



MIDIRS Search Pack

Search Pack M53

Feminism / gender issues in midwifery and maternity care

Records on feminism and gender issues in midwifery and maternity care. Includes the impact of these issues on workforce, education, breastfeeding and maternal health outcomes.

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M53 - Feminism / gender issues in midwifery and maternity care

(159)

990803-007

Why aren't midwives feminists?. Stephens L (1999), British Journal of Midwifery vol 7, no 8, August 1999, p 476

We are often reminded of the significance of the word midwife meaning 'with woman', so why is it that so many midwives are happy to continue using language which perpetuates gender inequality? It is all part of the acceptance of the midwife to play second fiddle to the largely male discipline of obstetrics. Midwives must improve their support for one another in order to empower the profession. (1 reference) (JAL)

990506-004

Embracing the past, understanding the present, creating the future: feminism and midwifery. Davies D (1999), New Zealand College of Midwives Journal no 20, April 1999, pp 5-10

An exploration of some of the influences, such as medical domination and oppression by race and gender, which have shaped and continue to impact on women and midwives. Only through exposing dominant ideology will we afford ourselves an opportunity to recreate a society in which all members are equal. (15 references) (JAL)

990506-003

Alternatives in maternity care. Hickling R (1999), O & G vol 1, no 2, April 1999, pp 131-134

Australia is dominated by the medical model of maternity care, where pregnancy is treated as a disease and management of labour provides a cure. Alternatives to the medical model are considered, with particular reference to midwifery care, and to the UK's Changing Childbirth. The importance is stressed of meeting women's needs and expectations, rather than simply forcing them to fit in to existing moulds. (17 references) (JAL)

981104-008*

Gender inequalities in nursing careers: research summary. Finlayson LR, Nazroo JY (1998), London: Policy Studies Institute 1998. 8p

Summary of the findings of a study commissioned by the Department of Health which shows that although the minority of nurses and midwives are men, they are significantly more likely to be in senior positions than women. Factors which lead to this inequality are explored and implications for future policies in the National Health Service are discussed. (KL)

980908-035*

Survey of midwives and nurses uncovers major gender inequalities. (1998), RCM Midwives Journal (Supplement) September 1998, p 2

A recent survey of nurses and midwives employed by the NHS in England and Wales (1) shows that men are significantly more likely to progress to higher career grades than women. Four facts which need to be addressed to encourage more equal opportunities are identified. (1) Finlayson LR, Nazroo JY. Gender inequalities in nursing careers. London: Department of Health, 1998. (KL)

980705-033

Male power: a challenge to normal childbirth?. Stephens L (1998), British Journal of Midwifery vol 6, no 7, July 1998, pp 450-453

In the UK, recent government papers have attempted to give choice, continuity and control over childbirth choices to women. Maternity care has been dominated by the medical establishment, which in turn is dominated by men, with midwives and women seen in the traditional female powerless role of the caring nurturing woman. Midwives and women will need education at a more fundamental level to effect attitude changes if women are to be empowered through childbirth. (Author)

980306-018

What is gender? Feminist theory and the sociology of human reproduction. Annandale E, Clark J (1996), Sociology of

Feminist theory and research on the sociology of human reproduction have historically been bound together as each has developed. Yet recently sociologists of reproduction and 'women's health' have lost sight of core debates in feminist theory. They still tend to work with the assumption that feminism is an internally coherent body of thought, despite the emergence of significant internal divisions since the mid-1980s. In this paper we evaluate the challenge that feminist post-structuralism poses to prior conceptualisations of gender in the context of reproductive health through a critique of sociological work in this area from the 1970s and 1980s. We conclude with a critical exploration of the new insights that might emerge from a post-structuralist 'deconstruction' of gender in the context of human reproduction. (Author)

971022-008

The 'F' factor: feminism forsaken?. McLoughlin A (1997), Nurse Education Today vol 17, no 2, April 1997, pp 111-114

This article discusses the link between feminist theory and midwifery practice. By incorporating concepts of feminist theory within this article, it is appropriate therefore that it should be written in the first person. I hope to illustrate why feminist theory is especially relevant to midwifery education and practice, and shall briefly highlight some of the feminist ideologies which may best fit the midwifery model. I also discuss a system of nursing education based upon feminist principles and values, devised by Hedin & Donovan in 1989, and its potential for adaptation to midwifery education. (Author)

971003-013

Potential and problems: the value of feminist approaches to research. Draper J (1997), British Journal of Midwifery vol 5, no 10, October 1997, pp 597-600

As a predominantly female profession caring for women and their families, midwives are arguably in an ideal position to execute feminist research. The term, however, is often poorly understood and shrouded with misconceptions. This article seeks to clarify understanding by exploring the meaning of feminist research, describing its distinguishing characteristics, and examining both the potential and the problems associated with this approach. (Author)

970825-013

Feminist theory and the sociology of childbirth: a response to Allen Annandale and Judith Clark. Campbell R, Porter S (1997), Sociology of Health & Illness vol 19, no 3, June 1997, pp 348-358

Response to an article (1) which critiques modern sociological approaches to reproductive health. In this article the authors defend modern feminist perspectives and actions in relation to women's health during childbirth. (41 references) 1. Annandale E, Clark J. What is gender? Feminist theory and the sociology of human reproduction. Sociology of Health and Illness, vol 18, no 1, 1996, pp 17-44. (KL)

970720-009

Is birth a feminist issue?. Buckley S (1997), AIMS Australia Quarterly Journal vol 5, no 1, March 1997, pp 14-15

The author argues for the need of a feminist perspective on childbirth. (KL)

961003-014

A midwifery course case study - research in progress. Barnes M (1996), Australian College of Midwives Incorporated Journal vol 9, no 3, September 1996, pp 30-31

The author reports research in progress which involves a case study of a tertiary midwifery course. The theoretical framework for the study draws on feminist and poststructuralist theory. The research project concentrates on the following concerns: the processes in the course which facilitate or impede student learning and development; the extent to which a shift in educational paradigm and a woman-centred curriculum, might influence student attitudes and practices within the midwifery context and the extent to which a shift in educational paradigm and a woman-centred focus in the curriculum may facilitate change in childbirth and midwifery in the long term. (SJH)

960728-023

Professionalisation of midwifery in Britain: a feminist paradigm of practice?. Sandall J (1996), In: The art and science of midwifery gives birth to a better future. Proceedings of the International Confederation of Midwives 24th Triennial Congress, 26-31 May 1996, Oslo. London: International Confederation of Midwives 1996, pp 198-201

Introduction: 'Changing Childbirth', the report of the Expert Maternity Group has emphasised the importance of woman centred care and set out 10 key indicators of success to be achieved within 5 years. Continuity of midwifery care provided by community based group practices/teams of midwives has been advocated as one way to achieve these targets. This has resulted in a radical change in the way that midwives are expected to work and midwifery in Britain could be seen to be going through a process of professionalisation. Aims 1) To examine the impact of such a professionalisation process on occupational boundaries, midwifery practice and the organisation of midwifery work. 2) To examine the impact of providing continuity of care on midwives' professional and personal lives. Design: Stage I Multiple case study in three sites chosen to represent variations in the organisation and practice of innovative and traditional models of maternity care. Data collection included observation, interviews with key informants and midwives, and collection of policy and audit data. The data generated has been analysed using HyperResearch, a computerised qualitative data analysis package. Stage 2 Postal survey of a random 5% sample of the Royal College of Midwives (1100) analysed by SPSS. Results: The results from the case studies and survey are integrated and two themes will be examined in this paper. Firstly, the impact of the changes for midwifery as an occupation and secondly, whether midwives are creating a new paradigm of professional practice which challenges the traditional patriarchal model of a 'profession'. (Author)

960726-008

Birth plans reconsidered: the health - development link. Tirpak EM (1996), In: The art and science of midwifery gives birth to a better future. Proceedings of the International Confederation of Midwives 24th Triennial Congress, 26-31 May 1996, Oslo. London: International Confederation of Midwives 1996, pp 257-259

Although historically childbirth has been the domain of women the increased medicalization of the birthing experience has wrested the control from women. To prevent this phenomenon from continuing, midwives must develop and implement strategies to return the normal birthing process to the domain of women. One such strategy is socialising women to develop birth plans. This instrument encourages and empowers women to prepare for birth, assume control of the process, select the attendants, examine the potential decisions that may be encountered, and realistically prepare to participate in the decision making process. Midwives who require women to develop birth plans will foster inquiry, education, preparation, and valuable dialogue between provider and client. The ethical, feminist, and legal perspectives will be discussed and models will be presented. (Author)

960711-081

Gender-bias discrimination. Wheatley B (1996), Midwives vol 109, no 1301, June 1996, pp 168

The author, a male nurse working in labour and delivery in the United States, has received over \$50,000 in out-of-court settlements for discrimination on the basis of gender. He describes some of his experiences and would like to hear from male nurses in the UK who have had similar problems. (SJH)

960711-027

The power of language. Shirley KE, Mander R (1996), British Journal of Midwifery vol 4, no 6, June 1996, pp 298-300, 317-318

Language controls professional woman and inter-professional relationships, creating and maintaining power differentials. This article describes the relationship of language to power/knowledge. Words, when silent and controlling, maintain the asymmetry of power. Feminism and consumerism aim to correct the imbalance. (Author)

960523-002

Gossip, stories and friendship: confidentiality in midwifery practice. James S (1995), Nursing Ethics vol 2, no 4, December 1995, pp 295-302

Women often seek midwifery care as an alternative to the maternity services that are readily available within the insured health care system in Alberta. Some aspects of community-based, primary care midwifery in Alberta that characterize this alternative are the use of story-telling as a form of knowledge, the development of social connections among women seeking midwifery care, and nonauthoritarian relationships between midwives and women. In this paper, the concept of confidentiality, as it relates to these aspects of midwifery practice, is explored, using traditional, caring and feminist models of ethics. (Author)

960317-015

An international human right to reproductive health care: toward definition and accountability. Rahman A, Pine RN (1995), Health and Human Rights vol 1, no 4, 1995, pp 401-427

Exploration of the extent to which international human rights law requires governments to provide reproductive health information and services, supplying affordable, accessible, quality reproductive health care.

960307-047*

Breastfeeding is a feminist issue: women, work and breastfeeding. Wellstart International, Nurture (1994), Washington, DC: Wellstart International Bethesda, MD: Nurture 1994. 2 pages

Brief summary of issues of feminism and the status of women surrounding their right to breastfeed. Guidelines for a Mother-friendly workplace are given. (KL)

960115-122

Towards a gender analysis of breastfeeding. Bates C (1996), British Journal of Midwifery vol 4, no 1, January 1996, pp 5-6

The author discusses the need to investigate sexuality and gender as an important, but neglected, part of the reasons why more women choose not to initiate or continue with breastfeeding.

951212-002

Bonding theory - tying mothers in knots? A critical review of the application of a theory to nursing. Billings JR (1995), Journal of Clinical Nursing vol 4, no 4, July 1995, pp 207-211

Creation and application of theory in nursing/midwifery practice: While nurses and midwives have begun to create their own theories, it is not unusual for theories from other fields to be accepted and integrated into midwifery practice and become regarded as indisputable fact. This has and may still happen, with little or no critical analysis of the research, its methodology or the ideas that underpinned it in the first place. Over twenty years ago, two American paediatricians began publishing the results of their work on what became known as bonding theory. Klaus and Kennell's (1) limited and flawed research with a very small group of mothers and babies (only 28) was originally based on animal studies, in particular goats. Goat mothers, it seems, will reject their young even if separated for a very brief period following birth. Shortcomings aside, bonding theory was accepted by health professionals. This widespread acceptance somehow validated and elevated the theory into fact. Consequently, intranatal and postnatal care in western institutional practice was transformed. Routine separation of mother and baby at birth ceased and mothers were 'allowed' early contact with their newborn. Soon rooming-in became the norm as health professionals saw the benefits of this practice. Mothers, meanwhile, were expected to welcome these 'humane initiatives' in what was a highly medicalised era in the history of childbirth. (2) The theory became the expert doctrine of the day, with women being advised that early bonding was essential to the development of 'good' mother/child relationships. (3) However, all was not well; women in a Swiss hospital where the practice of early contact and rooming-in was rigidly imposed suffered from unhappiness, fatigue and despair. Feminist perspectives: From a feminist perspective, the bonding theory is hardly a user friendly approach. It appears to consolidate the patriarchal view that a woman's responsibility is not only childbearing but childrearing. If the mother/child bond is faulty then a maladjusted individual is the result. (4) Feminist sociologists may consider the theory pseudoscientific, but because it was represented as such a powerful tool, it made the theory appear natural and therefore not changeable. It legitimizes sex role divisions and places women firmly in the home. Such social engineering adds weight to the importance of the nuclear family while legitimizing the continued oppression of women. It also devalues the role of fathers to one of support only. (5) Conclusion: The contribution that bonding theory has made to the care of mother and baby should not be entirely discounted. What this review attempted to illustrate is the importance of critical review and analysis of any theory before it finds its way into practice. References: 1. Klaus MH, Kennell JH. Maternal-infant bonding. St. Louis: Mosby, 1976. 2. Schaffer HR. Mothering. London: Fontana/Open Books, 1977. 3. Romito P. The humanizing of childbirth: the response of medical institutions to women's demands for change. Midwifery, vol 2, 1981 pp 135-140. 4. Bowlby J. Attachment and loss. Vol 1: Attachment. London: Hogarth Press, 1969. 5. Meerabeau L. Images of fatherhood in antenatal literature: 1. Health Visitor, vol 60, no 3, Mar 1987, pp 79-81. (Abstract written for MIDIRS by Lynne List, senior midwifery lecturer)

951121-004*

Feminism, breasts and breast-feeding. Carter P (1995), Basingstoke: Macmillan Press Ltd 1995. 266p

