A. Lenander, L. Carlbom, M. Johansson, S. Lind, V. Apelthun

Women's Health: The Delivery Ward in Stockholm

What's new? While the situation within the delivery ward has been ongoing for several years, it became more widespread during fall 2021, when protests and mass-resignations broke out in Region Stockholm.

Why did it happen? Mostly due to lack of resources, total capacities at hospitals and midwives shortages. As well as a poor work environment, a high workload, and short-term selective economical measures being taken.

This is a complex ongoing situation within the entire nation

Why does it matter? Women's health is at unnecessary and avoidable risk, which could violate both article 12 in CEDAW and ICESCR, especially when it comes to their autonomy. It has also increased women's fear of giving birth.

What should be done? The Swedish Government must take responsibility for the current situation, and actions need to be taken that are more than mere words on paper. Significantly more midwives must be employed at the delivery units to make it possible to change the current situation. Restructure the delivery ward so women's autonomy can be respected.

Summary

Following public protests over the situation in delivery wards and mass resignations of midwives in Region Stockholm, politicians and public servants have responded by coming up with new recommendations and a plan to develop and improve maternity care. Funds have been set aside by the local board of politicians. As human rights students, we have set out to determine whether Sweden fulfills its commitment to the right to health within the area of maternity care in Stockholm's health care system. Health care is publicly funded. We have interviewed midwives, union representatives, and an obstetrician and have compared the recommendations and development plan to the answers of the midwives and union representatives interviewed. We have found some similarities and a significant discrepancy in the perceptions of what needs to be done between the politicians on the

one hand and the midwives and their representatives on the other hand.

Glossary

Caseload midwifery — A model of maternity care where a woman will see the same midwife all through pregnancy, birth, and postnatal care. Each midwife will be responsible for a maximum number of clients at any given time.

Differentiated care — When the health care given is adapted to the client's needs rather than a given in a standard form for all clients.

Fear of giving birth — The definition of fear of giving birth might differ between different studies and reports, which partly explain the various numbers that exist. They are also made at different times and with varying groups of participants. However, these different surveys indicate a widespread fear of birth among women. The circumstances in a delivery ward in the region of Stockholm seem to increase this fear.

Injuries — Physical injuries that occurred when, or in relation to, the woman giving birth.

One midwife per birthing woman — This has become the main claim by activists and protesting midwives. A report stated that the delivery experience would have been better if the workers were less stressed and their midwife had cared for fewer patients at the same time.

Regions — Sweden is divided into different regions. These regions are responsible for tasks and duties within a specific geographical area. They have their own policies and budgets. One of their responsibilities is to provide and regulate the health care within their area.

Methodology and delimitations

To investigate the problems brought up in this report, we have done a text analysis of reports and documents from the government, Region Stockholm, and non-governmental organizations (NGOs). These reports include the budget for maternity care in Region Stockholm, and authorities plan to improve the care and different areas within maternity care that are deficient. To compare these reports to how maternity care looks in practice, we have interviewed six midwives,

one obstetrician, one representative from the Swedish Association of Midwives, and two regional politicians to investigate further. In our interviews with the midwives and the obstetrician, we have tried to find out whether Region Stockholm's plan and budget are sufficient and if they have had a say in developing this. In our interviews with the politicians, we have tried to get a more descriptive and detailed view of their plan and of the current situation.

We specifically chose to focus on Region Stockholm.

Since this is a complex ongoing situation within the entire nation, we have done some delimitations. For instance, we will only examine the situation at hospitals within Region Stockholm. We specifically chose to focus on Region Stockholm as it was there that this situation erupted and where the protests took place.

The budget and the plans can differ between the regions, and therefore it would be too complex to investigate all regions in this report. We have also decided not to interview the women who have given birth or who are currently pregnant. To get a good overview of the situation, we would have to interview many women, which we felt were not manageable within our given timeframe. If we were to only interview two or three women, it might be difficult to tell if their view is a common problem and a shortcoming in the care or just a personal opinion or experience. We have analyzed documents and reports that showcase how women can and have been treated and exposed to, backed up by reports from the media. We decided to interview the midwives and ask them about the women's experiences, as they have treated a large number of women. Hopefully, we can give a broader perspective and insight into the situation and its extent.

Background and development

In history

In the past, midwives were not "attached" to a hospital. They visited the women giving birth in their own homes. Once there, the midwife stayed with the mother for as long as needed. Only complicated cases were taken to a hospital. Between 1890 and 1950, the rate of home births fell from 98 to 6 percent. Giving birth at the hospital is now the norm, and home births are unusual in Sweden today. One hundred home births occur every year, which is 0.1% of all births in the country (Sörmlands Museum, 2018).

Women were compared to cars.

Swedish healthcare has undergone four different development phases since the 1960s. The first phase was the expansion phase between 1960 and 1980. Growth in the number of health centers and an

expansion in specialized hospitals occurred. This development strengthened the midwife's role throughout the pregnancy process as a whole (Strömberg, 2019).

Midwives we have interviewed explained how things changed in the 1990s when politicians decided to shut down small delivery clinics since they had too few births. The new political goal was to centralize the delivery ward and make it more efficient by gathering everything in one place, in large hospitals, where access to emergency care was also available. Many women lost the security of having a clinic close by. After came a time when the concept of Lean (a working method developed for car factories) came into healthcare and its structure. The main goal was to make it even more efficient by comparing it with the industry. The focus was on how to speed up women's process. In that way, one would be able to shorten the birth process and make the women's time in care more efficient.

Midwife shortages

The maternity care of Sweden is often given as an excellent example of a functional and well-developed health care. Still, another image was provided in 2017, when the maternity care received media attention and caused protests all over Sweden. The protests and the pressure from the midwives had some effect, and in the 2018 budget plan, an investment in maternity care and women's health was presented (Alm Dahlin, 2017).

Many midwives quit working in the delivery unit because of the high workload.

The problems prevailed and the investments failed to have a long-lasting effect. In 2021, protesters once again took to the streets, demanding improved maternity care, and many midwives resigned at the same time, as a protest (Sveriges Kvinnolobby, n.d). In 2021, 19 out of 21 regions reported a shortage of midwives, and it is also none of the professions in the healthcare sector with the highest proportion of sick leaves (Socialstyrelsen, 2021).

The number of midwives has increased during the last 20 years, and many nurses apply to the master's programs in midwifery (Socialstyrelsen 2020; Vårdanalys, 2020). The workload of midwives has, however, also increased. It has become more common with births identified as "higher-risk deliveries" (Vårdanalys, 2020), and 8 out of 10 midwives also experience a higher administrational workload (Novus, 2020). The midwife shortages are expected to continue due to

Sweden's growing population, and many senior midwives with a lot of experience are expected to retire soon.

Maternity care in Sweden lacks both newly educated as well as experienced midwives (Socialstyrelsen, 2020). The Swedish worker's union for the healthcare sector, Novus (2020), reports that delivery units are particularly vulnerable as many experienced midwives leave the unit to work in other less strained workplaces. Their survey found that 40% of midwives who previously worked in a delivery unit switched workplace due to poor working conditions and low salaries. Over 90% of the participating midwives believed that more midwives would work in delivery units if the wages increased. Two out of the six midwives we interviewed mentioned that there should be more ways to affect your salary that are not solely based on how many years you have worked. Many midwives quit working in the delivery unit because of the high workload, and four out of six midwives we interviewed affirmed a shortage of senior midwives at delivery wards due to many leaving for other workplaces with better working conditions.

40% of midwives who previously worked in a delivery unit switched workplace.

All the midwives spoken to stated that the biggest problem within maternity care is the understaffing of midwives. The midwives note that this is a known issue and that different actions have been taken to solve this problem. Some hospitals have provided them with registered nurses; some have more medical doctors available. This leads to certain skill sets being lost, which results in poorer care for the women in labor, and many midwives care for more women at the same time than they feel that they can manage. The president of the Swedish Association of Midwives shared a similar view – that registered nurses seemed to replace midwives because of the shortages, even though midwives are far more competent.

One midwife stated that Sweden needs to make the students in midwifery fear the delivery ward less, and they need to make the midwives who left the profession willing to come back.

One midwife per birthing woman

One midwife per birthing woman has become the main claim and slogan used by activists and protesting midwives (Sveriges kvinnolobby, n.d). A survey executed by Novus (2020) demonstrates that 69% of the participating midwives wished to work under the

principle "one midwife per birthing woman." Yet only 1 out of 10 could maintain that principle during 21% (or more) of their shifts.

The Birth House (2019) states that a midwife's continued and ongoing presence during a woman's active labor is the most significant factor in diminishing interventions. When interviewing women who gave birth during 2018-2019 in Sweden, 12% answered that their midwife was not present during delivery. They said that their experience from the delivery would have been improved if the staff was less stressed and if their midwife had cared for fewer patients.

Laws and international documents

International

The International Covenant on Economic, Social, and Cultural Rights (ICESCR)

Article 12 establishes everyone's right to enjoy the highest attainable physical and mental health standard. The article lists state parties' steps, such as reducing stillbirth and infant mortality, improving environmental and industrial hygiene, and access to medical care for everyone. The Committee on Economic, Social, and Cultural Rights has extensively elaborated on article 12 with its General Comment 144 on the right to health and States parties' obligations. The Committee affirms that the right to health must be understood as a right to enjoy various facilities, goods, services, and conditions to achieve the highest attainable standard of health.

A state must guarantee the highest attainable standard of health.

