professional qualifications.

1993 Course book for midwives by Elisbeth Faxelid et al published. The first Swedish course book for midwives with only midwives as editors.

1994 Allocated quotas for parental leave introduced. Fathers' leave of one month introduced.

1995 Parental Leave Act. (1995:584).

1995 Civil Partnership Act for homosexuals.

1995 Qualification description for qualified nurses and qualification description for qualified midwives published by the National Board of Health and Welfare.

1996 The Swedish Association of Midwives establishes a Scientific Council.

1998 Government Bill 'Kvinnofrid' Methods for minimizing violence against women.

1999 Sex Purchase Act. It becomes illegal to pay for casual sexual intercourse in Sweden.

2000 Breastfeeding Network (AMNIS) founded in Sweden. The network is made up of representatives of professional groups and voluntary organisations which spread information about breastfeeding to their target groups.

2000 The Swedish Association of Midwives and the Health Professionals Union go their separate ways. Automatic membership and affiliation to both organisations ceases. The Swedish Association of Midwives is the professional association for Sweden's qualified midwives and midwifery students and represents primarily the midwife's area of expertise.

2001 Emergency contraceptive pills available over the counter from pharmacies.

2001 State of the Art. Management of a normal delivery. The National Board of Health and Welfare. The aim of the obstetric care during delivery is, with the least possible intervention in the course of the delivery, to achieve a healthy mother, a healthy baby and a positive experience of the delivery.

2003 The Swedish Association of Midwives institutes a special prize presented to the person who has made an extraordinary contribution to the health of mothers and children. The prize winner can be a midwife or another person working in healthcare or in society at large who has brought about lasting change which affects women's sexual and reproductive health.

2003 Cohabitation Act (2003:376) includes both heterosexual and homosexual cohabitees.

2005 Lesbian couples granted the right to insemination at hospitals in Sweden. (LU25)

2006 Higher Education Reform 2006 (SFS 2006:1053) Harmonising to international examination requirements.

2006 Qualification description for qualified midwives revised by the National Board for Health and Welfare. Three of a midwife's essential areas of activity are: sexual and reproductive health, research and training, as well as leadership and organisation. A comprehensive view and ethical method of conduct shall form a basis for and permeate all areas of expertise.

2007 Foreign women granted the right to have abortions in Sweden.

2009 The Swedish Association of Midwives institutes an International Council.

2009 Gender neutral matrimonial legislation is passed in the Swedish Parliament.

2010 The first number of Sexual and Reproductive Healthcare, the Swedish Association of Midwives' scientific journal.

2011 The Swedish Association of Midwives is the professional association for Sweden's qualified midwives and midwifery students with 6369 members. The Association's aims are to promote the professional development of midwives, increase in knowledge and research within the professional areas of the midwife with the focus on sexual, reproductive and antenatal health. Midwifery training is carried out at college/university level located at eleven centres in Sweden. Nearly 100 midwives have defended their theses. Approximately 6,500 midwives work within healthcare.

300 & 125 ÅR

300 ÅR MED UTBILDADE BARNMORSKOR, 125 ÅR MED ETT EGET FÖRBUND OCH EN NOLLVISION FÖR MÖDRADÖDLIGHET.

THANKS TO all who have contributed to the Swedish Association of Midwives Jubilee Book.

THIS IS HOW we would like the future to be …

Sexual and reproductive health is a human right. All women can choose where, when, how and if, they wish to give birth to children. No woman gives birth to a child without professional help and all women have access to contraceptives and abortion care. There is midwifery training in every country. Trained and professionally competent midwives work across the world in sexual and reproductive healthcare. The work of the midwife is based on the international code of ethics. Women and men, girls and boys all receive the same professional reception and care. Midwifery organisations are strong and work together. All people know about the World Health Organisation's definition of health. The United Nations' Women's Convention is followed and the millennium goal is achieved. The world has a zero vision for maternal mortality.

Visions for our future
The Swedish Association of Midwives (2010)