I think breasts are fascinating. Take nipples, for example. We all have them - and yet nothing tends to make the average Western adult quite so cringingly squeamish as the sight of a nipple just going quietly about its daily business. And then out of these disturbing little bumps squirts breastmilk, a fluid most of us as adults have never even seen, let alone tasted. Can this thin, watery, bluish liquid really be good for babies? It's not even as sweet-tasting as that

creamy powder you can get free at the clinic. Hmm. So why don't women breastfeed? Carter's book is part of a feminist-inspired literature currently addressing this perennial question through an examination of wider social, cultural, economic and political factors - such as our discomfort with public nipples. Working within a post-structuralist feminist perspective, Carter offers a discussion that is both sensitive and academic. For example, she provides a careful and thoughtful exploration of sexuality in the context of breasts and breastfeeding. Undermining simplistic contrasts such as that between 'breast' and 'bottle-feeders', Carter provides thought-provoking analyses of the many contradictions and paradoxes that contemporary breastfeeding engenders. Perhaps the biggest paradox of all is that giving one's baby an expensive and inferior substitute for breastmilk can sometimes be a positive strategy of empowerment, transferring at least some of the burden of nurturing away from the hardpressed mother and sharing it out amongst others. In contrast to, for example, Gabrielle Palmer's lively and vigorous book *The politics of breastfeeding* (Pandora, 1993), Carter's is at times heavy going. It is well-researched and comprehensively-referenced and, in addition to the theoretical analysis, Carter has interviewed 30 women in Newcastle (26 white and 4 from India or Pakistan) who had their first baby between 1920 and 1980. Unfortunately, nowhere in the book does she discuss the exact methodology of the research, and one has to nose out meagre fragments of information on the research process scattered around the book. Aside from this surprising omission, the book is well-presented, scholarly rather than an easy read, but very worthwhile as a sustained critical analysis of a complex and vital field of study. (Reviewed for MIDIRS by Sarah Goode, doctoral researcher)

951111-055

Post-natal depression: the relevance of sociological approaches. Thurtle V (1995), *Journal of Advanced Nursing* vol 22, no 3, September 1995, pp 416-424

Post-natal depression is much discussed yet definitions and approaches are not homogenous, neither in terms of the cause of post-partum mental ill health, its treatment or how further research in the area should proceed. This paper seeks to examine post-natal 'upsets' and to consider the different explanations that have been and could be made of post-partum mental ill health. The paper reviews the dominant biomedical and psychological approaches, evaluating their ability to explain post-natal mental illness. The writer believes biological and psychological approaches are in the ascendance but seeks to demonstrate that they do not present a full picture. Sociological approaches drawing upon stress, labelling and feminist models are examined, exploring new ways of looking at post-natal illness. The paper concludes that biological and psychological approaches do not provide complete explanations and a multidisciplinary approach is needed. Most significantly the woman's own perception of post-natal ill health is largely absent from the literature. The need for an approach using ethnographic methods is highlighted. (Author)

951101-010

Feminism and homebirth. Horey D (1995), *Homebirth Australia Newsletter* no 40, August 1995, pp 15-18

Discussion of the influences of feminism on women's rights to home birth. (KL)

951017-195

A global witch-hunt. Wagner M (1995), *The Lancet* vol 346, no 8981, 14 October 1995, pp 1020-1022

Discussion of the role and status of the midwife in the struggle for control of the maternity services, with the underlying issues of money, power, gender and choice. Litigation and malpractice proceedings are being used as a weapon to erode the professional standing of midwives. (KL)

951007-008*

Reproducing the womb: images of childbirth in science, feminist theory, and literature.. Adams AE (1994), New York: Cornell University 1994. 267p

Received for review.

950905-011

Ways of knowing in midwifery. Davis D (1995), *Australian College of Midwives Incorporated Journal* vol 8, no 3, September 1995, pp 30-32

Scientific ways of knowing dominate our society today and this has major ramifications for midwifery. This article outlines the historical development and cultural understanding of ways of knowing in our society today. It is suggested that the patriarchal societies in which our ways of knowing have developed have emphasised scientific ways of knowing while other ways such as intuition and embodied knowledge received little acknowledgement. This

article then goes on to explore these other ways of knowing, discusses their implications for midwifery care and suggests that to embrace many and varied ways of knowing is to more fully realise our abilities and potential as midwives. (Author)

950705-009*

Breastfeeding is a feminist issue: women have a right to choose breastfeeding. Wellstart International, Nurture Centre to Prevent Childhood Malnutrition, World Alliance for Breastfeeding Action (WABA) (1995), Washington: Wellstart International [1995]. 6p

Brochure summarising some of the barriers to women choosing breastfeeding, women's rights in the choice of infant feeding method, and the advantages of breastfeeding for both mother and infant. (KL)

950627-064

Comfortable men, uncomfortable women. Murphy-Black T (1995), In: Murphy-Black T ed. Issues in midwifery. Edinburgh: Churchill Livingstone 1995, pp 275-297

Discussion of some of the issues surrounding the role and status of women within the maternity services - both the health professionals and the pregnant women. (KL)

950627-002

Respect for women's choice. Friend JR (1995), Maternal and Child Health Journal vol 20, no 6, June 1995, pp 202-204, 206

Over the last few years there has been a marked change in the relationship between doctors and their patients. Gone are the days when beneficence evident since the days of Hippocrates, dominated our conduct and if left to preside today leads to the charge of paternalism. The rising star is respect for the person or bodily integrity (sometimes loosely termed autonomy). This requires the skills of communicating appropriate information in a form digestible to the patient - the other player in a level partnership. Acknowledging that the doctor has his own autonomy, yet it is the patient who makes the choices that determines the action for her (and her foetus if relevant). 'Self determination need not be either combative or submissive, but founded in relationships of mutuality of respect.' The correct process of communication and imparting information, also known as empathy, establishes a relationship with the patient where shared decisions can be made leading to shared responsibilities. Experience shows that not only is this process, which gives respect for women's choices, more satisfactory and healthy for the patient but it is also more satisfying for the doctor who values the relationships which are an intimate part of being an obstetrician and gynaecologist.

(Author)

950619-120

Network for positive care in obstetrics and gynaecology. Kitzinger S (1995), Birth vol 22, no 2, June 1995, p 116

Brief introduction to the work of the Network for Positive Care in Obstetrics and Gynaecology, a UK based multidisciplinary group of feminists working in midwifery, psychology, psychiatry, law, general practice, obstetrics and gynaecology, and sociology who are working towards improving maternity care for women. (KL)

950613-045*

Gender and the professional predicament in nursing. Davies C (1995), Buckingham: Open University Press 1995. 220p

The premise this book is based on is that we live in a world which is 'gendered male' and that this pervades all organisations and policy-making. While this is not a 'light' read, it is a well written, scholarly text and the language that is used is clear. It will help nurses, past or present, to reflect on their training, their role and their position in the hierarchy. (Reviewed by Nicky Symes, community midwife.)

950401-136

Network for positive care. Kitzinger S (1995), Midwives vol 108, no 1286, March 1995, pp 90-91

The Network for Positive Care in Obstetrics and Gynaecology is a multi-disciplinary group of feminists working in psychology, psychiatry, midwifery, law, general practice, obstetrics, gynaecology and sociology. The aim is to reduce obstetric procedures of questionable value and to form a support network. They are compiling a database of feminist researchers in reproductive health. (KL)

941210-028

Access to library services. Davies P (1994), Health Visitor vol 67, no 12, December 1994, p 433

To develop as a profession, nursing needs a credible academic education base. Yet access to library facilities is limited. Patrick Davies suggests a political motive: the deliberate holding back of a predominantly female profession. (Author)

941203-047

Midwifery: a career for women?. Allison J, Pascall G (1994), In: Evetts J ed. Women and career: themes and issues in advanced industrial societies. London: Longman 1994, pp 203-217

Discussion of midwifery as a career for women, their role and professional status. (KL)

941020-015

Jobs for the boys: male domination within nursing and midwifery. Edwards G (1994), British Journal of Midwifery vol 2, no 10, October 1994, pp 504-506

The Western world mainly operates within a patriarchal system which serves to subordinate women and results in social and education inequality, based purely on gender. This has implications for the status of women both socially and educationally and may be detrimental to the professional aspirations of women compared with those of men. I would suggest that the traditional female role is one that has learnt gender socialisation and will influence professional development. (Author)

941018-067

Explaining excessive rates of cesareans and other childbirth interventions: contributions from contemporary theories of gender and psychosocial development. LoCicero AK (1993), Social Science and Medicine vol 37, no 10, November 1993, pp 1261-1269

The current rate of cesarean sections in the U.S. is too high. Numerous mothers and babies are being placed at unnecessary risk of medical, behavioral and psychological complications. The problem has proven resistant to solution on a large scale, despite serious efforts on the part of a variety of individuals and groups. This paper considers reports on the interactions between obstetricians and mothers in labor in light of findings and theory in the areas of gender and psychosocial development. Examination of processes and standards of care in light of these findings and theory leads to the conclusion that the present model of obstetric services is consistent with a masculine style, and offers far less than optimal care for women. In fact, the gender-inappropriate elements of the model itself probably contribute to the excessive rates of interventions in labor. Social, political and historical factors are seen to support the obstetric model as is, leading to some pessimism about the possibility that the model could be modified sufficiently without major social change. The obstetric model is compared briefly with the more gender appropriate model of care provided by midwives. (Author)

941018-026

Is breastfeeding a feminist issue?. Fellow C (1994), New Zealand College of Midwives Journal no 11, October 1994, pp 22-25

No abstract available.

940921-027*

Breastfeeding: a feminist issue. World Alliance for Breastfeeding Action (1994), Penang, Malaysia: World Alliance for Breastfeeding Action (WABA) [1994?]. 4p

Summary of reasons why women's groups should support campaigns to promote breastfeeding. (KL)

940825-004*

Motherhood and modernity: an investigation into the rational dimension of mothering. Everingham C (1994), Buckingham: Open University Press 1994. 156p

No abstract available.

940803-008

Does physician pregnancy affect the management of miscarriage patients?. Duiker SS, Green L (1994), The Female Patient vol 19, no 6, June 1994, pp 83-84, 86-88

The question of whether female physicians are better qualified to care for female patients is not a new one. Similarly,

it can be asked whether a physician's current or past pregnancy experiences can have an effect on their management of patients who miscarry. And if so, is the impact primarily positive or negative? The pilot study presented here looks at this issue and at whether some compromise of physician objectivity may at times be beneficial. (Author)

940724-031

A feminist perspective on the study of home birth: application of a midwifery care framework. Bortin S, Alzugaray M, Dowd J, et al (1994), *Journal of Nurse-Midwifery* vol 39, no 3, May/June 1994, pp 142-149

Studies of home birth have compared it with hospital birth, with a focus on perinatal outcomes. Although such studies have established the safety of midwife-attended home births, this narrow view does not include all of the concepts represented in a proposed midwifery care framework derived from the philosophy of the American College of Nurse-Midwives. In this essay, the authors recommend the employment of qualitative research with a feminist perspective as a method to elucidate other concepts in the midwifery care framework, and suggest that future home birth research should explore the recognition and validation of the woman and her experiences, appropriate use of technology, and the influences of the birth environment. (Author)

940722-037

Breastfeeding and the women's movement: perceptions and practices. (1994), BFHI [Baby Friendly Hospital Initiative] News May 1994, pp 2-3

A collection of short articles on the promotion of breastfeeding in Bangladesh, Ghana, Japan, Norway, Philippines, and the United States of America. (KL)

940322-013

Vertical transmission in HIV infection/AIDS: a feminist perspective. Pinch WJ (1993), *Journal of Advanced Nursing* vol 19, no 1, January 1993, pp 36-44

HIV infection and AIDS create a unique dilemma for women in their potential for vertical transmission of these conditions. Selected feminist perspectives in ontology, epistemology, and axiology are reviewed to illuminate possible social, cultural, and political circumstances of these women. Drawing both on these perspectives and various sources of data about women with HIV/AIDS, some implications for nursing complete this discussion. (Author)

940112-017

Prenatal diagnosis and sex selection in 19 nations. Wertz DC, Fletcher JC (1993), *Social Science and Medicine* vol 37, no 11, December 1993, pp 1359-1366

As part of a study of ethics and human genetics in 19 nations, we surveyed attitudes of 71 medical geneticists in 4 developing nations (Brazil, Greece, India and Turkey), and 611 geneticists in 15 developed nations, using anonymous questionnaires. Overall, 52% in India, 30% in Brazil, 29% in Greece, and 20% in Turkey would perform prenatal diagnosis to select a male fetus for a couple with 4 daughters and no sons. Sex selection is the major use of prenatal diagnosis in India. The majority of the U.S.A. (62%) and Hungary (60%) would also do sex selection or refer. We discuss possible means of preventing sex selection while avoiding medical paternalism and promoting the autonomy of women. (Author)

931122-007

Nurse-midwifery as it reinforces and transforms the American ideology of gendered roles. Vosler AT, Burst HV (1993), *Journal of Nurse-Midwifery* vol 38, no 5, September/October 1993, pp 293-300

Nurse-midwives both reinforce and subvert American constructs of gender roles. They do this both within the context of their relationship with the medical establishment and within the context of their relationship with women and families they serve. The authors explore this paradox through an examination of American society's historical and present constructs of gender role, the ways in which the medical profession has absorbed and prescribed these constructs, the effect of these constructs on medical and nurse-midwifery childbirth management of care, and, within the contextual framework thus established, the role of nurse-midwives in reinforcing and subverting traditional gender role constructs. Finally, the impact of this paradox on the provision of nurse-midwifery care to women and families is explored. (Author)

931016-020

Reproductive technologies and court-ordered obstetrical interventions: the need for a feminist voice in nursing.

Hagell EI (1993), *Health Care for Women International* vol 14, no 1, January-February 1993, pp 77-86

As the developments in and increasing use of reproductive technologies continue and as court-ordered obstetrical interventions occur, questions regarding nurses' roles in these developments become increasingly important. In this article, I identify a number of issues surrounding these developments in reproductive health care and examine how nurses have dealt with these issues. I also attempt to encourage nurses to examine and discuss these developments from a critical, woman-centered perspective. A review of articles from the nursing literature (1985-1990) grouped together on the basis of the concerns identified, approach used, or subjects studied is presented. The majority of researchers view reproductive technologies as either acceptable or as requiring legislation and control. Few researchers in nursing have identified concerns about reproductive technologies or court-ordered obstetrical interventions from a feminist perspective. It is crucial that questions be raised about the underlying assumptions of these measures and about their implications for women as patients and for nurses as practitioners, women, and promoters of health. Otherwise, nurses may be supporting technologies and other measures that harm women and nursing itself. (Author)

930906-083

Feminist criticism of prenatal diagnosis: a response. Wertz DC, Fletcher JC (1993), *Clinical Obstetrics and Gynecology* vol 36, no 3, September 1993, pp 541-567

No abstract available.