In this report, we mainly focus on the notion of "the highest attainable standard of health" in article 12.1, which is further commented on in General comment No.14 on the highest attainable standard of health. It ″takes into account both the individual's biological and socio-economic preconditions and a State's available resources. Several aspects cannot be addressed solely within the relationship between States and individuals; in particular, good health cannot be ensured by a State, nor can States provide protection against every possible cause of human ill health."

General comment 14 also states the importance of emphasizing respect to the right to health and equality of access to health care and health services. It further comments that States have a special obligation to provide those who do not have sufficient means with the necessary health insurance and healthcare facilities. States also have to prevent discrimination on internationally prohibited grounds in

providing health care and health services, especially regarding the core obligations of the right to health.

Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW)

Sweden was the first state to ratify the CEDAW in 1980. Sweden has not made any reservations to the Convention and has ratified CEDAW's additional protocols.

All states shall take all appropriate measures to eliminate discrimination against women in the field of health care.

In this report, the main focus is on article 12 of the Convention, which states a state's obligation to Women's health. In article 12.1 it is written that states' who have ratified the convention ″shall take all appropriate measures to eliminate discrimination against women in the field of health care." The article also emphasizes that measures have to be taken and made by the state to ensure women's access to health care, and equal health care for men and women must be provided.

Article 12 also includes family planning, and article 12.2 affirms that women have a right to appropriate service during their pregnancy, confinement, and post-natal. It also consists of the state's obligation to provide free services when necessary and provide adequate nutrition during pregnancy and lactation.

Swedish Governments comment on maternity wards in CEDAW-meetings/report

The Government reports regularly to the UN CEDAW Committee on Sweden's compliance with CEDAW, but the Swedish Government rarely mentions the maternity ward of Sweden during their meetings with the Committee (CEDAW, 2016; CEDAW, 2021; Government offices of Sweden, 2019;). Shadow reports from CSOs report the delivery ward's shortcomings (The Birth House, 2016; Swedish CEDAW Network, 2021). None of Sweden's state reports from 2014 and 2019 (Government Offices of Sweden, 2014; Government Offices of Sweden, 2019) mention the maternity ward. The summary records from the meeting in 2016 (CEDAW, 2016) demonstrate that the maternity ward only was discussed in connection to the reproductive health of marginalized groups. It was stated that the maternal mortality rate in the country is meager. During Sweden's opening statement in 2021 (CEDAW, 2021), it was noted that "More needs to be done to achieve gender-equal health and care." They further referred to the general initiative to strengthen maternity care and women's health in general, which started in 2015.

This demonstrates that the Swedish government has not recognized the shortcomings of Sweden's delivery ward. The low maternal mortality rate is given as proof of well-functioning care. The short reference to the general initiative to strengthen maternity care might respond to the CSO's reports, indicating that the government believes they have fulfilled their responsibility by implementing this initiative. The maternity ward is never given an extended focus, and there are no signs of awareness about the problems that the CSOs raise. This provides us with the perception that the Swedish government does not have, or does not want to provide, a nuanced image of the delivery ward.

Sweden does not provide a nuanced image.

National

Patient Act[1]

In 2015, the Patient Act was brought into practice, and with it came new laws that regulate it. The chapters most relevant for this report are chapter 2, which deals with accessibility and states, in section 1, that health care and medical care should be easily accessible and guaranteed.

Chapter 3 brings up the duty to give out information and the right to receive it. It brings up matters such as when one can expect to receive care. Chapter 4 states the importance of consent – and that self-determination and integrity must be respected. Chapter 6 handles the matter of regular care contact and individual planning. However, this is probably more relevant before and after childbirth and not necessarily during birth.

Patients need to feel secure.

Health and Medical Services Act[2]

The Health Care act from 2017 replaced and updated the previous one (1982:763). It is a goal-oriented framework law, which contains overall goals and guidelines for health and medical care. The law focuses on the obligations of healthcare providers and operators and sets the aim for health care.

The chapters we deem most relevant for this report are chapter 3, section 1, which states that the goal of health and medical care is good health and care on equal terms for the entire population. Chapter 5 deals with the workplace and how it should function. Section 1 writes that health and medical care activities should be conducted to meet the

[1] Patientlagen (2014:821)
[2] Hälso- och sjukvårdslag (2017:30)

requirements for good care. This means there should be an excellent hygienic standard, that patients need to feel secure, and the workers need to build and respect a patient's self-determination and integrity. The second section of the chapter also states that there should be staff and equipment available for good care. Section 4 sets forth the need for the unit to systematically and continuously be developed and secured.

Chapter 7 described organization, planning, collaboration, and the need for regions to plan health - and medical care based on the need for care among those covered by the region's responsibility for health and medical care. When planning, the region must consider other care providers' health and medical care.

Current situation

Injuries

Five out of the six midwives interviewed testified that they cannot always provide women with safe care during childbirth due to the conditions on the delivery ward, which the president of the Swedish Association of Midwives agreed with. One midwife believed that the strenuous work shifts are to blame, while another believed clinics with a high number of newly graduated midwives decrease safety.

The midwives cannot always provide women with safe care during childbirth.

One of the midwives noted the lack of injuries within maternity care has decreased, and so has their proportions. Another midwife pointed out that the women who choose to give birth at home have had better medical outcomes and overall better birth experience. Both the interviewed politicians and the doctor agree that fewer injuries seem to occur at a home birth.

Vårdanalys (2020) states the average care-time after delivery has decreased, which could be due to the declining injuries, but also as a result of the lack of available beds. In 1990 the average time to stay at the clinic after giving birth was four days; in 2016, it was 1,8 days. Shorter care time and a high workload make it challenging to provide personal-adjusted and safe care after delivery. This could explain why it is more common that women are re-enrolled, as their injuries (mental or physical) are not discovered at the hospital directly after giving birth.

Bed shortages

There is no guarantee that there will be available spots at the delivery units, which has caused widespread fear of giving birth and has often

been highlighted as a challenge for Region Stockholm to provide one (Sjöqvist Harland, 2017). At the same time, Novus's (2020) study states that 99% of birthing women in Sweden were able to give birth at a hospital, and 94% did so in their preferred hospital (Novus, 2020). On the other hand, Vårdanalys (2020) also states that over 10% were denied a place at the delivery clinic when the women first contacted and wanted to arrive at the hospital.

The delivery ward function as a baby factory.

Four out of six midwives indicate a constant bed shortage in Region Stockholm. One midwife explained the difference of giving birth in the 1990s, where women became angry if a hospital was at total capacity and refused to admit them. In contrast, today, they are happy if they managed just to be admitted to the hospital. Two midwives mention how women have been taken in without available space. This forces women who recently gave birth to be sent home, examination rooms and even corridors being used as delivery rooms instead of the standard delivery rooms. Three of the midwives referred the delivery ward as a "baby factory," where the focus is on which women are in the most pain and which women are going into labor first. Many women are left without support and help.

In cases where you have to receive the patient even though it is at total capacity (no vacant rooms or vacant midwives), the keyword "Cannot be referred" is used. The indicator "cannot be referred" was developed following pressure from some delivery clinics. In 2020, this applied to 929 women, and by 2021, the figure had risen to 967 women (Press-region Stockholm, 2022, personal communication 8/2).

When the wards are full, the midwives must prioritize among the women, and those who are not actively in labor are sent home. This causes many women to be sent home in a state of panic. When asked about the matter, one of the politicians said that regions present available hospital beds to demonstrate to the citizens that care can be provided if needed. They state that they are well aware of how one works within the health care sector and says, "So I know that you always find a way to solve the issue." This indicates that they, as politicians, are aware of the problem with bed shortages and count on the midwife to solve it by themselves.

Many women in Region Stockholm have testified to not being accepted into delivery units when they felt they needed it. Several women have testified about situations when they have suffered from staff shortages and lack of available space during childbirth. They emphasize that they felt unsure about giving birth again because of these fears. (SVT, 2021).

Fear of giving birth

Fear of birth has become more common in recent years. In 2014, 9.8% of women who gave birth in Stockholm were given treatment for their fear. In 2021, 15.6% were given some form of treatment. On a national scale, the numbers were at 8.2% in 2014 and 11,9% in 2021 (Med Sci Net, 2022).

Women are afraid of being left alone.

One midwife said that free birth (giving birth without a midwife) has increased. More and more women do not want to give birth at hospitals. Four other midwives mentioned primary and secondary fear of childbirth. They explained that the secondary fear, which occurs after the birth of a child, is higher than the primary, which exists before the delivery of your first child. Four midwives mentioned that many women want a cesarean section rather than giving birth vaginally. Another midwife says that women are afraid of being left alone. One midwife points out that the secondary fear of childbirth shows that the maternity care we have today can physically and mentally harm women. Both regional politicians emphasized that the fear of birth that more women experience shows that the care is not sufficient.

It is hard to identify how widespread the fear is.

It is hard to identify how widespread the fear is. Swedish Agency for Health Technology Assessment and Assessment of Social Services (SBU, 2021) criticizes the methods for identifying those who suffer from fear because regions use different methods that are not evidence-based. A study by Ternström (2018) reports much higher numbers than Med Sci Net; 22% of the women in the study suffered from fear of giving birth. Vårdanalys (2020) stated that 30% of interviewees felt unsafe and scared of giving birth.

Inadequate treatment

The Swedish Agency for Health and Care Services Analysis assessed the Swedish Government's plan to improve women's health implemented from 2016 to 2019. They concluded that maternity care has improved and become more evidence-based yet inadequate. The governments' extra focus on women's health care enabled regions to enhance their knowledge of already known problems (Vårdanalys, 2020). The civil organization The Birth House (2019) states that Sweden does not follow the recommendation for "Intrapartum care for a positive childbirth experience from WHO. The maternity ward in Sweden is often perceived to be "midwifery-led" in accordance with international recommendations. This is partly true as midwives

typically attend and lead deliveries, although they do so at high-risk hospital units, and doctor-written guidelines guide them.

The Birth House (2019) emphasizes that Sweden's treatment of pregnant women violates women's autonomy, as Sweden only provides one form for childbirth: at hospitals. Obstetric units expose an unnecessarily large group of women at risk of unnecessary interventions and injuries. Home births are rare in Sweden; only 100 planned home births out of 30 000 deliveries occur at home. The Swedish government does not provide financial aid to make it possible to offer different forms of childbirth. Giving birth at a delivery unit increases the risk of injuries as a midwife often cares for several births simultaneously.

Despite their preferences, most women give birth assisted by a midwife they did not previously know (The Birth House, 2019). The circumstances of delivery are rarely adjusted following the women's wishes. Many women report that they felt that the communication with the midwife during the delivery was inadequate due to the staff's high workload. The women also wished to be more involved in their pregnancy and birth (Vårdanalys, 2020).

Delivery units expose a large number of women for unnecessary risks.

Although the woman giving birth does have the right to a so-called "informed choice" regarding different procedures and the right to be informed about what refusing a care intervention entails, that is often not the case. You should be allowed to either accept or refuse care interventions, but in many cases, you can get told that these things should be done anyways – just in case, as a safety measure. "As a midwife, you hold immense power. You can make a woman do almost anything," one midwife said. Two midwives indicated that specific procedures, like vaginal procedures, were not always made for the right reasons. One of them stated that it at one point was done because their supervisor wanted to see if they would have time to do it. Another noted that consent was not always fully there, but stress and time made them do it anyway – even though it is a very invasive procedure.

Many midwives also noted that procedures were done that were not always necessary. For example, CTG-scans being performed to monitor the heartbeat – instead of a midwife simply being present, epidurals being taken because the woman would rather take that than be alone in labor, and many of the women being put on different drips. One midwife even stated that humankind would have been extinct long ago if these things were vital. Two of the midwives indicated that

they were frustrated because much research is available that proves what methods – the most important of them being the midwife's presence during birth - are successful and can make a difference, yet that does not seem to matter.

"It is frustrating to want to give good care to these women and yet feel like you are unable to. You should not feel like you have to take certain pain medications, or feel like you are not prioritized because we are not able to support you the way we want to," one stated. At the same time, another explained that sometimes it is hard to show empathy because you are so tired and overworked. In addition, it is not always medically safe because sometimes routines and resources that should be in place are overlooked.

Government Response

Strategies and guidelines

Strategies for women's health – before, during, and after pregnancy.

In 2019, the Swedish Association of Local Authorities and Regions (SKR) gave out the report *Strategies for women's health – before, during, and after pregnancy*. The report aims to get a more distinct description and overview of how the money put into maternity care should be used. The report, therefore, includes a strategic plan to facilitate the Region's work and responsibility (SKR, 2019).

The report highlights that although Sweden is one of the states with the lowest maternal mortality and highest survival among newborns, several areas are lacking. Some of these areas that need improvement are childbirth injuries, women's participation in their care, and competence provision (SKR, 2019).

SKR deems that two conditions need to be in place to achieve these goals. The conditions are strengthened competence provision and good employee and leadership in place.

The proposed strategies are selected based on an overall assessment of the surveys and interviews made because they must be directly linked to one or more sub-goals in the strategic plan. The five strategies are (SKR, 2019); To involve women and their families, to design care and interventions according to the needs of the woman and the family, to ensure a cohesive care chain, to develop working methods and to strengthen knowledge management.

In June 2021, the Swedish Government commissioned Socialstyrelsen to draw up national guidelines for maternity care. The purpose of these guidelines includes promoting continuity, participation, and equal care for women during pregnancy, childbirth, aftercare, and that the right competence for women's different needs is available. This

should be done by coordinating existing knowledge support within maternity health care and analyzing whether additional knowledge needs to be developed. (Regeringen, 2021).

Five strategies to improve the delivery ward.

In the final report of a commission from 2019, the authority's surveys show shortcomings and significant variations in pregnancy and maternity care. Some of these shortcomings are prevention, following up, and treatment of congenital disabilities. Especially within care after childbirth, which needs to be improved both at the hospital and after returning home (Regeringen, 202). There is no room to give everyone individualized aftercare (Socialstyrelsen, 2019).

In 2021, the government invested 1,5 billion SEK on women's health and maternity care. A large part of this investment consists of multi-year agreements between the state and SKR to stimulate and strengthen the Region's development. For example, in December 2019, the government and SKR reached an agreement *To increase accessibility and equality in maternal, health, and maternity care and strengthen initiatives for women's health 2020-2022*. The government and SKR also reached a supplementary agreement in January 2021, which consisted of person-centered, accessible, and equal health care for pregnancy, childbirth, and aftercare between 2021 and 2022 (Regeringen, 2021).

The commission points out that the Region's work should be based on reliable and up-to-date knowledge. For example, knowledge support from healthcare authorities is based on the best available knowledge about care and treatment (Regeringen, 2021).

The Future of Maternity care in Region Stockholm

The regional board of the Region Stockholm Assembly has suggested measures intending to establish a safe and secure quality of treatment for the mothers and the children, an increased work environment for the staff, and work on the competence within the unit. These measures also require an additional 555,5 million SEK for these efforts between 2022 and 2024 (Regionrådsberedningen, 2021).

The region leadership office highlights the quality of medical treatments within the Region due to the staff. It acknowledges that they are aware of the demanding work environment, with many expressing that they lack time to perform all their tasks. This has also led to many midwives deciding to leave their job (Regionrådsberedningen, 2021).

The Region states that they have taken the viewpoints and opinions in high regard when making this plan. The aim is to improve the situation and look over possible solutions. The result is that Stockholm, as the first Region within the country, will implement the

reform "One midwife per birthing woman" (Regionrådsberedningen, 2021).

In the report from Regionrådsberedningen (2021) we have chosen to focus on the list of suggestions put forward in the plan, which are:

Ensure safe and secure quality of treatment for the mothers giving birth.

Further efforts are needed to strengthen competence and introduce new working methods that provide the conditions for continued safe and secure maternity care that meets the needs of women and children. Working with one midwife per childbirth in the active phase is beneficial for the woman. *Start-up: First quarter 2022.*

Workplace rotation - enables employees to have variation in their work and use all their skills and competence in pregnancy, childbirth, and aftercare. *Start-up: Internal rotation is already underway at some clinics. A new form of employment needs to be developed to enable rotational service between outpatient and inpatient care. Start-up: First quarter 2022*

Increased medical staff for improved flows. Increase the density of doctors in the areas where the doctor's competence is needed, so that pediatric examinations can be carried out quickly and efficiently for better flows. This does not mean that doctors should perform the midwife's work. *Start-up: First quarter 20*

Throughout the entire pregnancy process, improved processes between maternity care, childbirth, aftercare, and non-local processes. An external analysis of maternity care should be carried out to develop maternity care further. An essential part of the investigation will be to consider the need for safety and quality for the child, i.e., neonatal care, and quality and security in maternity care for the pregnant woman. *Start-up: First quarter 2022*

Clear competence and career models make career steps visible, enable scheduling according to the competence mix, and form the basis for competence development. *Start-up: Fourth quarter 2021*

Supervision and mentorship facilitate the transition from studies to working life and provide security through structured introductions, mentorship, and strengthened supervision. *Start-up: First quarter 2022*

Evaluate the application and effect of the working time model in maternity care. *Start-up: Second quarter 2022*

Exchanging tasks. Care-related service staff relieves care staff with tasks such as patient-centered cleaning, meal handling, and storage management.

Budget and financial aid

In the Region's budgets for 2020 and 2021, one of their stated goals was that parents-to-be should be offered a well-developed and safe delivery ward (Region Stockholm, 2020).

In 2020, Region Stockholm received 215 million SEK in targeted government subsidies for maternity care (Region Stockholm, 2020). In 2021, the sum was increased to 330 million SEK (Regionrådsberedningen, 2021)

The region is putting money into the delivery ward.

In its budget, Region Stockholm writes that government subsidies contribute to resources for the development of the establishments, but they do not provide long-term and stable planning conditions.

In 2020, St Göran's hospital was expanded with two new buildings, including a delivery ward. (Region Stockholm, 2020). The Region writes in its budget that it is crucial to have competence provision in maternity care. The new delivery clinic at St Göran's Hospital is part of this (Region Stockholm, 2020).

In the same budget, they write that today's reimbursement levels make it possible to have fewer patients at birth, which "stimulates safe and equal care." It is stated that the number of children who die in childbirth should be reduced, which is currently about 100 children per year in Stockholm (Region Stockholm, 2020).

"You have to be willing to wait several years to possibly see a slight change"

Midwives' response

Most of the midwives interviewed knew what was not working in the delivery ward, and all were aware of how it could be fixed. The problem, two of them stated, is that at one point, you get tired of waiting for change, and instead, you decide to push on – because that is the choice you have. You either have to be willing to wait several years to possibly see a slight change or move away to something else within your profession that is not as catastrophic as the delivery ward.

"We are not lazy – that is not the reason as to why we cannot work full-time – it is the workload – it is way too heavy," one of them stated, and all of the other midwives' statements follow similar patterns.