930906-081

Provider biases and choices: the role of gender. Wertz DC (1993), *Clinical Obstetrics and Gynecology* vol 36, no 3, September 1993, pp 521-531

No abstract available.

930212-007

A feminist perspective on postnatal depression. Jebali C (1993), *Health Visitor* vol 66, no 2, February 1993, pp 59-60

Many women will experience postnatal depression (PND) after the birth of their child and will receive treatment which is generally medically prescribed. The definitions and treatment of PND to a great extent remain in the hands of the medical profession: an area dominated by men, where PND is usually perceived as an individual illness. Christine Jebali explores from the alternative viewpoint of feminist theory PND as a condition exclusive to women. (Author)

2025-13273

The Impact of Gender Equality-Based Learning Programs on Character Building in Undergraduate Midwifery Students:

A Cross-Sectional Study in DKI Jakarta. Ichwan EY, Supradewi I, Sari GN, et al (2025), *Women, Midwives and Midwifery* vol 5, no 1, February 2025, pp 1-10

Background: Gender inequality significantly affects women's reproductive health and overall well-being. Midwives play a crucial role in addressing these issues through gender-equitable practices.

Purpose: This study aims to evaluate the effectiveness of gender equality-based learning programs in shaping the character of undergraduate midwifery students.

Methods: A cross-sectional study involving 298 midwifery students in DKI Jakarta was conducted. Data collection used sequential sampling and a validated questionnaire distributed via Google Forms. Logistic regression analyzed associations between students' characteristics and gender-equitable character.

Results: Students with poor gender knowledge were 30 times more likely to exhibit gender-inequity characters (OR=30.18, 95% CI=11.40-79.91). Negative attitudes towards gender concepts increased the risk of gender-inequity characters by 44% (OR=1.44, 95% CI=1.05-1.98). A learning environment lacking gender equity doubled this risk (OR=2.83, 95% CI=1.98-4.04).

Conclusion: Incorporating gender-equitable concepts and practices into midwifery curricula is essential for developing gender-equitable midwives. This integration could reduce gender disparities and improve health outcomes. (© by

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Full URL: <https://doi.org/10.36749/wmm.5.1.1-10.2025>

2025-12331

The Impact of The Strengthened Gender Sensitive Midwifery Care on Pregnant Women's Knowledge, Attitude and Acceptance of Midwifery Care. Maryanah M, Supradewi I, Barkinah T (2021), *Women, Midwives and Midwifery* vol 1, no 3, October 2021, pp 39-46

Background: Gender sensitive midwifery services are needed by women, especially during pregnancy, childbirth and puerperium. Gender inequality in society has a negative impact on the acceptance of antenatal care for mothers. Gender sensitive midwifery care is needed to improve maternal health status during pregnancy.

Purpose: This study aims to determine the impact of gender sensitive midwifery care on pregnant women's knowledge, attitude and acceptance of midwifery care

Method: This was a quantitative experimental study with pre-posttest for 1 group design. The subjects of this study were pregnant women who received midwifery care from 40 midwives, totaling 200 pregnant women obtained through purposive sampling in 2 provinces. Paired t-test was used to measure the difference in the results of the variables measured in pregnant women before and after 3 months of the intervention given by midwives.

Results: Pregnant women's knowledge, attitude and acceptance of midwifery care increased after they received intervention from midwives. The mean difference (MD) for knowledge was -2.07 ($r=0.864$), p value=0.000 in DKI Jakarta, and MD=-2.70 ($r=0.467$), p value= 0.000 in South Kalimantan. For attitude in DKI Jakarta, MD=-1.03 ($r= 0.99$, p value=0.000) and in South Kalimantan the mean difference (MD) was -2.8 ($r= 0.445$, p value=0.000). For acceptance of gender sensitive midwifery care in DKI Jakarta MD=-2.71 ($r= 0.67$, p value= 0.000) and South Kalimantan MD=-4.5 ($r=$ p value=0.000).

Conclusion: There was a difference and increase in score for knowledge, attitude and acceptance of midwifery care with gender sensitivity in pregnant women before and after the intervention was given to the midwives in the two provinces. It takes great attention from midwives to ensure that all pregnant women receive a gender sensitive midwifery care. (© Authors retain copyright of their work while granting the journal non-exclusive publishing rights upon acceptance. Authors ensure that their work is original, has not been published elsewhere, and is not under consideration by another journal.)

Full URL: <https://doi.org/10.36749/wmm.1.3.39-46.2021>

2025-12296

'Practising outside of the box, whilst within the system': A feminist narrative inquiry of NHS midwives supporting and facilitating women's alternative physiological birthing choices. Feeley CL (2019), August 2019. 308 pages, 110 pages

This thesis presents the findings of an original study that explored NHS midwives practice of facilitating women's alternative physiological birthing choices - defined in this study as 'birth choices that go outside of local/national maternity guidelines or when women decline recommended treatment of care, in the pursuit of a physiological birth'. The premise for this research relates to dominant sociocultural-political discourses of medicalisation, technocratic, risk-averse and institutionalisation that has shaped childbirth practices in the UK. For midwives working in the NHS, sociocultural-political and institutional constraints can negatively impact their ability to provide care to women making alternative birth choices. A meta-ethnography was carried out, highlighting a paucity of literature in this area. Therefore, the aim of this study was to generate practice-based knowledge to answer the broad research question: 'what are the processes, experiences, and sociocultural-political influences upon NHS midwives' who self-define as facilitative of women's alternative birthing choices'.

Underpinned by a feminist pragmatist theoretical framework, a narrative methodology was used to conduct this study. Professional stories of practice were collected via self-written narratives and interviews to understand the processes of facilitation (the what, how, why), their experiences of carrying out facilitative actions (subjective sense-making),

and what sociocultural-political factors influenced their practice. Through purposive and snowball sampling, a diverse sample of 45 NHS midwives from across the UK was recruited. A sequential, pluralistic narrative approach to data analysis was carried out, and a theoretical model was developed using the whole dataset.

The findings were subjected to three levels of analysis. First, 'Narratives of Doing' highlight how and what midwives did to facilitate women's alternative choices. The sub-themes reflect the temporal nature of a wide range of actions/activities involved when caring for women making alternative birthing decisions. The second analysis; 'Narratives of Experience' - highlighted the midwives polarised experiences captured as 'stories of distress', 'stories of transition,' and 'stories of fulfilment'. For the third level of analysis, a theoretical model of 'stigmatised to normalised practice' was developed using notions of stigma/normal, deviance/positive deviance. A six-domain model was developed that accounted for the midwives sociocultural-political working contexts; micro, meso, and macro. The implications of this research related to a number of identified constraints, protective factors, and enabling factors for midwifery practice. Key barriers included negative organisational cultures that restricted both midwives' and women's autonomy. Disparities between the midwives' philosophy and their workplace culture were highlighted as a key stressor and barrier to delivering woman-centred care. Protective factors related to the benefits of working in supportive, like-minded teams that mitigated against their wider stressful working environments. Facilitating factors included positive organisational cultures characterised by strong leadership where midwives were trusted and women's autonomy was supported. Therefore, this study has captured what has been achieved, and what can be achieved within NHS institutional settings. Through the identification of both challenges and facilitators, the findings can be used to provide maternity professionals and services with insights of how they too can facilitate women's alternative birthing choices. (© Author)

Full URL: <https://knowledge.lancashire.ac.uk/id/eprint/30680/>

2025-11867

Advancing gender equity in gynecology and obstetrics: perspectives from the German workforce. Neuhold J, von Versen-Höyneck F (2025), Archives of Gynecology and Obstetrics vol 312, no 5, November 2025, pp 1621 - 1629

Purpose

Despite the high proportion of women in medical education and clinical training, female physicians remain underrepresented in leadership and academic positions in Gynecology and Obstetrics in Germany. This study investigates structural and cultural factors contributing to this disparity and highlights trends in workforce composition and recognition in the field.

Methods

We conducted a descriptive, cross-sectional analysis using publicly available data from the German Federal Statistical Office and the German Medical Association (2004–2024), as well as database from the German Society for Gynecology and Obstetrics (DGGG).

Results

In 2023, women comprised 73% of gynecologists in Germany. Female representation declined with advancing career stage. In 2024, 82% of resident physicians at German university hospitals were women, while they held 26% of department head positions in Gynecology and Obstetrics. Female membership in the DGGG reached 75%, with 40% on the executive board. In 2022, 65% of major awards went to men, while women received most poster and lecture prizes (61%) at the biannual conference.

Conclusions

While gender diversity in the clinical workforce has improved, systemic inequities persist in academic and leadership domains. Addressing these requires structural reforms, increased transparency in recruitment and promotion processes, and targeted programs supporting women's professional advancement. Enhanced visibility, mentorship, and inclusive institutional policies are essential to ensure gender-equitable development in the specialty. (© 2025, The Author(s))

Full URL: <https://doi.org/10.1007/s00404-025-08167-4>

2025-01873

New technologies for safe practice and training during pregnancy: a gynecologist and forensic pathologist perspective narrative review. Capasso E, Marisei M, Aquino CI, et al (2025), Frontiers in Surgery 17 January 2025, online

This paper investigates the intersection of gender health equity within two distinct medical residency programs: obstetrics & gynecology and forensic pathology. It specifically addresses the unique challenges that young female

residents encounter during pregnancy, emphasizing the Italian regulatory frameworks and recommendations pertinent to both fields. The online search for this narrative review was based on keywords such as: “medicine” AND “education” AND “pregnancy” on the main online scientific database along with “metaverse” AND “education” AND “pregnancy”. The analysis reveals the heightened risks faced by female medical doctors in surgical and forensic environments, underlining the need for targeted support. Additionally, this study explores the perceived potential of augmented reality (AR) and the metaverse as innovative solutions to mitigate biological risks, thereby enabling pregnant surgeons to maintain effective practice during this critical period. The findings obtained from a literature review aim to contribute to ongoing discussions about improving gender equity in medical training and practice, regarding the surgical and forensic field where the temporary stopping period may result in a different surgical learning curve compared to that of male colleagues. (Author)

Full URL: <https://doi.org/10.3389/fsurg.2025.1513832>

2025-00249

Principal investigator gender and clinical trial success: analysis of over 3000 obstetrics and gynecology trials. Steinberg JR, DiTosto JD, Turner BE, et al (2025), *AJOG Global Reports* vol 5, no 1, February 2025, 100427

BACKGROUND

In obstetrics and gynecology (OBGYN) research, gender disparities permeate through leadership, funding, promotion, mentorship, publishing, compensation, and publicity. Few studies have investigated OBGYN clinical trial leadership as it relates to investigator gender. Thus, we undertook an investigation of principal investigator (PI) gender and clinical trial success.

OBJECTIVE

To characterize United States (US) OBGYN clinical trials by PI gender and analyze the association between PI gender and features of trial success.

STUDY DESIGN

This is a cross-sectional study of all US-based obstetric and gynecologic clinical trials registered on ClinicalTrials.gov (2007–2020). We examined associations between PI gender (ie, led by women, men, or both) and four primary outcomes that capture clinical trial success: early discontinuation (ie, absence of early discontinuation is a feature of success), reporting of complete trials to ClinicalTrials.gov, publication in a peer-reviewed journal, and clinical trial participant diversity (reporting of racial and ethnic diversity data and representation of diverse cohorts). Multivariable analyses controlled for subspecialty, multiple PI status, source of funding, primary purpose, phase, number of arms, enrollment, year of trial registration, blinding, oversight by a Data Safety Monitoring Committee, and number of study sites. Sensitivity analysis accounted for individual PI who led multiple clinical trials. Univariable and multivariable logistic regression analysis models were applied. We conducted multiple imputation for missing covariable data. There were no missing exposure or outcome data in the final cohort.

RESULTS

We reviewed 12,635 clinical trials focused on OBGYN. Of the 4342 trials with at least one site in the US, PI names were available for 3087 trials (71.1%). The majority of OBGYN trials were women-led (women 1696, 54.9%; men 1272, 41.2%, coled 119, 3.9%). A greater proportion of obstetrics trials (617, 60.0%) were women-led than gynecology trials (1079, 52.4%). Family planning had the greatest proportion of women-led trials (145, 74.7%), whereas reproductive endocrinology and infertility had the lowest (50, 30.9%). A greater proportion of industry-funded trials were led by men (123, 64.7%). In adjusted analysis, women-led trials had lower odds of early discontinuation (men-led reference; women-led adjusted odds ratio [aOR] 0.58, 95% confidence interval [CI] 0.44, 0.77). Women-led trials reported results less frequently (men-led reference; women-led aOR 0.52, CI 0.40–0.62) but no significant difference was seen in publication (men-led reference; women-led aOR 1.02, CI 0.57, 1.81). Women-led trials had greater odds of reporting race and ethnicity participant data (men-led reference; aOR 1.87, CI 1.27–2.47) but there was no difference in cohort diversity by PI gender.

CONCLUSION

Women investigators lead approximately half of OBGYN clinical trials in the US. Women-led trials discontinue less frequently, publish at similar rates, and include data on diversity more frequently than men-led trials. Women are as successful as men in conducting clinical trials and, in certain domains, more successful. Our findings place the impetus on the OBGYN professional ecosystem to support women's academic careers. (Author)

Full URL: <https://doi.org/10.1016/j.xagr.2024.100427>

2024-14013

Perspectives and needs of neonatology division directors regarding gender equity. Machut KZ, Owens L, Gadek L, et al (2025), *Journal of Perinatology* vol 45, no 5, May 2025, pp 689–694

Gender inequities in pediatrics are extensively documented despite women predominating the workforce. As a landscape assessment of gender equity in university-based neonatology divisions in the United States, we collected gender equity measures from academic neonatology division directors; 83% (n = 106) participated. The majority recognized addressing gender inequity was a middle-to-top priority, though they reported minimal gender inequities in their division. Most division directors are men and a higher proportion of full professors are men, but they reported minimal differences in time to promotion, leadership positions, and awards. Half of centers analyzed compensation by gender; all reported no gender difference. The existence of gender-equity-promoting strategies was variable and uncertain by many directors. They reported lack of bandwidth, personnel, and resources as the largest barriers to tracking and addressing gender inequities. These perceived minimal gender inequities diverge from published objective data and highlight the need to track and report metrics accurately and systematically. (Author)

2024-10816

Midwifery Students' Experiences of Bias in the Clinical Setting: Prevalence, Types, and Impact. Loomis H, Hackley B, Alexander-Delpech P, et al (2025), *Journal of Midwifery & Women's Health* vol 70, no 1, January/February 2025, pp 50-60

Introduction

Exposure to bias in clinical learning environments may undermine students' confidence, cause emotional harm, impede learning, and potentially delay graduation. However, little is known about the prevalence of bias experienced by midwifery students in the United States. This cross-sectional, descriptive study aimed to quantify clinical midwifery students' experiences of bias based on 7 self-identified characteristics (gender identity, race or ethnicity, body size, age, sexual orientation, religion, and occupational background). Additionally, this research explored the impact of bias on student well-being, learning, and professional commitment.

Methods

The survey consisted of 39 items addressing (1) prevalence and types of bias, (2) emotional impact and influence on clinical learning, (3) ways students coped, (4) whether anyone spoke up at the time bias occurred, (5) whether students reported bias to faculty, and (6) impact of bias on commitment to midwifery. The survey was distributed to midwifery students and recent graduates in 2022 via American College of Nurse-Midwives email discussion lists and social media. Participants were eligible if they were in a clinical rotation in an Accreditation Commission for Midwifery Education-accredited midwifery program between 2019 and 2022.

Results

Surveys were returned by 383 participants, with 301 meeting inclusion criteria. Most participants (66.5%) reported personally experiencing or witnessing bias against at least 1 of 7 personal characteristics. The most commonly reported biases were related to gender, occupational background, age, and race or ethnicity. Only half of the participants reported these occurrences to someone with academic authority, and nearly a third considered withdrawing from their educational programs.

Discussion

In this study bias was common and significantly impacted students. These results underscore the need for creative and bold interventions at personal, educational, and institutional levels to prevent and mitigate bias. Safeguarding clinical learning environments will enable students to thrive, graduate with confidence and competence, and thereby contribute to the diversification and strengthening of the midwifery profession. (Author)

Full URL: <https://doi.org/10.1111/jmwh.13680>

2024-07861

The impact of gender on the self-confidence of practical and surgical skills among OBGYN residents: a trinational survey. Meister T, Foessleitner P, Breuer G, et al (2024), *Archives of Gynecology and Obstetrics* vol 309, no 6, June 2024, pp 2669–2679

Introduction

Gender disparities exist in the OBGYN discipline. This study investigates, for the first time, whether gender impacts on the confidence of practical and surgical skills among OBGYN residents, and of being prepared to work as a specialist.

Methods

The gynecological societies of Austria, Germany, and Switzerland established a web-based survey of 30 questions that was sent to all registered OBGYN members-in-training from August to September 2020. Data collection, controlling and analysis were performed by the Swiss Federal Institute of Technology in Zurich (ETH).

Results

A total of 422 participants took part in the survey, of which 375 (88.9%) were female, 46 (10.9%) were male, and one (0.2%) was divers. The diverse participant was excluded from further analyses. The gender distribution was comparable in all three countries. Multiple regression analyses showed that gender is an independent variable significantly impacting on the confidence levels in performing standard gynaecological ($p = 0.03$) and obstetric ($p < 0.001$) procedures. Similarly, the feeling of confidence in being prepared for working as a specialist in a clinic showed to be gender-dependent ($p < 0.001$), however, not the feeling of being prepared for working as specialist in an outpatient setting ($p = 0.37$). The “female factor” significantly decreases the confidence rating for surgical and practical skills and for working in a hospital. Covariates including year of training, country, workload, receiving regular feedback, and implemented simulation training were included in all analyses.

Discussion

Improvements of residency programs to promote female doctors to overcome factors reducing their confidence in their own OBGYN skills are highly warranted. (Author)

Full URL: <https://doi.org/10.1007/s00404-023-07202-6>

2024-06094

Utilizing maternal healthcare services: are female-headed households faring poorly?. Ghatak S, Dutta M (2024), BMC Pregnancy and Childbirth vol 24, no 299, April 2024

Background

Utilization of maternal healthcare services has a direct bearing on maternal mortality but is contingent on a wide range of socioeconomic factors, including the sex of the household head. This paper studies the role of the sex of the household head in the utilization of maternal healthcare services in India using data from the National Family Health Survey-V (2019–2021).

Methods

The outcome variable of this study is maternal healthcare service utilization. To that end, we consider three types of maternal healthcare services: antenatal care, skilled birth assistance, and postnatal care to measure the utilization of maternal healthcare service utilization. The explanatory variable is the sex of the household head and we control for specific characteristics at the individual level, household-head level, household level and spouse level. We then incorporate a bivariate logistic regression on the variables of interest.

Results

24.25% of women from male-headed households have complete utilization of maternal healthcare services while this proportion for women from female-headed households stands at 22.39%. The results from the bivariate logistic regression confirm the significant impact that the sex of the household head has on the utilization of maternal healthcare services in India. It is observed that women from female-headed households in India are 19% (AOR, 0.81; 95% CI: 0.63,1.03) less likely to utilize these services than those from male-headed households. Moreover with higher levels of education, there is a 25% (AOR, 1.25; 95% CI: 1.08,1.44) greater likelihood of utilizing maternal healthcare services. Residence in urban areas, improved wealth quintiles and access to healthcare facilities significantly increases the chances of maternal healthcare utilization. The interaction term between the sex of the household head and the wealth quintile the household belongs to, (AOR, 1.39; 95% CI: 1.02, 1.89) shows that the utilization of maternal healthcare services improves when the wealth quintile of the household improves.

Conclusion

The results throw light on the fact that the added expenditure on maternal healthcare services exacerbates the existing financial burden for the economically vulnerable female-headed households. This necessitates the concentration of research and policy attention to alleviate these households from the sexual and reproductive health distresses. (Author)

Full URL: <https://doi.org/10.1186/s12884-024-06445-8>

2024-04282

The gender debate: is midwifery education ‘women’s work’?. Chenery-Morris S, Divers J (2024), British Journal of Midwifery vol 32, no 4, April 2024, pp 202–207

This series of six articles is inspired by themes arising from the Royal College of Midwives State of Midwifery

Education report. The series explores the current landscape and challenges in educating the future midwifery workforce, particularly those that pertain to the higher education workforce. This second article highlights some of the inequalities experienced by the majority female midwifery education workforce and their impact, exploring how these inequalities are symptomatic of many of the inequalities women experience more generally within patriarchal structures. The article examines if midwifery education is 'women's work', and how this can work to impede progression in leadership, research and scholarship for midwifery academics. How midwifery curricula can influence the future academic workforce in dismantling inequality is also considered. (Author)

2024-02865

Racial, Ethnic, and Gender Composition Among Neonatal Nurse Practitioner Faculty Ranks. Bell T, Newberry DM (2024), *The Journal of Perinatal and Neonatal Nursing* vol 38, no 2, April/June 2024, pp 178-183

Background:

Despite increases in nursing faculty diversity, representation is lacking in positions of higher faculty rank. Challenges for minority faculty include decreased awareness of promotion standards, less mentoring, and increased stress from being the sole representative of their respective underrepresented population.

Methods:

The purpose of this study was to determine the racial, ethnic, and gender composition of neonatal nurse practitioner (NNP) faculty in the United States. A nonexperimental survey was sent to all accredited NNP programs to describe demographics of NNP faculty in the United State.

Results:

Of the 128 survey participants, 84% self-identified as White. Forty-eight of the participants ranked Professor or Associate professor were White. In contrast, all other races only had 8 respondents who were of the higher faculty ranks. There were only 2 male participants; one identified as full professor and one as associate professor.

Conclusion:

Limitations of this project included a small sample size leading to an inability to determine statistical significance. Previous evidence supports decreased diversity in higher faculty rank in other healthcare providers and the results of this study add to that body of literature. Barriers to increased diversification need to be rectified to ensure health equity to all patients. (Author)

2024-00838

Gender gap—Gender-specific development in the field of obstetrics and gynecology in Germany in the last 20 years.

Hertling S, Kaiser M, Schleussner E, et al (2023), *Frontiers in Medicine* 7 December 2023, online

Background: Gender Gap refers to differences between men and women in terms of access to medical education, career development, and leadership positions in medical practice and research. Although women now make up most medical school graduates in many countries, they are often underrepresented in higher positions.

Objective: The aim of this study is therefore to analyze the gender-specific development in the field of Obstetrics and Gynecology in Germany over the past 20 years and to survey the current status quo.

Materials and methods: An narrative review was carried out on the development of female graduates of human medicine, the proportion of women in contract medical care and clinical care, as well as the gender-specific evaluation of obtaining a gynecological/obstetric additional qualification. habilitation figures in the field of Obstetrics and Gynecology were evaluated about gender distribution. All data were received from federal institutes.

Results: A total of 46.7% (n = 95,234) of all inpatient doctors were female. A total of 46.7% (n = 95,234) of the physicians in hospitals were female. A total of 46% (1,832/3,958) were the portion of females as assistant physicians, 39.8% (n = 45,551) as specialists, 35.3% (n = 18789) as senior physicians, 25.1% (n = 2394) as first senior physicians and 25% (n = 10) as chief physicians in hospital. A total of 64.6% (n = 3958) of the physicians in Obstetrics and Gynecology were female. A total of 46% (1,832/3,958) were the portion of females as assistant physicians, 64.6% (n = 3958) as specialists, 65.0% (n = 1919) as senior physicians, 26.4% (n = 207) first senior physicians and 25% (n = 10) as chief physicians in Obstetrics and Gynecology.

Discussion: The problem with the gender gap in medicine, does not seem to be access to teaching or starting a

residency. But in the functions with increasing responsibility and management functions, e.g., as senior physicians, women are already rarely seen. In Obstetrics and Gynecology, too, there is a shortage of women in leading positions, despite the relatively high numbers, for example as senior physicians. Factors like maternity and establishing a family are points mentioned therefore, but also stereotypes seem to be considerable facts.

Conclusion: However, it is important to recognize the need for more women in higher positions in medicine and actively work to encourage more women to choose a career in medicine. (Author)

Full URL: <https://doi.org/10.3389/fmed.2023.1207388>

2024-00606

Excluding Male Trainees in Obstetrics and Gynecology: Why We Do It and Why It's Wrong. Collins SA (2024), International Urogynecology Journal vol 35, no 1, January 2024, pp 31 - 34

This article explores the current landscape of clinical education in obstetrics and gynecology for medical students, residents, and fellows who identify as male. Academic, clinical instruction should be inclusive for the betterment of the training experience for all, but most importantly, for the betterment of women's health. (Author)

2023-04677

Significant deficiency in mentorship amongst female neonatologists in the United States: a descriptive national survey by women in neonatology. Leeman KT, Gray M, Dammann C, et al (2023), Journal of Perinatology vol 43, no 4, April 2023, pp 526–528

A brief communication regarding the landscape and gender gaps in mentorship amongst neonatologists in the United States. (AS)

2023-03338

Gender-inclusive research instructions in author submission guidelines: results of a cross-sectional study of obstetrics and gynecology journals. Dunn MC, Rosenfeld EB, Ananth CV, et al (2023), American Journal of Obstetrics & Gynecology MFM vol 5, no 6, June 2023, 100911

Background

People with marginalized gender identities, including people with transgender and gender-expansive identities, have been historically excluded from research. Professional societies recommend the use of inclusive language in research, but it is uncertain how many obstetrics and gynecology journals mandate the use of gender inclusive research practices in their author guidelines.

Objective

To evaluate the proportion of “inclusive” journals with specific instructions about gender inclusive research practices in their author submission guidelines, and to compare these journals to “non-inclusive” journals based on publisher, country of origin, and several metrics of research influence. Another objective was to qualitatively evaluate the components of inclusive research in author submission guidelines.

Methods

We performed a cross-sectional study of all obstetrics and gynecology journals in the Journal Citation Reports, a scientometric resource, in April 2022. One journal was indexed twice (due to a name change), and only the journal with a 2020 Journal Impact Factor was included. Author submission guidelines were reviewed by 2 independent reviewers to identify inclusive versus non-inclusive journals based on whether journals had gender inclusive research instructions. Journal characteristics, including publisher, country of origin, impact metrics (e.g., Journal Impact Factor), normalized metrics (e.g., Journal Citation Indicator), and source metrics (e.g., number of citable items), were evaluated for all journals. Median (interquartile range [IQR]) and median difference between inclusive versus non-inclusive journals with bootstrapped 95% confidence interval were calculated for journals with 2020 Journal Impact Factors. We also thematically compared inclusive research instructions to identify trends.

Results

Author submission guidelines were reviewed for all 121 active obstetrics and gynecology journals indexed in Journal Citation Reports. Overall, 41 (33.9%) journals were inclusive, and 34 (41.0%) journals with 2020 Journal Impact Factor were inclusive. Most inclusive journals were English language publications and originated in the United States and Europe. In an analysis of journals with a 2020 Journal Impact Factor, inclusive journals had higher median Journal Impact Factor (3.4 [IQR 2.2, 4.3] versus 2.5, [IQR 1.9, 3.0] median difference 0.9, 95% confidence interval (CI) 0.2, 1.7) and median 5-year Journal Impact Factor (3.6, [IQR 2.8, 4.3] versus 2.6 [IQR 2.1, 3.2; median difference 0.9, 95% CI 0.3, 1.6) compared to non-inclusive journals. Inclusive journals had higher normalized metrics, including median 2020

Journal Citation Indicator (1.1, IQR 0.7, 1.3 versus 0.8, IQR 0.6, 1.0; median difference 0.3, 95% CI 0.1, 0.5) and median normalized Eigenfactor (1.4, IQR 0.7, 2.2 versus 0.7, IQR 0.4, 1.5; median difference 0.8, 95% CI 0.2, 1.5). Inclusive journals also had higher source metrics, including more citable items, total items, and Open Access Gold subscriptions. The qualitative analysis of gender inclusive research instructions revealed that most inclusive journals recommend that researchers use gender-neutral language and provide specific examples of inclusive language.