Solutions

The midwives gave us their view of how women's right to health can be secured during delivery. The most recurring factor was the need for *more midwives* at delivery units. One midwife states, "There need to be more of us! That is the key to many of our problems! If we want more people to work here, we must work tolerably and have time for

our patients!". The midwives state that increased staffing would result in a positive spiral: better working conditions - making birthing units a more attractive workplace - which would attract more midwives to work there. In the end, this improves the standard of care for women. It would be possible to work by the principle "One to One care." One midwife describes how this would contribute to solving the problems regarding shortages, as some rooms are kept closed due to understaffing. The ongoing task-shifting at delivery units could end, and midwives would be able to perform their chores – they have high competence and should not have to delegate to others.

"There need to be more of us! That is the key to many of our problems!"

The challenge of breaking the negative spiral remains - how does one get more midwives to delivery units when midwives do not want to work there? Four midwives mention wages as the key to this issue. Four of them propose that one can pay midwives a full salary (for 100% work) for working 80%. This was also suggested by the president of the Swedish Association of Midwives. She points out that the profession of midwives has the highest amount of sick leave in the healthcare sector due to the strained working conditions. The midwives describe that working fewer hours would create a more sustainable working environment, and they are less likely to quit or fall ill. It would also enable more midwives to start working at the delivery units. Three midwives describe how the salary is an indicator of a profession's value. An increase in the midwives' pay would indicate that the profession could receive a higher position in society.

Some other solutions mentioned were: work-rotation, better introduction for newly examined midwives, more clinics for birthing women, and that the Region and government must listen to the women and midwives to form a maternity care that ensures safe care for birthing women.

One Midwife per birthing woman

All midwives wished to work by the principle "One midwife per birthing woman," which was often mentioned in connection with the need for more midwives. This is described as an evidence-based method, which one midwife pressed "This is scientifically proved. There are studies that prove that continuous support from a midwife decreases the risk of interventions." They also believed that working-rotation would be more functional with this principle in place and found it unlikely that midwives from other units would join without it and compared the current situation to madness. It seems as if more midwives would consider working at delivery units if this principle was implemented. This is proven by one midwife, who quit her job at a delivery unit but said she would return if this method were followed.

It is a rule, rather than the exception, to have at least two women giving birth at the same time in your care, often even three or more. "It is impossible to be in two places simultaneously, and that is what is required of most midwives in Stockholm today". If staffing increases, you can be more present for the woman, and her partner provides a calm and peaceful environment, and the support she needs, leading to birth with fewer complications. As long as the midwife shortages are not addressed, the government's statement will remain empty words on paper.

"It is impossible to be in two places simultaneously"

Individualized care

Three of the midwives spoke about how the delivery ward should be structured to allow women to have caseload midwifery throughout pregnancy, delivery, and aftercare. This is described as a way to increase women's sense of security and safety. They spoke of former, closed down smaller and midwifery-led clinics and the current project "My midwife" (Min barnmorska) as good examples for an improved delivery ward.

The principle of caseload midwifery was often mentioned in connection with a wish to differentiate maternity care with high-risk and low-risk units. Five midwives spoke about this issue and explained that differentiation within delivery wards would enable women to decide over their bodies and the type of treatment they receive. It would also make the delivery ward more evidence-based, and the risk of unnecessary interventions increases when low-risk deliveries are done at high-risk units. To create midwifery lead low-risk units where women can stay from the beginning of their delivery to their journey home is therefore given as one of the essential solutions. The Swedish Association of Midwives president describes this as a long-term solution "With different types of care, for different types of deliveries, with bigger units focusing on the medical aspects, and smaller units where the healthy deliveries are left to be just that."

Enable women to decide over their bodies and the type of treatment they receive.

Midwives' view of the government's response and international documents

None of the midwives mentioned or commented on any of the international conventions, but the consensus was that they – as midwives - could not provide the birthing women with the best possible care due to the heavy workload and lack of staffing, which is problematic due to what is stated in these conventions. One midwife also mentioned that Sweden does not follow WHO's guidelines, which state that a woman should give birth at a place where she feels safe and secure, and she thought that this was not the case for Sweden.

Regarding SKR's plan, there seemed to be a discord between the plan and the everyday working experience among the midwives. One midwife stated that while it sounded good, it was too abstract, without clear advice on what to do and how it would work in practice. "The midwives will work their asses off to fulfill this vision that SKR has created." Another midwife had similar thoughts that she has not heard how they will reach this point and are competent – they only need more time. Another midwife said that SKR could not state that the delivery ward has a staffing shortage because they would have to hire more staff if they did.

"The midwives will work their asses off to fulfill this vision that SKR has created."

The fourth one was slightly more positive, saying that there has been provided funding to improve these areas, prevent ruptures and injuries and provide training for the midwives, which she considered significant. Regarding the goal to include the woman and her family in the labor process, one of the midwives bluntly stated that this is not true. "We have not been able to include the woman in the labor process. We do not."

Midwives' view of the region's response

All but one of the interviewed midwives seemed to be aware of Region Stockholm's plan to improve the delivery ward. While they did not agree with everything being said and could not see everything work in practice – they generally believed that it was a step in the right direction but that the step had taken far too long to take.

The interviewed midwives were all favorable to "One midwife per birthing woman," being a part of the Regions plan. Two midwives were skeptical of the given definition as it focuses on the active phase of labor, as it is hard to define and calculate that timespan. One midwife stated that she would rather see that one midwife per birthing woman started when she first arrived at the hospital until she left. One midwife said that her workplace had begun to follow this principle and was currently restructuring their birthing unit. While she was favorable to it, she still pressed the need for an increase of midwives at her unit, an opinion that most of the midwives we talked to shared.

The midwives interviewed favored the workplace rotation program but also stated that not all midwives might be interested in rotating between different departments. One noted that this is a "twisted version" of what the midwives want, while one midwife said this might be used by the employers to "shuffle staff around" as they seemed fit.

"A step in the right direction but that the step had taken far too long to take."

Two of the midwives interviewed agreed on the notion to increase the number of medical doctors to improve flows in the health care system. Two others disagreed since they believed that the lack of midwives

was the primary issue.The midwives seemed skeptical about the act of improving processes between the different clinics, and only one of them agreed on this point. Two of them stated that they did not understand its meaning and found it confusing.

Only one of them reflected upon the concept of evaluating the application and effect of the working time model in maternity care and stated that it is already in place at two hospitals in Stockholm, which she said is "being between a rock and a hard place."

"Like being between a rock and a hard place."

All of the midwives favored a mentorship program, and one of them stated that this is what is needed for new midwives to "dare to" work in the delivery ward. A few of them said that there had been a mentorship program at their workplace before but that it had been removed due to lack of funding. One midwife said that it simply was not present at their workplace today.

The midwives all had different thoughts of the plan to hire extra service staff to ease up the work tasks of the medical staff. A couple of them said it was a good plan, but one of them stated that there is not much they could hand over to other personnel since they distributed as much as possible. Another midwife said that hiring cleaning staff would ease the workload of nurse's assistants.

Ensuring the right to women’s health in Sweden

The delivery units in Stockholm do not ensure women's rights. National laws are repeatedly broken, as women are not guaranteed safe and consensual care. The root of the problem is the midwife shortages, which violates Chapter 5 and section 2 in The Health and Medical Services act, which states that units should be staffed and equipped to provide good care. The midwife shortage also leads to violations of other laws.

Chapter 5 and section 2 of the Health and medical services act are also relevant regarding bed shortages as the units are not sufficiently equipped. Patient act, chapter 1 states that care should be easily accessed and guaranteed, and the health and medical services act chapter 3 section 1 states equal care for all. The midwives said that while most women give birth at delivery units, they are often directed to another hospital than their initial wish, sent back home when they first wish to go in and sent to aftercare prematurely. Some have to give birth in the waiting- or examinations room. This shows that care is not easily accessible nor accessible throughout the whole delivery phase. Women do not receive the same standard of treatment - it varies greatly depending on the day they give birth and how burdened the unit is at the time.

The root of the problem is the midwife shortages

The health and medical services act, chapter 5 Section 1, states that health and medical care activities should be conducted to meet the requirements for good care. A critical aspect of this is that patients need to feel secure. Many midwives said they wished they could stay with their patient to increase her sense of safety. The shortage of beds and midwives has led to a widespread fear of giving birth among women.

The Patient act chapter 4 states that consent, self-determination, and integrity must be respected. Respect for self-determination and integrity is also a requirement for good care, said in the Health and medical services act, chapter 5, section 1. The midwives have testified that women's autonomy is violated when they perform procedures that would not be necessary if the midwives had more time for their patients. Some examples were: vaginal procedures, usage of technical devices such as CTG (which increases the risk of unnecessary interventions), panicked women deciding to take an epidural because midwives could not stay with them and make them feel capable of managing the pain. The midwives also highlighted that the Swedish health care structure violates the right to self-determination as it only provides one form of childbirth.

Self-determination and integrity must be respected.

The right to appropriate service during pregnancy stated in CEDAW article 12.2 is also violated. The strained conditions at the delivery units lead to the standard of care given to women varies greatly between clinics and days with high and low workloads. The lack of midwives has forced medical staff to use less time-consuming methods, increasing the risk of unnecessary interventions. This spreads fear of giving birth, as the healthcare system traumatizes some women rather than providing them with proper care. ICESCR Article 12 states that everyone has the right to enjoy the highest attainable physical and mental health standards. Both the midwives and regional politicians acknowledged that Sweden has the knowledge, capacity, and resources to have a higher standard at our delivery units. Interestingly, the government has not acknowledged it during meetings with the commission of CEDAW, nor with ICESCR.

What can be done?