Conclusions

Fewer than half of obstetrics and gynecology journals with 2020 Journal Impact Factor have gender inclusive research practices in their author submission guidelines. The study underscores the urgent need for a majority of obstetrics and gynecology journals to update their author submission guidelines to include specific instructions about gender inclusive research practices. (Author)

Full URL: <https://doi.org/10.1016/j.ajogmf.2023.100911>

2023-00563

Recruitment and Selection: Establishing Representation of LGBTQIA+ and Inclusivity Standards at the Very Onset of Entering the Midwifery Profession. Griffiths E (2023), *The Practising Midwife* vol 26, no 1, January 2023, pp 8-13

This article is a follow up to Samantha Meegan's "Finding the Future Midwife: How the revised Standards of Proficiencies for Midwives Support Pre-registration Midwifery Programme Admissions Processes", published in the November 2022 issue of *The Practising Midwife*. (Author)

2022-06071

Navigating midwifery solidarity: A feminist participatory action research framework. Buchanan K, Newnham E, Geraghty S, et al (2023), *Women and Birth: Journal of the Australian College of Midwives* vol 36, no 1, February 2023, pp e169-e174

Background

A core aspect of midwifery philosophy is the optimisation of normal physiology; however, this has been challenged as a radical idea in the medicalisation of birth. Research has demonstrated the benefits of midwifery in improving outcomes for both mothers and babies. The understanding of midwifery benefits fails to reach wider sociocultural contexts as births become more medicalised. Midwifery research requires an action arm, to help translate theory to practice and mobilise midwives in solidarity with women towards action and change.

Aim

The aim of this article is to describe a Feminist Participatory Action Research (FPAR) by establishing the philosophical underpinnings, theory and methodology with an exemplar.

Methods

FPAR has two distinct yet intertwined parts, a research arm and an action arm. The study was conducted using FPAR, and collaboration with nine women, who led transformative action within their community. The exemplar details the use of the FPAR framework.

Findings

A FPAR framework was developed through this research to guide researchers aiming to use the FPAR design. The framework details four steps: 1. Create, 2. Collaborate, 3. Consider, and 4. Change. The iterative FPAR cycles were shown in this study to centre women in the research and guide the community research group towards transformative action.

Conclusion

FPAR is shown in this project to assist midwifery researchers to realise solidarity and provides support for other midwifery researchers in applying feminist theory and participatory methodologies to bring about transformation within their research. (Author)

2022-04836

Trans and non-binary experiences of maternity services. Survey findings, report and recommendations. LGBT Foundation (2022), 63 pages. January 2022

Report from the Improving Trans Experiences of Maternity Services (ITEMS) project, a collaborative research project led by the LGBT Foundation, which sheds light on the experiences, insights and needs of trans men and non-binary people who have accessed perinatal services. Finds multiple areas where trans and non-binary birth parents are receiving inadequate care, before, during and after the birth of their babies. (CI)

Full URL: <https://dxfy8lrzbpwv.cloudfront.net/Files/97ecdae-833d-4ea5-a891-c59f0ea429fb/ITEMS%2520report%2520final.pdf>

2022-04767

The Inequity Inbox: A Model for Addressing Bias in the Clinical Environment. Lagon EP, Mitchell C, Bryant AC, et al (2022), American Journal of Obstetrics & Gynecology MFM vol 4, no 5, September 2022, 100666

The impact of racism, sexism, and bias on patient care and provider wellbeing is receiving increasing attention. Most institutions utilize safety reporting systems to record instances of discrimination and identify opportunities for improvement in patient care and workplace culture. However, such systems may not capture events that staff do not feel safe reporting without an option to submit anonymously. We describe our experience developing a multicenter anonymous online reporting system for staff and students that have experienced or witnessed microaggressions, bias, or unequal treatment. (Author)

2021-08554

Gender equality and pay equity for midwives. International Confederation of Midwives (2021), The Hague, The Netherlands: International Confederation of Midwives 2021. 4 pages

International Confederation of Midwives (ICM) position statement on pay equity and gender equality for midwives.

ICM encourages member associations to work towards funding models that recognise pay parity principles and eradicate gender inequality in the midwifery profession and maternity services. This document was adopted at Virtual Congress in 2021. (LDO)

Full URL: https://www.internationalmidwives.org/assets/files/statement-files/2021/09/ps2021_en_gender-equality-and-pay-equity-for-midwives.pdf

2021-05093

“We at least say we are equal”: Gender equality and class in healthcare professionals’ discursive framing of migrant mothers. Símonardóttir S, Rúðólfssdóttir AG, Gottfreðsdóttir H (2021), Social Science and Medicine vol 281, July 2021, 114089

In the last few decades, the demography of Iceland has become increasingly diverse with an immigrant population similar to that of the other Nordic countries. Women comprise almost half of all international migrants and many of those female migrants require maternity care in their host countries. While some literature describes how migrant women experience the healthcare provisions of their host countries, less is known about the experience of providing the service, from the perspective of the healthcare practitioners. In this study we adopt a social constructionist perspective to explore the discourses of knowledge healthcare professionals in Iceland draw on in their discussion of prenatal and postpartum healthcare in Iceland. Interviews were conducted with 16 healthcare professionals with extensive experience of providing maternity care to migrant women to understand how they construct and make sense of the needs and behaviour of migrant women seeking maternity care. Our findings suggest that some healthcare professionals subject migrant women to normative professional discourses of parenting, without considering how those ideals are tailored to white, middle class women. Migrant mothers and pregnant women are thus excluded from the middle-class mothering norms that are ascribed to Icelandic women. Our findings also highlight how national identity, such as being part of a gender equal society and the image of Iceland as a classless society, influences how healthcare professionals view migrant women. This underscores the importance of cultural reflexivity, and policies and scholarship where an intersectional understanding of gender, class and migrant worker status is at the forefront. (Author)

2021-04552

Cultivating Awareness of Sexual and Gender Diversity in a Midwifery Curriculum. Arias T, McArdle J, Rayment Jones H, et al (2021), Midwifery vol 101, October 2021, 103050

Abstract

Objective: To explore the perspectives of student midwives, midwifery educationalists and midwifery clinicians from and connected to one University in order to identify strategies to enhance awareness of sexual and gender diversity in a pre- registration midwifery curriculum.

Design: A mixed method study including an online survey and a series of focus groups

Setting: One University in London

Participants: 47 survey respondents and 16 focus group participants

Findings: Two Inductive themes were developed from the data analysis: Practising Open Mindedness and Cultivating Openness and four sub themes; Making Assumptions, Developing self- awareness, Challenge and Discomfort and Safe

spaces. Participants proposed learning strategies that they thought would facilitate cultivating openness and open mindedness. (Author)

2021-03844

Alarm sounded over global shortage of midwifery and neonatal workforce. Ford S (2021), Nursing Times 5 May 2021

There is a global shortage of 900,000 midwives, with the gap between rich and poor nations' workforce numbers set to increase, according to a landmark United Nations report. (Author)

Full URL: <https://www.nursingtimes.net/news/policies-and-guidance/alarm-sounded-over-global-shortage-of-midwifery-and-neonatal-workforce-05-05-2021/>

2021-03061

The State of the World's Midwifery 2021. United Nations Population Fund, International Confederation of Midwives, World Health Organization (2021), New York: UNFPA May 2021. 80 pages

The State of the World's Midwifery (SoWMy) 2021 builds on previous reports in the SoWMy series and represents an unprecedented effort to document the whole world's Sexual, Reproductive, Maternal, Newborn and Adolescent Health (SRMNAH) workforce, with a particular focus on midwives. It calls for urgent investment in midwives to enable them to fulfil their potential to contribute towards universal health coverage (UHC) and the Sustainable Development Goals (SDG) agenda. (Author, edited)

Full URL: <https://www.unfpa.org/publications/sowmy-2021>

2021-02128

Midwifery and gender discrimination in Ontario, Canada. Besana J (2021), The Student Midwife vol 4, no 2, April 2021, p 17

This four-part series explores the joys and challenges of being an independent midwife (IM). In Ontario, midwives are self-employed, independent contractors paid by the Provincial Government's Ministry of Health (MOH). They are publicly insured and provide free, accessible care to residents. In this issue of The Student Midwife, Joanna Besana discusses how gender discrimination affects midwives in Ontario. (Author)

2021-00633

The relationship between inequitable gender norms and provider attitudes and quality of care in maternal health services in Rwanda: a mixed methods study. Doyle K, Kazimbaya S, Levitov R (2021), BMC Pregnancy and Childbirth vol 21, no 156, 22 February 2021

Background

Rwanda has made great progress in improving reproductive, maternal, and newborn health (RMNH) care; however, barriers to ensuring timely and full RMNH service utilization persist, including women's limited decision-making power and poor-quality care. This study sought to better understand whether and how gender and power dynamics between providers and clients affect their perceptions and experiences of quality care during antenatal care, labor and childbirth.

Methods

This mixed methods study included a self-administered survey with 151 RMNH providers with questions on attitudes about gender roles, RMNH care, provider-client relations, labor and childbirth, which took place between January to February 2018. Two separate factor analyses were conducted on provider responses to create a Gender Attitudes Scale and an RMNH Quality of Care Scale. Three focus group discussions (FGDs) conducted in February 2019 with RMNH providers, female and male clients, explored attitudes about gender norms, provision and quality of RMNH care, provider-client interactions and power dynamics, and men's involvement. Data were analyzed thematically.

Results

Inequitable gender norms and attitudes – among both RMNH care providers and clients – impact the quality of RMNH care. The qualitative results illustrate how gender norms and attitudes influence the provision of care and provider-client interactions, in addition to the impact of men's involvement on the quality of care. Complementing this finding, the survey found a relationship between health providers' gender attitudes and their attitudes towards quality RMNH care: gender equitable attitudes were associated with greater support for respectful, quality RMNH care.

Conclusions

Our findings suggest that gender attitudes and power dynamics between providers and their clients, and between female clients and their partners, can negatively impact the utilization and provision of quality RMNH care. There is a need for capacity building efforts to challenge health providers' inequitable gender attitudes and practices and equip them to be aware of gender and power dynamics between themselves and their clients. These efforts can be made alongside community interventions to transform harmful gender norms, including those that increase women's agency and autonomy over their bodies and their health care, promote uptake of health services, and improve couple power dynamics.

Full URL: <https://doi.org/10.1186/s12884-021-03592-0>

20201124-28*

Quality and women's satisfaction with maternal referral practices in sub-Saharan African low and lower-middle

income countries: a systematic review. Ameyaw EK, Njue C, Tran NT, et al (2020), BMC Pregnancy and Childbirth vol 20, no 682, 11 November 2020

Background

sub-Saharan African Low and Lower-Middle Income Countries (sSA LLMICs) have the highest burden of maternal and perinatal morbidity and mortality in the world. Timely and appropriate maternal referral to a suitable health facility is an indicator of effective health systems. In this systematic review we aimed to identify which referral practices are delivered according to accepted standards for pregnant women and newborns in sSA LLMICs by competent healthcare providers in line with the needs of pregnant women.

Methods

Six electronic databases were systematically searched for primary data studies (2009-2018) in English reporting on maternal referral practices and their effectiveness. We conducted a content analysis guided by a framework for assessing the quality of maternal referral. Quality referral was defined as: timely identification of signal functions, established guidelines or standards, adequate documentation, staff accompaniment and prompt care by competent healthcare providers in the receiving facility.

Results

Seventeen articles were included in the study. Most studies were quantitative (n = 11). Two studies reported that women were dissatisfied due to delays in referral processes that affected their health. Most articles (10) reported that women were not accompanied to higher levels of care, delays in referral processes, transport challenges and poor referral documentation. Some healthcare providers administered essential drugs such as misoprostol prior to referral.

Conclusions

Efforts to improve maternal health in LLMICs should aim to enhance maternity care providers' ability to identify conditions that demand referral. Low cost transport is needed to mitigate barriers of referral. To ensure quality maternal referral, district level health managers should be trained and equipped with the skills needed to monitor and evaluate referral documentation, including quality and efficiency of maternal referrals.

Trial registration

Systematic review registration: PROSPERO registration CRD42018114261. (Author)

Full URL: <https://doi.org/10.1186/s12884-020-03339-3>

20200710-22*

Subversive acts and everyday midwifery: Feminism in content and context. Hawke M (2021), Women and Birth: Journal of the Australian College of Midwives vol 34, no 1, February 2021, pp e92-e96

Background

Midwives are often at the forefront of political campaigns for women's empowerment, overtly advocating for women's rights and reproductive justice. However, midwives can also be found engaging in inadvertent activism on a daily basis within routine care. When casting a feminist lens over both the content and context of midwifery practice in Australia, subversive acts and opportunities for feminist reform can be found.

Aim

To interrogate the significance of feminism in midwifery practice, identifying feminist successes and further opportunities for implementation including: analysis of the Midwifery Standards for Practice; the primary tenets of woman-centred care; the content versus context of midwifery in Australia; and feminist opportunities for enhanced practice. This paper will discuss the importance of feminism in midwifery practice and its significance in informing optimal midwifery care.

Discussion

Incorporating women's voice and respecting women's bodies and agency in the delivery of care is a fundamental component of midwifery practice. However, while the content of midwifery practice is innately feminist in its

emphasis on woman-centred care, it will be argued that the context of birthing in Australia is not. The resultant effect is the emergence of victim blaming in maternity care and the construction of an archetypal 'good birthing woman'.