As we have seen, the government and Region Stockholm both took initiatives and plans to provide a better delivery ward. The solutions suggested by the midwives are reflected in the authorities' plans to some extent, but some critical parts are missing.

The initiative from SKR highlights some aspects that the midwives also describe as insufficient. Some of these areas are women's involvement, developing interventions according to women's needs,

and increased accessibility. The initiative is vague and does not specify how these areas can be improved. It does not target the main problem presented by the midwives: to increase the staffing at delivery units. Therefore, there is a risk that the implementation of the SKRs initiative could result in additional workload for the midwives.

The plan from Region Stockholm is more specific and sets clear solutions. The most important one is to have one midwife per birthing woman. However, Region Stockholm does not state how this can be achieved. The midwives describe a negative spiral: they have a high workload due to understaffing, which leads to more midwives leaving delivery units, creating a more increased workload that no one wants to work with. The authorities do not provide a solution for how this spiral can be broken. The midwives and the Swedish Association of Midwives president suggested a short-term solution to break the loop: let midwives work 80 percent for a 100 percent salary. This would enable them to manage the workload and continue working at delivery units. It would also make delivery units a more attractive workplace where more midwives would be willing to take up employment. The matter of salary was avoided during the formation of the regional plan. The regional politicians stated that they, as politicians, do not set wages, which seems like the issue might remain.

Sweden's healthcare system would need to be restructured to differentiate the delivery ward

The problems of the delivery ward in Stockholm cannot be fixed by just increased staffing and by working with one midwife per birthing woman. Many midwives emphasized the structural challenges as Sweden only provides one form of childbirth - at high-risk units. This is against evidence-based research regarding the safest forms of childbirth, and it violates the right to self-determination. Therefore, Sweden's healthcare system would need to be restructured to differentiate the maternity ward.

Who carries the responsibility?

Midwives have expressed frustration over their inability to provide women with appropriate care. The midwives felt as if no one took responsibility to improve the conditions of the delivery units. They felt like they were left to fend for it by themselves and that the obligation to provide women with safe care was solely on their shoulders. One midwife said, "We are the ones who make sure that nothing terrible happens; by burning ourselves out, we ensure that the patient is not exposed to something dangerous, we sacrifice ourselves." They describe that they have raised these issues with their bosses, who cannot improve their working conditions. The regional politicians stated that they have done this by providing resources and that the hospital's leaders are responsible for how the changes are

The authorities do not provide a solution for how this spiral can be broken.

implemented. The government highlights the SKR initiative from 2015 and 2019 but does not further acknowledge the problem. "We have spoken about this gap between different levels for many years. Each level can clear themselves from responsibility. (...) The region can always blame the government for giving them poor conditions. SKR is responsible for a lot. They can either say that they support their different regions or that they cannot get involved because it's the region's responsibility", the president of the Swedish Association of Midwives said. "The blame of responsibility between the different levels can always be passed around. And actually, I think it is devastating because in the end: no one takes it." There is a need to find a sustainable solution and acknowledge that responsibility lies with the authorities.

"We are the ones who make sure that nothing terrible happens; by burning ourselves out"

Recommendations

To the Swedish Government

- Take responsibility for the current delivery care situation by ensuring enough staffing in the delivery ward.
- The call for one midwife per birthing woman should be heard. A policy stating this needs to be implemented.
- Take responsibility for the bed shortages. All pregnant women throughout Sweden should feel confident and secure that there is a place for them to give birth when the time comes.
- Ensure pregnant women's needs regarding pregnancy, childbirth, and breastfeeding are met.
- Find out the women's needs/wishes regarding pregnancy, childbirth, and breastfeeding/aftercare. This needs to occur at the start of pregnancy to better plan for the future.
- Differentiate the maternity ward and ensure individualized care.
- Give all pregnant women the opportunity for continuity in the care chain.
- Give funding to increase midwives' salaries.

To Region Stockholm

- Increase the staffing of midwives at the delivery units.
- Complete the plan for future maternity care and follow through with it.
- Clarify the following points in the plan: numbers 2, 4, and 8.
- Give all pregnant women the opportunity for continuity in the care chain. "My midwife" for everyone – equal care.
- Open midwife-led departments for low-risk births where all women who so wish should have the opportunity to give birth.

To the management at hospitals in Region Stockholm

- Open up for continuity in the care chain (for hospitals which does not offer the opportunity already)
- Open up midwife-led units for low-risk births.
- Prepare better working time models to attract midwives to the unit.
- Improve the work environment at the delivery units to attract more midwives.
- Offer reduced working hours for midwives.
- For a short period, allow midwives to work at 80 percent while offering them a 100 percent salary.

To the CEDAW and ICESCR committees

- Call on Sweden to take responsibility for the situation, based on its conditions regarding:
    - Equal care throughout the country
    - Women's right to give birth in a safe environment
    - Women's right to appropriate care during pregnancy, childbirth, and aftercare
    - Women's right to self-determination and autonomy

Endnotes

Alm Dahlin, Johanna. 2017. *Med rätt att föda - En granskning av satsningar på förlossningsvården i budget propositionen för 2018.* Stockholm: Sveriges Kvinnolobby https://sverigeskvinnolobby.se/wp-content/uploads/2017/12/med-ratt-att-foda-web-1.pdf (Accessed 2022-02-05)

Committee on the Elimination of Discrimination against Women [CEDAW]. 2016. Summary record of the 1380th meeting. CEDAW/C/SR.1380. *Sixty-third session.* https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fSR.1380&Lang=en (Accessed 2022-02-05)

Committee on the Elimination of Discrimination against Women [CEDAW]. 2021. Summary record of the 1819th meeting*. *Eightieth session.* https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fSR.1819&Lang=en (Accessed 2022-02-05)

Government Offices of Sweden. 2014. *Eight and Ninth Periodic Report by State parties due in 2014. Sweden* https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=CEDAW%2fC%2fSWE%2f8-9&Lang=en (Accessed 2022-02-05)

Government Offices of Sweden. 2019. *Tenth Periodic Report by the Government of Sweden on the measures by the Convention on the Elimination of All Forms of Discrimination against Women.* https://www.regeringen.se/4a7286/contentassets/96124d209ce147aa88b6dbdd538fb296/tenth-periodic-report-by-the-government-of-sweden-on-cedaw.pdf (Accessed 2022-02-05)

Med Sci Net AB. 2022. *Graviditetsregistret Statistik.* https://www.medscinet.com/gr/resultat.aspx (Hämtad 2022-01-31)

Novus. 2020. *Barnmorskor*. PowerPoint Presentation. https://mb.cision.com/Main/1515/3104023/1241887.pdf (Accessed, 2022-01-30)

Regeringen. 2021. *Uppdrag till Socialstyrelsen att utarbeta nationella riktlinjer för förlossningsvården.* https://www.regeringen.se/49e71e/contentassets/847417c715fc465d93672debe345a8a3/uppdrag-till-socialstyrelsen-att-utarbeta-nationella-riktlinjer-for-forlossningsvarden.pdf (Hämtad 2022-02-17)

Regeringskansliet och Sveriges Kommuner och Regioner [Regeringskansliet och SKR]. 2019. *Ökad tillgänglighet och jämlikhet i mödrahälso- och förlossningsvården samt förstärkta insatser för kvinnors hälsa*. https://skr.se/download/18.1f376ad3177c89481f74b6a2/1615459235325/Overenskommelse-kvinnors-halsa-forlossningsvarden-20-22.pdf (Hämtad 2022-02-10)

Region Stockholm. 2020. *Med ansvar för framtiden - Budget 2020 för Region Stockholm.* RS2019-0829 https://www.regionstockholm.se/contentassets/75c77cc6c2414d8b97dbd6ad9afd046d/budget-2020-for-region-stockholm-regionfullmaktige.pdf

Regionrådsberedningen. 2021. *Framtidens förlossningsvård i Region Stockholm*. Stockholm: Region Stockholm. https://www.regionstockholm.se/globalassets/bilagor-till-nyheter/2021/11/p-2-rs-2021-0890-framtidens-forlossningsvard-i-region-stockholm.pdf (Hämtad 2022-02-10)

SFS 2014:821. Patientlag.

SFS 2017:30. Hälso- och sjukvårdslag.