Implications and recommendations

Moving away from the myth of the 'good birthing woman' and the act of victim blaming, midwifery could instead direct its focus towards challenging the rigid systems and structures within which midwives implement care. By further embracing feminist principles midwives will ensure a truly woman-centred future. (Author)

Full URL: <https://doi.org/10.1016/j.wombi.2020.05.013>

20200327-16*

Gender inequality in early initiation of breastfeeding in Bangladesh: a trend analysis. Sen KK, Mallick TS, Bari W (2020), International Breastfeeding Journal vol 15, no 18, 16 March 2020

Background

Early initiation of breastfeeding within 1 hour after birth is essential for newborns, because it reduces risk of neonatal mortality and hypothermia to a great extent and also helps in preventing the long-term chronic diseases and in increasing energy and immunity to newborn. In order to reach the 'very good state' of timely or early initiation of breastfeeding recommended by WHO, Bangladesh needs to increase the current rate of 51.24 to 100%. An attempt has been made in this study to examine how the early breastfeeding practice changes among male and female children with time controlling the factors associated with this practice.

Methods

Data from last four consecutive Bangladesh Demographic and Health Surveys (BDHS) have been used in the study. The participants were included whose child born within the last 5 years preceding the surveys of 2004, 2007 and 2011, and within the last 3 years preceding the survey of 2014 in the study and the respective selected participants were 5145, 4765, 7099 and 4370. To conduct the trend analysis, the descriptive statistics of selected variables along with prevalence of early initiation of breastfeeding have been computed by different years and a multiple logistic regression model has been fitted to the pooled dataset of 2004-2014 considering survey years as time.

Results

Rate of early initiation of breastfeeding increased as time progressed and it was faster for female child compared to male child. For example, female children were significantly 10 and 6% less likely to be initiated early than their counterparts in 2004 and 2007, respectively; whereas after 2007 both male and female children were equally treated for breastfeeding practice. It was also found that rate of early initiation significantly increased for one unit increased in survey year and this increasing rate was higher for female child compared to male child. For example, for one unit of increased in survey year, the early initiation of breastfeeding increased by 60% for male child and by 67% for female child. Besides, survey time, gender, education of parents, wanted index child, mode of delivery, antenatal care visits, wealth index, exposure to media and division were found to have potential influence on early initiation of breastfeeding.

Conclusion

Demographic and health surveys conducted in Bangladesh since 2011 have shown no evidence of gender discrimination regarding timely initiation of breastfeeding. In order to achieve the target rate of early initiation of breastfeeding recommended by WHO, it requires to take effective intervention regarding maternal and child health education. (Author)

Full URL: <https://doi.org/10.1186/s13006-020-00259-y>

20200320-5*

'You see, we women, we can't talk, we can't have an opinion'. The coloniality of gender and childbirth practices in Wixárika indigenous families. Gamlin JB (2020), Social Science and Medicine vol 252, May 2020, 112912

How women make decisions about care-seeking during pregnancy and childbirth, is a key determinant of maternal and child health (MCH) outcomes. Indigenous communities continue to display the highest levels of maternal and infant mortality in Mexico, a fact often accounted for by reference to inadequate access to quality services. A growing body of research has identified gender inequality as a major determinant of MCH, although this has rarely been situated historically in the context of major social and epistemological shifts, that occurred under colonialism.

I used a feminist ethnography to understand the structural determinants of Indigenous maternal health. I drew on research about the colonial and post-colonial origins of ethnic and gender inequality in Mexico and specifically the Wixárika Indigenous region, in order to identify the different ways in which women have historically been disadvantaged, and the processes, situations and interaction dynamics that emerged from this. Sixty-four Wixárika women were interviewed while pregnant, and followed up after the birth of their child between January 2015 and April 2017. These data were triangulated with structured observations and key informant interviews with healthcare

providers, teachers, community representatives and family members.

The findings suggest that gender inequalities were introduced with the colonial system for governing Indigenous regions, and became naturalised as Wixárika communities were increasingly integrated into the Mexican nation. The associated structures of marriage, community and interpersonal relationships now operate as forms of institutionalised gender oppression, to increase Indigenous women's vulnerability, and influence decisions made about care and childbirth. Ethnographic data analysed in historical context evidence the continuity of colonial forms of inequality, and their impact on wellbeing. While welfare and health programmes increasingly aim to address gender inequality on social and relational levels, by rebalancing gendered household dynamics or empowering women, the historical and colonial roots of these inequalities remain unchallenged. (Author)

Full URL: <https://doi.org/10.1016/j.socscimed.2020.112912>

20190710-23*

Analysing constructions of childbirth in the media; Moving possibilities for childbirth beyond gender essentialism.

Kurz E, Davis D, Browne J (2020), *Women and Birth: Journal of the Australian College of Midwives* vol 33, no 4, July 2020, pp 377-382

Problem

Birth can be a contentious issue with maternity care providers and consumers alike advocating fiercely defended and polarising views. These positions are largely shaped by opposing biomedical and natural childbirth constructions of birth. Contemporary debate on homebirth is one such example which illustrates this divide.

Aim

To reconceptualise birth by deconstructing current constructions of childbirth contained in homebirth articles published by one online media source in Australia.

Methods

Australia's self-acclaimed largest women's media company was searched for articles pertaining to homebirth. Articles which met inclusion criteria were analysed using poststructural feminist theory and deconstruction techniques informed by Davies and Gannon, Butler and others.

Findings

Gender essentialism present in both the biomedical and natural childbirth approaches constructs birth as an act of nature, dictated by biology rather than one with a sociohistorical location.

Discussion

Gender essentialism at birth serves to obscure the sociohistorical determinants of birth, making it appear as a static, immutable sort of act, rather than one which is defined by its sociohistorical location and which can be redefined, even reinvented, by its sociohistorical location.

Conclusion

Gender essentialism is an enduring phenomenon, underpinning seemingly opposing constructions of childbirth. Disengaging childbirth from essentialisms of woman's nature may create possibilities and meanings of childbirth that could be useful for childbearing women. (35 references) (Author)

20190508-3

The feminist sage femme: linking theory and practice through feminism. Ridley N (2019), *The Practising Midwife* vol 22, no 5, May 2019, pp 20-24

Feminism can often be associated with radical and hostile views, but the heart of feminism is about achieving equal rights for all. Women have achieved greater equality over recent years; however the gender gap continues, to varying degrees around the world - fuelling ongoing oppression of women. Within this article, we look at how we can educate girls, women and midwives about achieving gender equality, and how feminism can be embedded within our everyday midwifery care and how women can be empowered with some simple yet effective practices. (Author)

20181213-129*

Determinants of client satisfaction to skilled antenatal care services at Southwest of Ethiopia: a cross-sectional facility based survey. Lakew S, Ankala A, Jemal F (2018), *BMC Pregnancy and Childbirth* vol 18, no 479, 6 December 2018

Background

Patient satisfaction to Antenatal care services has traditionally been linked to the quality of services given and the extent to which specific needs are met. Even though data in this area was limited in Ethiopia, improving quality of care was one of the strategies in health sector development program IV. This study, therefore, attempted to assess client satisfaction to skilled antenatal care services in the study area.

Methods and materials

A cross-sectional facility based survey was conducted among women who were attending antenatal care clinic, using quantitative method triangulated with qualitative data collection. Participants were selected using systematic sampling method according to the flow pregnant women to the antenatal care clinics. The study was carried out in all functional public health centers in the district. During the survey, 405 women were interviewed. A logistic regression model was applied to control for confounders.

Results

Out of the total respondents, overall satisfied to skilled antenatal care services were about 277(68%). The most common specific component of antenatal care that had good-satisfaction by the respondents was 'Privacy' at examination (81.7%). Most satisfied health education session was 'Diet and nutrition' session (82.2%). Absence of sonar test, no doctor and long waiting time were commonest causes of dissatisfaction. Respondents who have > 2 previous antenatal care visit were 3 times more likely (AOR = 2.93; 95% CI, 1.21, 7.12) to have satisfaction to antenatal care services as compared to those with < 1 visit. Women whose current visit fourth were 9 times more likely (AOR = 9.02, 95% CI; 1.76, 46.1) to be satisfied for antenatal services than those who were in the first visit. Women with family monthly income of \$US 25-100 per month were 60% (AOR = 0.4, 95% CI; 0.2, 0.8) less likely to have satisfaction by skilled antenatal care services than those who had monthly household income below \$US 25.

Conclusion and recommendation

Women who reported good-satisfaction to overall skilled antenatal care services were highest as compared to previous Ethiopian study findings. Demographic, economic, obstetric and distance factors were independent predictors of satisfaction to skilled antenatal care services. Non natives must be encouraged to seek satisfying services.

(37 references) (Author) [Please note: this article is a digital version which may undergo minor changes in the future]

Full URL: <https://doi.org/10.1186/s12884-018-2121-6>

20181114-2*

Using Gender-Neutral Language in Birth Classes. Muza S (2018), Science and Sensibility 13 November 2018

In the context of Transgender Awareness Week in the US, Sharon Muza offers suggestions for how to make birth classes inclusive. She points out that pregnant people may identify as female, as male and sometimes as neither or both at the same time. The article stresses the importance of recognising that the pregnant person gets to determine how they identify and how they want to be addressed. (CAP)

20181109-18

The F word: Midwifery students' understanding of feminism. Davison C, Geraghty S, Dobbs K (2018), British Journal of Midwifery vol 26, no 11, November 2018, pp 731-737

Background:

Not all midwives embrace the word feminism however, it could be argued that providing midwifery care is an expression of feminism's core values.

Aims:

To describe and explain the views and knowledge of midwifery students on feminism and midwifery.

Methods:

A qualitative descriptive approach, employing an anonymous online questionnaire was implemented and analysed using thematic and content analysis.

Findings:

Eight themes were identified in this study that revealed midwifery student's views and knowledge on feminism and the impact it may have on midwifery clinical practice.

Conclusions:

This study suggests midwifery students should receive adequate education regarding feminism. The advantages of midwifery students understanding feminism within the midwifery professional are undeniable and it is important that feminism is integrated into midwifery programmes. (28 references) (Author)

20181023-40*

Management of intersex newborns: Legal and ethical developments. Dickens BM (2018), International Journal of Gynecology & Obstetrics vol 143, no 2, November 2018, pp 255-259

Countries worldwide are increasingly expanding male/female binary sex classifications to recognize a third status. Intersex newborns may be included in this third category on birth certification. Parents, families, and communities require counselling and education to accommodate intersex newborns without stigma or discrimination. Whatever its

biological or genetic origin, intersex status is a natural if relatively uncommon condition (one in 1500-2000 live births) that distinguishes sex from gender. The tendency of societies to recognize only male and female genders at birth has resulted in intersex children being subjected to invasive surgery and related, sometimes lifelong, medication to confirm them as male or female. On gaining maturity, some are severely distressed and resentful that early gender assignment was mistaken, particularly when excision of testes to enforce femininity or of ovaries to enforce masculinity has denied them procreative capacity. Emerging principles support postponement of such interventions until intersex individuals can make a gender choice for themselves. (18 references) (Author)

20180501-65

The Division of Access and Equity, Midwives Alliance of North America. Farrell MV (2018), Midwifery Matters (USA) vol 5, No 1, Spring 2018, p 2

Comments on the Division of Access and Equity (DAE), a newly created organisational division of the Midwives Alliance of North America (MANA), and also reflects upon the divisions in the midwifery profession and the ways in which these divisions impact on midwifery practice. (JSM)

20170706-39*

Pregnancy: Discrimination [written answer]. House of Commons (2017), Hansard Written question 1277, 27 June 2017

Dominic Raab responds to a written question from Mrs Madeleine Moon to the Secretary of State for Justice, regarding what steps he is taking to improve access to justice for women who have experienced maternity and pregnancy discrimination; and if he will make a statement. (MB)

Full URL: <http://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2017-06-27/1277/>

20170308-48*

'Very Good' Ratings in a Survey of Maternity Care: Kindness and Understanding Matter to Australian Women. Todd AL, Ampt AJ, Roberts CL (2017), Birth vol 44, no 1, March 2017, pp 48-57

Background

Surveys have shown that women are highly satisfied with their maternity care. Their satisfaction has been associated with various demographic, personal, and care factors. Isolating the factors that most matter to women about their care can guide quality improvement efforts. This study aimed to identify the most significant factors associated with high ratings of care by women in the three maternity periods (antenatal, birth, and postnatal).

Methods

A survey was sent to 2,048 women who gave birth at seven public hospitals in New South Wales, Australia, exploring their expectations of, and experiences with maternity care. Women's overall ratings of care for the antenatal, birth, and postnatal periods were analyzed, and a number of maternal characteristics and care factors examined as potential predictors of 'Very good' ratings of care.

Results

Among 886 women with a completed survey, 65 percent assigned a 'Very good' rating for antenatal care, 74 percent for birth care, 58 percent for postnatal care, and 44 percent for all three periods. One factor was strongly associated with care ratings in all three maternity periods: women who were 'always or almost always' treated with kindness and understanding were 1.8-2.8 times more likely to rate their antenatal, birth, and postnatal care as 'Very good.' A limited number of other factors were significantly associated with high care ratings for one or two of the maternity periods.

Conclusions

Women's perceptions about the quality of their interpersonal interactions with health caregivers have a significant bearing on women's views about their maternity care journey. (40 references) (Author)

20160428-15*

Equality essentials. Royal College of Midwives (2016), London: Royal College of Midwives April 2016. 15 pages

One of a series of Royal College of Midwives (RCM) Equality and Diversity publications, which has been produced for RCM Workplace Reps and members. Provides information about the nine protected characteristics of the Equality Act 2010 and a discussion about the different types of discrimination. (KM) [The full publication is available from:

<https://www.rcm.org.uk/equality-and-diversity>]

Full URL: <https://www.rcm.org.uk/media/5410/equality-essentials3-002.pdf>

20160330-54*

Comparison of women in department leadership in obstetrics and gynecology with those in other specialties. Hofler LG, Hacker MR, Dodge LE, et al (2016), *Obstetrics & Gynecology* vol 127, no 3, March 2016, pp 442-447

OBJECTIVE: To compare the representation of women in obstetrics and gynecology department-based leadership to other clinical specialties while accounting for proportions of women in historical residency cohorts.

METHODS: This was a cross-sectional observational study. The gender of department-based leaders (chair, vice chair, division director) and residency program directors was determined from websites of 950 academic departments of anesthesiology, diagnostic radiology, general surgery, internal medicine, neurology, obstetrics and gynecology, pathology, pediatrics, and psychiatry. Each specialty's representation ratio-proportion of leadership roles held by women in 2013 divided by proportion of residents in 1990 who were women-and 95% confidence interval (CI) were calculated. A ratio of 1 indicates proportionate representation.

RESULTS: Women were significantly underrepresented among chairs for all specialties (ratios 0.60 or less, $P \leq .02$) and division directors for all specialties except anesthesiology (ratio 1.13, 95% CI 0.87-1.46) and diagnostic radiology (ratio 0.97, 95% CI 0.81-1.16). The representation ratio for vice chair was below 1.0 for all specialties except anesthesiology; this finding reached statistical significance only for pathology, pediatrics, and psychiatry. Women were significantly overrepresented as residency program directors in general surgery, anesthesiology, obstetrics and gynecology, and pediatrics (ratios greater than 1.19, $P \leq .046$). Obstetrics and gynecology and pediatrics had the highest proportions of residents in 1990 and department leaders in 2013 who were women.

CONCLUSION: Despite having the largest proportion of leaders who were women, representation ratios demonstrate obstetrics and gynecology is behind other specialties in progression of women to departmental leadership. Women's overrepresentation as residency program directors raises concern because education-based academic tracks may not lead to major leadership roles. (30 references) (Author)

20160307-30

Midwives, gender equality and feminism. Walsh D (2016), *The Practising Midwife* vol 19, no 3, March 2016, pp 24-26

Gender inequality and the harmful effects of patriarchy are sustaining the wide spread oppression of women across the world and this is also having an impact on maternity services with unacceptable rates of maternal mortality, the continued under investment in the midwifery profession and the limiting of women's place of birth options. However alongside these effects, the current zeitgeist is affirming an alignment of feminism and gender equality such that both have a high profile in public discourse. This presents a once in a generation opportunity for midwives to self-declare as feminists and commit to righting the wrongs of this most pernicious form of discrimination. (5 references) (Author)

20160216-14*

Gaining insight into how women conceptualize satisfaction: Western Australian women's perception of their maternity care experiences. Lewis L, Hauck YL, Ronchi F, et al (2016), *BMC Pregnancy and Childbirth* vol 16, no 1, 4 February 2016

Background

The concept of maternal satisfaction is challenging, as women's and clinicians' expectations and experiences can differ. Our aim was to investigate women's experiences of maternity care in an urban tertiary obstetric setting, to gain insight into conceptualization of satisfaction across the childbirth continuum.

Methods

This mixed method study was conducted at a public maternity hospital in Western Australia. A questionnaire was sent to 733 women two weeks post birth, which included an invitation for an audio-recorded, telephone interview. Frequency distributions and univariate comparisons were employed for quantitative data. Thematic analysis of interview transcripts was undertaken to extract common themes.

Results

A total of 54 % (399 of 733) returned the questionnaire. Quantitative results indicated that women were less likely to feel: involved if they did not have a spontaneous vaginal birth ($P = 0.020$); supported by a midwife if they had a caesarean ($P = <0.001$); or supported by an obstetrician if they had a spontaneous vaginal birth ($P = <0.001$).

Qualitative findings emerged from 63 interviews which highlighted the influence that organization of care, resources and facilities had on women's satisfaction. These paradigms unfolded as three broad themes constructed by four sub-themes, each illustrating a dichotomy of experiences. The first theme 'how care was provided' encompassed: familiar faces versus a different one every time and the best place to be as opposed to so disappointed. The second theme 'attributes of staff' included: above and beyond versus caring without caring and in good hands as opposed to handled incorrectly. The third theme 'engaged in care' incorporated: explained everything versus did not know why and had a choice as opposed to did not listen to my needs.

Conclusions

Quantitative analysis confirmed that the majority of women surveyed were satisfied. Mode of birth influenced women's perception of being involved with their birth. Being able to explore the diversity of women's experiences in relation to satisfaction with their maternity care in an urban, tertiary obstetric setting has offered greater insight into what women value: a sensitive, respectful, shared relationship with competent clinicians who recognise and strive to provide woman focused care across the childbirth continuum. (43 references) (Author) [The full text of this article is available free of charge at: <http://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-015-0759-x>] [Please note: BMC initially publish articles in a provisional format. If there is a note on the document to indicate that it is still provisional, it may undergo minor changes]

Full URL: <http://bmcpregnancychildbirth.biomedcentral.com/articles/10.1186/s12884-015-0759-x>

20150901-59

Feminism and the moral imperative for contraception. Espey E (2015), *Obstetrics & Gynecology* vol 126, no 2, August 2015, pp 396-400

This commentary is adapted from the Irvin M. Cushner Memorial Lecture, 'Feminism and the Moral Imperative for Contraception,' given at 2014 Annual Clinical Meeting of the American College of Obstetricians and Gynecologists in Chicago. It provides a brief and simplified historical review of the feminist movement, primarily in the United States, focusing on feminism's association with contraception. This commentary reflects the perspective and opinions of the author. Contraception is fundamental to a woman's ability to achieve equality and realize her full social, economic, and intellectual potential. (23 references) (Author)

20150506-25

Why midwives should be feminists. Walsh D, Christianson M, Stewart M (2015), *MIDIRS Midwifery Digest* vol 25, no 2, June 2015, pp 154-160

Gender inequality and oppression is a pervasive feature of human cultures and societies across the world and this is reflected in women's reproductive health with unacceptably high maternal mortality rates in low-income countries and excessive rates of intervention in childbirth in high-income countries. Midwifery, a profession whose *raison d'être* is to be 'with women' with an explicit focus on maximising their reproductive health, has been slow to engage with a gendered analysis of these effects. There has also been a reluctance to utilise a feminist lens in addressing midwifery policy, practice and research. In this paper, we argue for change so that feminist values and gender equality become central to all midwifery endeavours. (67 references) (Author)

20140522-37

Has feminism faded? Dabrowski R (2014), *Midwives* no 3, 2014, pp 38-40

With an under-resourced workforce and more pressure on midwives' time than ever, is the profession still in touch with its feminist roots? (Author)

20120113-25

Feminism as a theoretical perspective for research in midwifery. Yuill O (2012), *British Journal of Midwifery* vol 20, no 1, January 2012, pp 36-40

Over the last few decades feminism has played a pivotal role in improving women's wellbeing, health and position in society, and yet the term 'feminist' is often misconceived as a picture of 'man-hating' women refusing any assistance from men. This results in a loss of appreciation of the true nature of feminism. Historically the midwifery profession has been oppressed since the biomedical domination of childbirth. The 'yummy mummy' culture that the media unrealistically promotes leads to further devaluation of motherhood. Midwives are in an ideal position to use feminism as a theoretical perspective to perform research which is truly women-centred, extrapolating their true needs and beliefs. (24 references) (Author)

20110228-81

Gender bias as a factor for nursing positions in women's health, obstetric and neonatal nursing. Association of Women's Health, Obstetric and Neonatal Nursing (2011), *JOGNN: Journal of Obstetric, Gynecologic and Neonatal Nursing* vol 40, no 1, January/February 2011, p 135

Explains the official position of the Association of Women's Health, Obstetric and Neonatal Nursing (AWHONN) on gender bias in the recruitment and selection of nurses in the fields of women's health, obstetric and neonatal nursing. (1 reference) (JSM)

20100202-73

Women and sex. Nelson S (2009), In: Squire C ed. The social context of birth. Abingdon: Radcliffe Publishing 2009, pp 24-39

The aim of this chapter is for readers to gain a critical understanding of the main theories of female sexuality. The relevance of the concepts of these theories to medicine, midwifery and nursing practice will be explored. The key themes that are considered are: scientific research on sexuality, ideological biases in the research, sexual health, the female body, Freudian theories, current images of female sexuality, heterosexuality and safe sex, pregnancy and sexuality, and cultural differences. (62 references) (Author)

20100202-71

Women and society. Squire C (2009), In: Squire C ed. The social context of birth. Oxford: Radcliffe Publishing 2009, pp 1-23

Pregnancy and childbirth are unique events in the lives of women. Midwives and health professionals need to have knowledge and understanding of the social and cultural context which influences women and their lives, and in which they give birth. Women's subjective and collective experiences of life will depend upon such factors as age, ethnicity, social and economic background and the way in which these factors interrelate, contradict and intersect with each other. The study of women's lives is complex but necessary for midwives and health professionals if they are to be able to practise in a so called 'woman-centred' manner. This chapter discusses the key feminist theories that have contributed to explanations of the experiences of being a woman, as well as considering the sex/gender debate. The concept of 'woman-centred practice' is also addressed with particular reference to postmodernist feminist theory. (55 references) (Author)

20081006-1*

'Is it just so my right?': women repossessing breastfeeding. Smith PH (2008), International Breastfeeding Journal vol 3, no 12, 4 August 2008, 6 pages

Infant feeding occurs in the context of continued gender inequities and in the context of a feminist movement that left women vulnerable to a system that defined the male body and mind as the norm. This paper draws from a qualitative analysis of interviews conducted with women artists at the 2005 Mamapalooza music festival in New York City, and conference participants at the 2005 La Leche League International and International Lactation Consultant Association Conferences and at the 2007 Reproductive Freedom Conference to understand our collective alienation from breastfeeding and to outline a process for how we might repossess breastfeeding as a positive function in women's lives. These women find power in honoring and validating their own experiences, in claiming those experiences as legitimate feminist actions, and then drawing on these experiences to seek new meanings, customs and norms that similarly honor, value and support their rights to those experiences. They argue that we need a feminist movement that fully incorporates women's needs as biological and reproductive social beings, alongside their needs as productive beings, and a movement that defines the female body and mind as the norm. (5 references) (Author)

20080714-70*

Equality laws 'are now holding women back'. Bennett R, Ahmed M (2008), Times 14 July 2008

Describes how the extension of maternity leave and parents rights could be jeopardising women's careers. Suggests that employers are put off employing or promoting women of child bearing age because of the prospect of having to give 12 months maternity leave, which will soon be subject to pay throughout. Also states that the level of maternity benefits has reinforced the assumption that children are cared for only by the mother, and failed to speed up a social revolution where both parents share equal responsibility for child care. (JSM)

20080714-55*

Maternity leave 'damages' careers. BBC News (2008), BBC News 14 July 2008

News item reporting comments made by the Chief Executive of the Equalities and Human Rights Commission that suggest some employers may not be offering women jobs or promotion because of the extended maternity leave entitlement which now stands at up to 12 months for each child. (JSM)

20071203-70

Experiences of sexual harassment of women health workers in four hospitals in Kolkata, India. Chaudhuri P (2007),

In 1997, the Supreme Court of India recognised sexual harassment in the workplace as a violation of human rights. However, little is known about the extent or persistence of sexual harassment. To obtain an understanding of women's experiences of sexual harassment in the health sector, an exploratory study was undertaken in 2005-2006 among 135 women health workers, including doctors, nurses, health care attendants, administrative and other non-medical staff working in two government and two private hospitals in Kolkata, West Bengal, India. Four types of experiences were reported by the 77 women who had experienced 128 incidents of sexual harassment: verbal harassment (41), psychological harassment (45), sexual gestures and exposure (15), and unwanted touch (27). None of the women reported rape, attempted rape or forced sex but a number of them knew of other women health workers who had experienced these. The women who had experienced harassment were reluctant to complain, fearing for their jobs or being stigmatised, and most were not aware of formal channels for redress. Experiences of sexual harassment reflected the obstacles posed by power imbalances and gender norms in empowering women to make a formal complaint, on the one hand, and receive redress on the other. (12 references) (Author)

20070803-4

The hidden barrier. Gender bias: fact or fiction?. Cude G, Winfrey K (2007), *Nursing for Women's Health* vol 11, no 3, June/July 2007, pp 255-265

Addresses the undoubted existence of gender bias in obstetrics and gynaecology, and neonatal care, with examples of discrimination against male nurses in nursing school and employment. Explores the historical reasons for this and suggests ways of rectifying it. (38 references) (VDD)

20070608-50

Is nursing sexist?. Tweddell L (2007), *Nursing Times* vol 103, no 23, 5 June 2007, p 8

Male nurses make up only 11% of the workforce but hold an unequal share of higher-paid posts. Louise Tweddell asks whether the profession is sexist. (Author)

20070122-74

Midwifery and gender equality. Zeidenstein L (2007), *Journal of Midwifery & Women's Health* vol 52, no 1, January/February 2007, pp 1-2

Discusses issues relating to gender equality, and highlights how midwives can be encouraged to 'listen to women' using the example of the use of peer pelvic examinations in midwifery education. (2 references) (SB)

20061215-67

Gender equality now or never: a new UN agency for women. Donovan P (2006), *Midwifery Matters* no 111, Winter 2006, pp 26-27

The senior advisor of Women's and Children's Issues, Office of the UN Special Envoy for AIDS in Africa argues that the UN needs a fully fledged women's agency with a presence in every country, a guaranteed budget, expert staff and targeted programmes. (CR)

20061215-28*

Exploring the dirty side of women's health. Kirkham M, editor (2007), London: Routledge 2007. 308 pages