Sjöqvist Harland, Johanna. 2017. *Förlossningsrädslan ökar bland länets kvinnor.* P4 Stockholm. https://sverigesradio.se/artikel/6783795 (Accessed 2022-02-05)

Socialstyrelsen. 2020. *Bedömning av tillgång och efterfrågan på legitimerad personal i hälso- och sjukvård samt tandvård: Nationella planeringsstödet 2020*. Stockholm: Socialstyrelsen. https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2020-2-6638.pdf (Hämtad 2022-02-08)

Socialstyrelsen. 2019. *Stärk förlossningsvården och kvinnors hälsa: Slutredovisning av regeringsuppdrag om förlossningsvården och hälso- och sjukvård som rör kvinnors hälsa*. Stockholm: Socialstyrelsen. https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2019-12-6531.pdf?fbclid=IwAR0GofRwERHjh2l1jQBw6tdiqN5U6gyFyS97jkg8FX_xyoCm-y6IENZM5lA (Hämtad 2022-02-15)

Socialstyrelsen. 2021. *Bedömning av tillgång och efterfrågan på legitimerad personal i hälso- och sjukvård samt tandvård: Nationella planeringsstödet 2021*. Stockholm: Socialstyrelsen. https://www.socialstyrelsen.se/globalassets/sharepoint-dokument/artikelkatalog/ovrigt/2021-2-7200.pdf (Hämtad 2022-02-08)

Sörmlands Museum. 2018. *Förlossningskrisen*. https://www.sormlandsmuseum.se/utforska/valet-ar-ditt/forlossningskrisen/artikel/ (Hämtad 2022-02-15)

Statens beredning för medicinsk och social utvärdering [SBU]. 2021. *Förlossningsrädsla, depression och ångest under graviditet.* https://www.sbu.se/sv/publikationer/SBU-utvarderar/forlossningsradsla-depression-och-angest-under-graviditet/?pub=50049 (Hämtad 2022-03-01)

Strömberg, Helén. 2019. *1959 års ekonomiska historia*. Umeå: Enheten för ekonomisk historia, Umeå universitet. http://umu.diva-portal.org/smash/get/diva2:1370039/FULLTEXT02.pdf (Hämtad 2022-01-31)

Sveriges Kommuner och Regioner [SKR]. 2019. *Strategier för kvinnors hälsa – FÖRE, UNDER OCH EFTER GRAVIDITET*. https://skr.se/download/18.5627773817e39e979ef5e488/1642507667911/7585-774-9.pdf (Hämtad 2022-02-17)

Sveriges Kvinnolobby. N.D. *Debatt: Förlossningsvården måste vara rustad för kris.*

https://sverigeskvinnolobby.se/debatt-forlossningsvarden-maste-vara-rustad-for-kris/ (Hämtad 2022-02-26)

Swedish CEDAW-Network. 2021. *Women in Sweden 2021.* https://tbinternet.ohchr.org/_layouts/15/treatybodyexternal/Download.aspx?symbolno=INT%2fCEDAW%2fNGO%2fSWE%2f46424&Lang=en Accessed 07 December 2021 (Accessed 2022-02-05)

Ternström, Elin. 2018. *Identification and Treatment of Women with a Fear of Birth*. Uppsala: Faculty of Medicine, Uppsala University. http://uu.diva-portal.org/smash/get/diva2:1196389/FULLTEXT01.pdf (Hämtad 2022-02-26)

The Birth House. 2016. *NGO information to the United Nations Committee on the elimination of discrimination against Women.* https://tbinternet.ohchr.org/Treaties/CEDAW/Shared%20Documents/SWE/INT_CEDAW_NGO_SWE_23094_E.pdf (Accessed 2022-02-05)

The Birth House. 2019. *Mistreatment and violence against women during reproductive health care with a focus on childbirth: The case of Sweden*. https://www.ohchr.org/sites/default/files/Documents/Issues/Women/SR/ReproductiveHealthCare/F%C3%B6delsehuset.pdf (Hämtad 2022-01-31)

United Nations. 1966. *International Covenant on Economic, Social and Cultural Rights.*

United Nations. 1979. *Convention on the Elimination of All Forms of Discrimination against Women*.

Vårdanalys. 2020. Förlösande för kvinnohälsan? *En uppföljning av satsningen på kvinnors hälsa*. Stockholm: Myndighet för vård- och omsorgsanalys. https://www.vardanalys.se/rapporter/forlosande-for-kvinnohalsan/ (Hämtad 2022-01-31)

Appendix

Interview questions for the midwives

Presentation of us and what we should do:
We are a group of five students at University college Stockholm who, within the framework of our master's program in human rights,

investigate how maternity care in Stockholm works and, more specifically, its challenges linked to its consequences for pregnant women. Today, the situation is that "women giving birth" risk not receiving the care they need, and we intend to find out why it does not work as it should and what possible solutions are available.

The interview
*Time: 1-2 hours
*Confidentiality: In addition to this group and our examiners, you will be anonymous. This means that we do not use your name unless you allow it.
*Dictaphone and text: What we are talking about will be written down and recorded. If you wish, we can summarize / you can read through the interview afterward and approve it.
Is it okay?
Feel free to let us know if you need a break!
Do you have any further questions for us before we start the interview?

Section 1: Introduction
Tell us a little about yourself, your background, how you came to be a midwife?
For how long have you worked as a midwife, and where? (different parts of the care chain? Maternity care, childbirth, and aftercare?)
Education, age, and workplace at the moment?
How does it work at your delivery ward?
What can a day look like?

Section 2: The Childbirth Crisis
Are the conditions in place in Stockholm for providing women with safe care today? (if not, what is missing? What is in place? What should be in place?)
What consequences are there for women giving birth? Do you have an example?
What do you think is the reason?
What conditions need to be in place?
Has it changed over time?
Why has it become like this? What are the problems based on?
We have read that the number of midwives per woman giving birth is not lower today than before, despite midwives warning that they are few in the workplace. Why do you think that is the case?
What are the factors that increase the workload?

Consequences for women giving birth
We have read that many midwives believe that the patient's safety is threatened and that women and children are exposed to risks. Does that image reflect your experience? (How? Why?)

Fear and anxiety before childbirth have increased among women (in Stockholm). Is this something you notice in your work? (How can it be expressed?)
Cesarean sections have increased - what do you think it could be due to?
Have you been in a situation where a woman (or child) has been affected? Do you have a concrete example? (Why did it happen that way?)
Have you experienced that you and your colleagues have not been able to give the woman the best possible care? (Why? What were the consequences?)
Have you experienced that there has been a shortage of materials, for example, equipment, beds at birth? (What consequences has it had? Do you have any concrete examples?)
How do you feel that your communication with the women giving birth works? (Is it possible to take into account her will? That you can follow the birth certificate? Why? What are the primary problems?)

Section 3: Solutions
What can the solutions look like? (Suggestions we have encountered are higher salaries, projects such as "my midwife, one midwife per woman giving birth, expand places in the education for midwives. What do you think about these?)

The Government solutions:
SKR (Sweden's municipalities and regions in agreement with the state) has invested only in 2015 and since 2019 to improve care for women in connection with childbirth. They believe that certain areas that need improvement are congenital disabilities, women's ability to participate in decisions about their custody, and the distribution of skills.
How do you see their description of the problem?
Do they focus on the right areas?

They believe that the most important solutions are: good distribution of skills and good leadership. They propose a couple of strategies to achieve this: include the woman and her family, design the care according to the woman and the family's needs and wishes, have a uniform care chain, develop the knowledge (SKR 2019, p.8)
What is your spontaneous reaction when you hear this?
Have they focused on relevant solutions and strategies?
Are the strategies feasible in your workplace? What is needed for them to be that?

Region Stockholm's Plan
Have you found out what Region Stockholm's plan for improved maternity care looks like?

What do you think of the plan?

They have raised the following eight points to improve future maternity care.

1. *Further efforts are needed to strengthen competence and introduce new working methods that provide the conditions for continued safe and secure maternity care that meets the needs of women and children.* ***Working with one midwife per childbirth in the active phase*** *is beneficial for the woman and the progress of childbirth and has been requested by the staff. Start-up: First quarter 2022.*

What do you think about this?
How do you work at the moment? (Do you follow this principle? How long have you been doing it? How was it introduced to you?)
Is it feasible in your workplace? (What is needed to work according to that principle?)

2. ***Workplace rotation*** *- enables employees to have variation in their work and for employees to use all their skills in pregnancy, childbirth, and aftercare. Through rotational service, it is possible to increase the business's flexibility and bridge care transitions in the pregnancy and childbirth process. Start-up: Internal rotation is already underway at some clinics. To enable rotational service between outpatient and inpatient care, a new form of employment needs to be developed. Start-up: First quarter 2022*
What do you think of this point? (Does it meet a need you have? What advantages and disadvantages do you see in working this way?)
Is this way of working possible in your workplace? How do you experience it?

3. ***Increased medical staff for improved flows.*** *Increase the density of doctors in the areas where the doctor's competence is needed, such as in the emergency department, to improve the processes and ensure the availability of neonatologists so that pediatric examinations can be carried out quickly and efficiently for better flows. This does not mean that doctors must perform the midwife's work to meet a greater need for medical competence as childbirth occurs both at an older age and with several medical risk components. Increased efforts from doctors are necessary to ensure sufficient capacity in emergency and emergency lines. Start-up: First quarter 2022*
What do you think about this proposal?
Have you been involved in situations where doctors were not on-site? (Tell me more. Why that situation arises? What were the consequences?)

4. ***Improved processes refers to the entire pregnancy process, between maternity care, childbirth, aftercare, and not local***

processes. An external analysis of maternity care should be carried out in order to further develop maternity care. *The report shall provide a description of successful organizational models and a review of relevant quality measures for maternity care. The inquiry shall consider views from all parts of the care involved in the childbirth process. The material can form the basis for decision-making, governance, and the Region's maternity care development. An essential part of the investigation will be to consider the need for safety and quality for the child, i.e., neonatal care, and quality and security in maternity care for the pregnant woman. Start-up: First quarter 2022*
What do you think about this?
How do you think the care chain works? (Is there a collaboration between the different departments/activities? What does it look like? What would improve it?)

5. ***Clear competence and career models*** *make career steps visible, enable scheduling according to the competence mix, and form the basis for competence development. Start-up: Fourth quarter 2021*
How do you view that proposal?
How do you think scheduling works in your workplace?
Are the right skills in place during the shifts? (How does competence development work? The Stockholm region's plan puts quite a lot of focus on skills development; do you think that is relevant?)
Losing experienced midwives. What does it look like at your work? (was up in the media last fall that older, more experienced midwives retire or change workplace due to the work environment)
The shortage of midwives, how is it in your workplace? (what consequences for women giving birth?)

6. ***Supervision and mentorship*** *facilitate the transition from studies to working life and provide security through structured introduction, mentorship, and strengthened supervision. Start-up: First quarter 2022*
What do you think about this?
How does it work in your workplace with new midwives? (Routines? In practice? How much time is set aside?)
How has it worked in the past?

7. ***Evaluate the application and effect of the working time model in maternity care.*** *Start-up: Second quarter 2022*
Any thoughts on this?
What is the working time model for you today?

8. ***Exchanging tasks*** *- care-related service staff relieves care staff with tasks such as patient-centered cleaning, meal handling, and storage management*

What do you think about this?
Is this something you need? (Are there more areas that are not addressed that need to be relieved?)

Closing questions about the plan
What do you think of the plan? Does it focus on the most critical points?
Do you think it improves the situation for women giving birth?

Section 4: communication routes and management
When Region Stockholm's action plan was produced, did you get to be involved?
Were you involved in the conversation?
Were there meetings between the Region and the union? (How does the union work in your ward? Do you feel that the unions can influence the situation?)

Management and communication channels
- How do you think that communication with your immediate managers and their managers' works.
- Do you know where to turn for improvement suggestions or complaints?
- Have you (or any colleague) done it? Have they listened? (Do you get insight into / can influence? Conversations? Collaborations? With management and politicians?)

Is there something you want to add or something else you want to bring up that I/we have not asked about?
Thanks for the interview. Could we come back if we have any additional questions?

Interview questions Politician

Presentation of us and what we should do:
We are a group of five students at University college Stockholm who, within the framework of our master's program in human rights, investigate how maternity care in Stockholm works and, more specifically, its challenges linked to its consequences for pregnant women. Today, the situation is that "women giving birth" risk not receiving the care they need, and we intend to find out why it does not work as it should and what possible solutions are available.

The interview
*Time: 1-2 hours
*Confidentiality: In addition to this group and our examiners, you will be anonymous. This means that we do not use your name unless you allow it.

*Dictaphone and text: What we are talking about will be written down and recorded. If you wish, we can summarize / you can read through the interview afterward and approve it.
Is it okay?
Feel free to let us know if you need a break!
Do you have any further questions for us before we start the interview?

Section 1: Introduction
Tell us a little about yourself, your background, how you became a politician in Region Stockholm?
What is your role today?
What room do you have to influence maternity care?
How do you think maternity care works today?
Do women giving birth receive safe care?
Is there a childbirth crisis in Stockholm today?

Women's rights
Article 12 in the Women's Convention (CEDAW): Health care:
"1. States Parties shall take all appropriate measures to eliminate discrimination against women in the field of health care to ensure, based on equality of men and women, access to health-care services, including those related to family planning. "2. Notwithstanding the provisions of paragraph 1 of this article, States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation."
Is this being complied with today in Stockholm? How?

The media image in the autumn of 2021 and back to 2017.
Women testify among other things:
* no room at the hospital when they are ready to give birth
* tools are missing during childbirth
* Midwives are missing in the room. Partners must instead help with childbirth
* Fear of giving birth again - (secondary fear of childbirth higher than primary)
What do you think when you hear this?
Why has it become like this?
Have these issues been addressed at the regional level?
Do you know how common it is?
Are there statistics? Ex. on the lack of staffing and what consequences this can and will have for women giving birth?

Midwives testify about:
*benefit examinations are done in the waiting room (SVT)

*Work environment unsustainable
*We can not refer women anywhere
*We have been screaming for several years now we can no longer bear it (resign)
*Managers resign from management responsibility (all four maternity managers at sea) and then resign when they do not receive a response
What do you think when you hear this?
What is the communication between the midwives and the region?
How do the midwives get their voices heard? Channels for communication? Forum?
What is the communication between managers and the region?
Between hospital management and region?
Unions?

Statistics
Midwives flee childbirth: What does the region's plan look like to attract all midwives back? (not only those who resigned last autumn but also the elderly and experienced who changed jobs, etc.)
The work environment - is connected with bm leaving the birth - how does the region think about this? What does the plan look like?
Maternity ruptures 3-4 higher in Stockholm than the rest of the country (National Board of Health and Welfare 2020, p.44?) What does the plan look like to improve these statistics?
Lack of delivery places - almost 1000 women received the answer that they could not enter the hospital when it was time to give birth due to "full everywhere." What is the region's plan to solve this? (929 in 2020, 967 in 2021)
Why is there no plan for this in the "package of measures"?

Regions Stockholm's plan for the future of maternity care - 8 points to improve
We will now go through the points and ask about these:

1. Further efforts are needed to strengthen competence and introduce new working methods that provide the conditions for continued safe and secure maternity care that meets the needs of women and children. Working with one midwife per childbirth in the active phase is beneficial for the woman and the progress of childbirth and has been requested by the staff. Start-up: First quarter 2022.

Do you have anything to add at this point?
0. Workplace rotation - enables employees to have variation in their work and for employees to use all their skills in pregnancy, childbirth, and aftercare. Through rotational service, it is possible to increase the business's flexibility and bridge care transitions in the pregnancy and childbirth process.
What is the idea of this point? Can you develop it?

According to the midwives we interviewed, this point created a lot of anxiety and insecurity. Fear of losing control of their work situation, of being forced to change jobs. What do you have to say to them?
The request from the midwives' side was, e.g., continuity in the care chain; why has it not been addressed?
0. Increased medical staff
The reason for this?
0. Improved processes refer to the entire pregnancy process, between maternity care, childbirth, aftercare, and not local processes. An external analysis of maternity care should be carried out to develop maternity care further. The report shall provide a description of successful organizational models and a review of relevant quality measures for maternity care.
Could you develop this point?
0. Clear competence and career models - which make career steps visible, enable scheduling according to the competence mix, and can form the basis for competence development.
0. Supervision and mentorship facilitate the transition from studies to working life and provide security through structured introduction, mentorship, and strengthened supervision.
Do you have anything to add to these two?
0. Evaluate the application and effect of the working time model in maternity care
Can you develop this?
0. Exchanging tasks - care-related service staff relieves care staff with tasks such as patient-centered cleaning, meal handling, and storage management
Want to tell us more about this point?

How did these points come about?
Were you there?
Who represented the midwives? In the conversations before this "package of measures"?

How / by whom / why this particular person was chosen? (according to the midwives we interviewed, the region chose this midwife, and she did not represent the midwives who resigned and were critical.
What do you think about that?
Do you think this plan will improve the situation for women giving birth in Stockholm?

Why is the salary not mentioned?

In addition to the mentioned plan. Are there other plans to improve maternity care in Stockholm?

Is there something you want to add or something else you want to bring up that I/we have not asked about?

Thanks for the interview. Could we come back if we have any additional questions?

Interview questions - the representative from the Swedish Association of Midwives

Presentation of us and what we should do:
We are a group of five students at University college Stockholm who, within the framework of our master's program in human rights, investigate how maternity care in Stockholm works and, more specifically, its challenges linked to its consequences for pregnant women. Today, the situation is that "women giving birth" risk not receiving the care they need, and we intend to find out why it does not work as it should and what possible solutions are available.

The interview
*Time: 1-2 hours
*Confidentiality: In addition to this group and our examiners, you will be anonymous. This means that we do not use your name unless you allow it.
*Dictaphone and text: What we are talking about will be written down and recorded. If you wish, we can summarize / you can read through the interview afterward and approve it.
Is it okay?
Feel free to let us know if you need a break!
Do you have any further questions for us before we start the interview?

Section 1: Introduction
Tell us a little about yourself, your background, how you became a midwife?
For how long have you been engaged in the Swedish association of midwives, and why?
Education and age?

Section 2: The Childbirth Crisis
Are there conditions for giving women safe care during childbirth? (if not what is missing? What is in place? What should be in place?)
What are the consequences?

What is the cause of the crisis?
Has it changed over time?

Why has it become like this? What are the problems based on?

Section 3: Solutions
What can the solutions look like? (Suggestions we have encountered are higher salaries, projects such as "my midwife, one midwife per woman giving birth, expand places in the education for midwives. What do you think about these?)

The Government solutions:
SKR (Sweden's municipalities and regions in agreement with the state) has made an investment only in 2015 and since 2019 to improve care for women in connection with childbirth. They believe that certain areas that need to be improved are: birth defects, women's ability to participate in decisions about their custody and the distribution of skills.

They believe that the most important solutions are: good distribution of skills and good leadership. They propose a couple of strategies to achieve this: include the woman and her family, design the care according to the woman and the family's needs and wishes, have a uniform care chain, develop the knowledge (SKR 2019, p.8)
What is your spontaneous reaction when you hear this?
Have they focused on relevant solutions and strategies?
Are the strategies feasible? What is needed for them to be that?

Region Stockholm's Plan
Have you found out what Region Stockholm's plan for improved maternity care looks like?
What do you think of the plan?

They have raised the following eight points to improve future maternity care.

1. *Further efforts are needed to strengthen competence and introduce new working methods that provide the conditions for continued safe and secure maternity care that meets the needs of women and children.* ***Working with one midwife per childbirth in the active phase*** *is beneficial for the woman and the progress of childbirth and has been requested by the staff. Start-up: First quarter 2022.*

What do you think about this?
Is it feasible? (What is needed to work according to that principle?)

2. ***Workplace rotation*** *- enables employees to have variation in their work and for employees to use all their skills in pregnancy, childbirth and aftercare. Through rotational service, it is possible to increase the flexibility of the business and to bridge care transitions in the pregnancy and childbirth process. Start-up: Internal rotation is already underway at some clinics. To enable rotational service between outpatient and inpatient care, a new form of employment needs to be developed. Start-up: First quarter 2022*
What do you think of this point? (Does it meet a need you have? What advantages and disadvantages do you see in working this way?)
Is this way of working possible? How do you experience it?

3. ***Increased medical staff for improved flows.*** *Increase the density of doctors in the areas where the doctor's competence is needed, such as in the emergency department to improve the processes and ensure the availability of neonatologists so that pediatric examinations can be carried out quickly and efficiently for better flows. This does not mean that doctors must perform the midwife's work, it is to meet a greater need for medical competence as childbirth takes place both at an older age and with several medical risk components. Increased efforts from doctors are necessary to ensure sufficient capacity in emergency and emergency lines. Start-up: First quarter 2022*
What do you think about this proposal?

4. ***Improved processes, refers to the entire pregnancy process, between maternity care, childbirth, aftercare and not local processes. An external analysis of maternity care should be carried out in order to further develop maternity care.*** *The report shall provide a description of successful organizational models and a review of relevant quality measures for maternity care. The inquiry shall take into account views from all parts of the care that are involved in the childbirth process. The material can form the basis for decision-making, for governance and the development of the region's maternity care. An important part of the investigation will be to consider both the need for safety and quality for the child, i.e. neonatal care, and quality and security in maternity care for the pregnant woman. Start-up: First quarter 2022*
What do you think about this?
How do you think the care chain works? (Is there a collaboration between the different departments / activities? What does it look like? What would improve it?)

5. ***Clear competence and career models*** *- which make career steps visible, enable scheduling according to the competence mix and can form the basis for competence development. Start-up: Fourth quarter 2021*

How do you view that proposal?

How do you think scheduling works in your workplace?

Losing experienced midwives. Is that a problem in the Stockholm region?

6. ***Supervision and mentorship*** *- which facilitates the transition from studies to working life and provides security through structured introduction, mentorship and strengthened supervision. Start-up: First quarter 2022*

What do you think about this?

7. ***Evaluate the application and effect of the working time model in maternity care.*** *Start-up: Second quarter 2022*

Any thoughts on this?

8. ***Exchanging tasks*** *- care-related service staff relieves care staff with tasks such as patient-centered cleaning, meal handling and storage management*

What do you think about this?

Closing questions about the plan

What do you think of the plan? Does it focus on the most important points?

Do you think it improves the situation for women giving birth?

Section 4: communication routes and management

Did you get to be involved when Region Stockholm's action plan was produced?
Were you involved in the conversation?
Were there meetings between the Region and the union? (How does the union work in your ward? Do you feel that the unions can influence the situation?)

Management and communication channels

- How do you think that communication with your immediate managers, and their managers works.
- Do you know where to turn for improvement suggestions or complaints?
- Have you (or any colleague) done it, have they listened? (Do you get insight into / can influence? Conversations? Collaborations? With management and politicians?)

Is there something you want to add or something else you want to bring up that I / we have not asked about?
Thanks for the interview, could we come back if we have any additional questions?

Interview questions Obstetrician

Presentation of us and what we should do:
We are a group of five students at University college Stockholm who, within the framework of our master's program in human rights, investigate how maternity care in Stockholm works and, more specifically, its challenges linked to its consequences for pregnant women. Today, the situation is that "women giving birth" risk not receiving the care they need, and we intend to find out why it does not work as it should and what possible solutions are available.

The interview
*Time: 1-2 hours
*Confidentiality: In addition to this group and our examiners, you will be anonymous. This means that we do not use your name unless you allow it.

*Dictaphone and text: What we are talking about will be written down and recorded. If you wish, we can summarize / you can read through the interview afterward and approve it.
Is it okay?
Feel free to let us know if you need a break!
Do you have any further questions for us before we start the interview?

Section 1: Introduction
Tell us a little about yourself, your background, how you became an obstetrician ?
For how long have you worked as an obstetrician, and where?
Education, role and workplace at the moment?

Section 2: The Childbirth Crisis
Are the conditions in place in Stockholm for providing women with safe care today? (if not what is missing? What conditions need to be in place?
What consequences are there for women giving birth? Do you have an example?
Has it changed over time?
Why has it become like this? What are the problems based on?

Consequences for women giving birth
We have read that many midwives believe that the safety of the patient is threatened and that women and children are exposed to risks. Does that image reflect your experience?
Fear and anxiety before childbirth has increased among women (in Stockholm). Is this something you notice in your work? (How can it be expressed?)
Have you been in a situation where a woman (or child) has been affected, do you have a concrete example?
Have you experienced that there has been a shortage of materials, for example equipment, beds at the birth? (What consequences has it had? Do you have any concrete examples?)
How do you feel that your communication with the women giving birth works? (Is it possible to take into account her will? That you can follow the birth certificate? Why? What are the basic problems?)

Section 4: Management and communication channels
What is the division of responsibilities between midwives and doctors at the birth?
Who creates guidelines? How many are there?

How does the communication between midwives and doctors work?
What are the communication paths between midwives, doctors and managers?
How do you think that communication with your immediate managers works.

How does it work with the region / politicians? Do you have contact with them or does your manager?
How much of midwive's voices can reach politicians? When the crisis arose, it appeared that there was a gap in communication.

Section 3: Solutions
What do you think the future maternity care will look like for it to work optimally? What needs to change? What is needed?
What can the solutions look like?

The Government solutions:
SKR (Sweden's municipalities and regions in agreement with the state) has made an investment only in 2015 and since 2019 to improve care for women in connection with childbirth. They believe that certain areas that need to be improved are: birth defects, women's ability to participate in decisions about their custody and the distribution of skills.
How do you see their description of the problem?
Do they focus on the right areas?

They believe that the most important solutions are: good distribution of skills and good leadership. They propose a couple of strategies to achieve this: include the woman and her family, design the care according to the woman and the family's needs and wishes, have a uniform care chain, develop the knowledge (SKR 2019, p.8)
What is your spontaneous reaction when you hear this?
Have they focused on relevant solutions and strategies?
Are the strategies feasible in your workplace? What is needed for them to be that?

Region Stockholm's Plan
Have you found out what Region Stockholm's plan for improved maternity care looks like?
What do you think of the plan?

They have raised the following eight points to improve future maternity care.

1. *Further efforts are needed to strengthen competence and introduce new working methods that provide the conditions for continued safe and secure maternity care that meets the needs of women and children.* ***Working with one midwife per childbirth in the active phase*** *is beneficial for the woman and the progress of childbirth and has been requested by the staff. Start-up: First quarter 2022.*

What do you think about this?
How do you work at the moment? (Do you follow this principle?)
Is it feasible in your workplace?

2. ***Workplace rotation*** *- enables employees to have variation in their work and for employees to use all their skills in pregnancy, childbirth and aftercare. Through rotational service, it is possible to increase the flexibility of the business and to bridge care transitions in the pregnancy and childbirth process. Start-up: Internal rotation is already underway at some clinics. To enable rotational service between outpatient and inpatient care, a new form of employment needs to be developed. Start-up: First quarter 2022*
What do you think of this point? (Does it meet a need you have?)
Is this way of working possible in your workplace? How do you experience it?

3. ***Increased medical staff for improved flows.*** *Increase the density of doctors in the areas where the doctor's competence is needed, such as in the emergency department to improve the processes and ensure the availability of neonatologists so that pediatric examinations can be carried out quickly and efficiently for better flows. This does not mean that doctors must perform the midwife's work, it is to meet a greater need for medical competence as childbirth takes place both at an older age and with several medical risk components. Increased efforts from doctors are necessary to ensure sufficient capacity in emergency and emergency lines. Start-up: First quarter 2022*
What do you think about this proposal?

4. ***Improved processes, refers to the entire pregnancy process, between maternity care, childbirth, aftercare and not local processes. An external analysis of maternity care should be carried out in order to further develop maternity care.*** *The report shall provide a description of successful organizational models and a review of relevant quality measures for maternity care. The inquiry shall take into account views from all parts of the care that are involved in the childbirth process. The material can form the basis for*

decision-making, for governance and the development of the region's maternity care. An important part of the investigation will be to consider both the need for safety and quality for the child, i.e. neonatal care, and quality and security in maternity care for the pregnant woman. Start-up: First quarter 2022
What do you think about this?
How do you think the care chain works?

5. ***Clear competence and career models*** *- which make career steps visible, enable scheduling according to the competence mix and can form the basis for competence development. Start-up: Fourth quarter 2021*

How do you view that proposal?

How do you think scheduling works in your workplace?

Are the right skills in place during the shifts? (How does competence development work?)

Losing experienced midwives. What does it look like at your work? (was up in the media last fall that older more experienced midwives retire or change workplace due to the work environment)

The shortage of midwives, how is it in your workplace? (what consequences for women giving birth?)

6. ***Supervision and mentorship*** *- which facilitates the transition from studies to working life and provides security through structured introduction, mentorship and strengthened supervision. Start-up: First quarter 2022*

What do you think about this?

How does it work in your workplace with new midwives? (Routines? How much time is set aside?)

7. ***Evaluate the application and effect of the working time model in maternity care.*** *Start-up: Second quarter 2022*

Any thoughts on this?

8. ***Exchanging tasks*** *- care-related service staff relieves care staff with tasks such as patient-centered cleaning, meal handling and storage management*

What do you think about this?

Closing questions about the plan

What do you think of the plan? Does it focus on the most important points?

Do you think it improves the situation for women giving birth?

Did you get to be involved when Region Stockholm's action plan was produced?

Were you involved in the conversation?

Is there something you want to add or something else you want to bring up that we have not asked about?

Thanks for the interview, could we come back if we have any additional questions?