Women leak, inevitably and often bountifully. In this book, a selection of international contributors examine bodies, leakage and boundaries, illuminating the contradictions and dilemmas in women's healthcare. Using the concept of pollution, *Exploring the Dirty Side of Women's Health* highlights how women and health issues are categorised and health workers and women are confined to roles and places defined as socially appropriate. The book explores current and historical practices, such as: childbirth and midwifery practice; policies and social practices around breastfeeding; gynaecological nursing, female incontinence and sexually transmitted infections; miscarriages and termination of pregnancy. *Exploring the Dirty Side of Women's Health* addresses things out of place, from the idea of 'dirty work' to feeling 'dirty', from diagnoses that disrupt our self-image to beliefs and practices which undermine health service provision. This book uses the contradictions in our thinking around pollution and power to stimulate thinking around women's health. It will appeal to students and academics researching midwifery, anthropology, gender studies and nursing as well as midwives and breastfeeding counsellors. (Publisher). What a fascinating read and a brilliant concept! Aimed at a varied audience, from students and academic researchers to practising midwives, breastfeeding counsellors and others supporting pregnant women and new mothers, this collection brings together interesting and

comprehensive research. It is a wide-ranging book, with geographical, cultural and historical breadth. The book takes as its theme the concept of pollution and uses Mary Douglas' idea of dirt as 'matter out of place'. By exploring the many ways in which women, their bodies and their bodily experiences are construed as 'dirty', the four sections examine this in relation to women's health care, often with a focus on power relationships and boundaries. One section has chapters devoted to research about traditional birth attendants (the dais) in India and Pakistan, another looks at women's health care more widely (including sexual health, gynaecological nursing and older women and miscarriage). I found the chapters about the Indian subcontinent fascinating to read, despite not being of direct relevance to me personally or professionally. The two chapters with an historical focus are also really interesting, particularly where links are made between what has happened in the past and contemporary practice. All the pieces make strong theoretical and contextual links. Although the overall theme will be appealing to many, others will particularly value specific aspects. As a breastfeeding researcher I was immediately attracted to the four chapters exploring different aspects of the idea of 'breastfeeding as pollution'. This section is a good illustration of the breadth of the work, looking at the experiences of breastfeeding women, both in the UK and in India, as well as those of professionals. As a qualitative researcher I was also drawn to the emphasis throughout the book on women's experiences, both as professionals and as users of health care services and the blurring of (leaking from) the boundaries between the two. Academics in a range of related fields should find much that is useful in this book but, as I've shown, there is also plenty of relevance to practitioners. I am sure that those working more directly with pregnant women and babies than I am will find much to reflect on in relation to both experience and practice. The chapters are all clearly written and very accessible and the book as a whole makes a very good read, whatever the professional background of the reader. It would be a good addition to a university library collection, particularly in an institution training health and social care professionals. Although published over a year ago now it retains its relevance and will do so for some time to come. I have two main criticisms of the book - one is that it may be perceived as 'too academic' and therefore not read by many who would find it very interesting and useful. Secondly, because it is published by an academic publisher it is expensive; this is a shame as this probably puts it out of the reach of many practitioners unless they have access to a good library. Reviewed by Sally Dowling, lecturer, University of the West of England

20061106-47

Reclaiming a new archetype. O'Mara P (2006), *Mothering* no 139, November/December 2006, pp 10-14

Discusses current stereotypes of the mother and argues that women need to reclaim a 'vibrant archetype', which depicts the mother as a powerful and creative being rather than as a victim who is easily overpowered by her role. (SB)

20050714-27

Dilemma. Dimond B (2005), *Nursing Times* vol 101, no 28, 12 July 2005, p 18

Response to a question regarding what employees can expect if they complain that they are being sexually harassed by a senior nurse manager. (CR)

20040824-17*

Sacred cycles: the spiral of women's well-being. Wickham S (2004), London: Free Association Books 2004. 186 pages

Have you ever thought about how you would like to be born, wondered why tampon adverts always use blue liquid or dreamed of living in a society where Government-funded luxury hotels for women who needed space? Have you ever wondered why so many women living in the West still believe their bodies are inferior to men's and that others hold responsibility for their health and well-being? By comparing the things we have been taught about our bodies to real women's experiences, women-centred research and common sense wisdom, this book explores women's reproductive health and well-being through the eyes of women themselves, examining myths and opinions and questioning whether the things we learn from the media and through education systems are serving us well. The author explores a wide variety of historical and cultural perspectives and, drawing on the experiences of over 100 women, the major transitions of women's lives are described. Does science have all the answers, or is there a space for other ways of knowing? Are medical recommendations more accurate than old wives' tales? How do women care for themselves during their menstrual cycles, or during menopause, and would it be better to turn our ideas of health and healing upside down? This book will enable women to realise that they are the experts in their own lives and health, and enable men to deepen their understanding of who we are. (Publisher) MIDIRS REVIEW: Women of all ages will be heartened and inspired by this charming book, which leaves one generally celebrating being female. (Men may also find this book useful and be able to reach new understandings of women). Midwives and student midwives will be able to refer to several chapters, which relate particularly sympathetically and with empathy to the

childbearing woman. Other chapters which are unrelated to midwifery are, however, relevant to women's health and may be read for a fuller understanding of women's issues contributing in turn to a more holistic viewpoint. The general style of the book is an easy discussion of particular women's issues, using information gained from various sources. The author talked to 100 women about their experiences and uses this research alongside similar literature, exploring myths, old wives' tales and scientific research. There is also the use of a tool from Susan Weed which the reader is referred to which can be accessed in full from her website. Weeds' tool is based on 'wise woman tradition', which is said to integrate Western medicine and complementary therapies: being based on seeing people as whole, healthy and interconnected. As a complementary and alternative medicine (CAM) therapist I would argue with the author's suggestion that (CAM) practitioners promote the idea that humans are 'bad' and need to change. This unproductive and disempowering way of working has been cited as a criticism of CAM in the past and is seen as outdated now in CAM circles. I endorse the 'wise woman tradition' and would use many of the philosophies underlying this practise in my own CAM work. One small criticism of the book was the odd grammatical error, which led to some sentences being unclear. I assume that this was due to unfortunate editing/typesetting and not the authors' own work, which reads very easily and informally. In conclusion, as a midwife lecturer I would recommend this book particularly to first year midwifery students for help with their own personal self awareness journey as they undertake training. I will also be passing on this book to other midwife lecturers to read for their own personal and professional use mainly due to the positive and uplifting attitudes expressed therein. Reviewed by Penny Charles, lecturer in midwifery & women's health, King's College University.

20040810-1

Exploring women's descriptions of distress and/or trauma in childbirth from a feminist perspective. Moyzakitis W (2004), Evidence Based Midwifery vol 2, no 1, July 2004, pp 8-14

Aim: To explore women's experience of distress and/or trauma in childbirth - to consider the depth and meaning of birth that was 'awful', birth that 'changed women forever'. Objectives: To understand how women describe and make sense of their experiences. Method: The design was exploratory and descriptive using a qualitative feminist approach to interviewing six women who had lived through a traumatic or distressing birth experience. Data analysis was conducted in an inductive manner from the women's descriptive accounts. Findings/results: Four major themes emerged: the role of caregivers, impact on self-image, impact on relationships and severity of experience. Features within the sub-categories include lack of information, an acute sense of misuse of power by some professionals, lack of support and betrayal. Women expressed feeling alienated from the birth. Some experienced a sense of loss and grief for 'self', others described strategies to preserve the integrity of 'self'. All the women reported problems in their relationship with their babies, partners and others and five developed postnatal depression (PND). Implications: Childbirth experiences are layered with meaning that is embedded in the memories of women forever. As midwives we need to be cognisant of the life experience that we help women to shape when they come into our care. (60 references) (Author)

20040511-2

Nursing resistance as ethical action: literature review. Peter E, Lunardi VL, Macfarlane A (2004), Journal of Advanced Nursing vol 46, no 4, May 2004, pp 403-416

Background. Much has been written about nursing as a predominantly female profession whose members display passivity, submission, obedience and powerlessness. Alternatively, some authors have presented evidence of nurses' capacity to exercise power, revealing the possible relationship between powerlessness and ethical compromise. Thus, empowerment strategies for nurses can yield ethical action. Aim. The aim of this paper is to use analysis of the literature to demonstrate how the actions and responses of nurses to ethical concerns are examples of nurses exercising power. Method. Empirical studies published in the nursing literature between 1990 and 2003 have been analysed to illustrate how nurses' actions of resistance can ensure that moral values are realized in practice. Foucauldian notions of power relations and feminist ethics provide the theoretical framework. Conclusions. Nurses were found to resist in situations where they experienced moral conflicts in relation to the actions of health professionals; however, instances were cited where they did not. Consequently, strategies for nursing education and management are proposed to increase nurses' understanding of the potential acts of resistance that they could employ in situations of moral conflict or concern. (66 references) (Author)

20040402-38

Role of gender in health disparity: the South Asian context. Fikree FF, Pasha O (2004), BMJ vol 328, no 7443, 3 April 2004, pp 523-826

South Asia's girls and women do not have the same life advantage as their Western counterparts. A human rights based approach may help to overcome gender related barriers and improve the wellbeing of men, women, and children. (49 references) (Author)

20040220-6

Instinctive birth: finding the pulse. Baker JP (2003), *Midwifery Today* no 68, Winter 2003, pp 15-16

Considers whether women have an instinct to give birth, and reflects on the reasons why the feminist movement has developed in such a way as to focus on a woman's right not to be a mother (abortion) and not on the promotion of her instinct to be a mother (natural childbirth). Calls for mothers and midwives to ignore the pressures to make 'progress' in labour and instead to trust to their own instincts and the contribution of the baby to its own birth. (3 references) (RM)

20031208-9

Midwifery practice: ways of working. Bates C (2004), In: Stewart M ed. *Pregnancy birth and maternity care: feminist perspectives*. Edinburgh: Books for Midwives 2004. pp 121-142

Conducts a feminist analysis of midwifery practice by reviewing the impact the UK Government's reforms to maternal health services have had on midwives' professional role and status. Considers whether midwifery's struggle for survival as a respected and autonomous profession has been caused by patriarchal attitudes in the medical establishment, using the example of conflicts of opinion between the medical profession and midwives on the desirability of home births. Discusses changing patterns of midwifery care including team midwifery, caseload midwifery, one-to-one midwifery practice, and independent midwifery. (105 references) (RM)

20031208-5

Feminism and intrapartum care: a quest for holistic birth. Walsh D (2004), In: Stewart M ed. *Pregnancy birth and maternity care: feminist perspectives*. Edinburgh: Books for Midwives 2004. pp 57-70

Considers different models of midwifery and obstetric care for women during labour, birth and the immediate postnatal period from the perspective of feminist philosophy, including: women's control over their place of birth; the style of care during birth; and positioning in labour and birth. Examines the perception that the labour ward is dominated by 'masculine, paternalistic' attitudes as opposed to 'feminine' or 'feminist' views typified by midwifery care. (95 references) (RM)

20031208-4

Pregnancy. Stephens L (2004), In: Stewart M ed. *Pregnancy birth and maternity care: feminist perspectives*. Edinburgh: Books for Midwives 2004. pp 41-55

Considers different feminist perspectives of pregnancy and its relationship with women's social status. Discusses models of midwifery care in the antenatal period which are based on feminist principles (64 references) (RM)

20031208-3

Feminisms and the body. Stewart M (2004), In: Stewart M ed. *Pregnancy birth and maternity care: feminist perspectives*. Edinburgh: Books for Midwives 2004. pp 25-40

Considers social constructions of the female body including notions of the 'ideal' body and the effect that this has on women's self-image. Discusses views of the body from a medical and healthcare perspective, specifically women's views of their bodies during pregnancy, childbirth and while breastfeeding. (58 references) (RM)

20031208-2

Gender and sexuality. Cronin A (2004), In: Stewart M ed. *Pregnancy birth and maternity care: feminist perspectives*. Edinburgh: Books for Midwives 2004. pp 11-23

Examines the relationship between gender and sexuality and considers the social constructions of both heterosexuality and homosexuality. Outlines feminist concepts of sexuality. Discusses healthcare provision to gay and lesbian patients including how perceived or actual attitudes of health care professionals towards homosexuals may interfere with the quality of care provided. (58 references) (RM)

20031208-18

Off the beaten track - feminist virtue ethics and midwifery. (2003), In: Thompson FE. Mothers and midwives: the ethical journey. Oxford: Books for Midwives 2003, pp 59-73

Discusses the values and assumptions of feminist theory and considers the application of a feminist approach to midwifery ethics as an alternative to traditional, male-orientated, moral philosophy. (44 references) (RM)

20031208-13

Journey to midwifery through feminism: a personal account. Leap N (2004), In: Stewart M ed. Pregnancy birth and maternity care: feminist perspectives. Edinburgh: Books for Midwives 2004. pp 185-200

Personal account by a midwife of the influence of feminism on her decision to enter the profession and on the ways she has conducted her professional practice. Considers how feminist concepts apply to midwifery care, including the uses of language in caring for pregnant women and the notion of woman-centred care. (37 references) (RM)

20031208-12

Midwifery partnership with women in Aotearoa/New Zealand: a post-structuralist feminist perspective on the use of epidurals in 'normal' birth. Surtees R (2004), In: Stewart M ed. Pregnancy birth and maternity care: feminist perspectives. Edinburgh: Books for Midwives 2004. pp 169-183

Discusses feminist discourse practices in midwifery and applies them to the midwife's role in Aotearoa/New Zealand as the communicator and facilitator of women's care options. Considers the decision making partnership between the midwife and the woman in choosing the most appropriate method of pain relief for labour, and examines the various influences on the woman's decision to select epidural analgesia. (77 references) (RM)

20031208-11

Feminism and ways of knowing. Wickham S (2004), In: Stewart M ed. Pregnancy birth and maternity care: feminist perspectives. Edinburgh: Books for Midwives 2004. pp 157-168

Examines issues surrounding different concepts of evidence and knowledge and how these relate to women's knowledge during pregnancy and childbirth and midwives' knowledge of how to offer them the best possible care. Presents three feminist theories on science. Considers the nature of 'women's ways of knowing'. (37 references) (RM)

20031208-10

Feminist approach to midwifery education. Davies L (2004), In: Stewart M ed. Pregnancy birth and maternity care: feminist perspectives. Edinburgh: Books for Midwives 2004. pp 143-156

Considers whether a feminist pedagogical approach could be introduced into midwifery education. Examines the value of inquiry-based learning (IBL) as a vehicle for feminist pedagogy. (36 references) (RM)

20031208-1

Introducing feminism. Kaufmann T (2004), In: Stewart M ed. Pregnancy birth and maternity care: feminist perspectives. Edinburgh: Books for Midwives 2004. pp 1-10

Reviews the origins and theories of feminism and the application of feminist concepts and principles to midwifery care. (RM)

20031031-5*

Pregnancy, birth and maternity care: feminist perspectives. Stewart M (2004), Edinburgh: Books for Midwives Press 2004. 207 pages

The book is an edited collection of 13 chapters written by individuals from a range of backgrounds in midwifery practice, teaching and research. This book powerfully demonstrates how much they can learn from (and contribute to) a feminist perspective on pregnancy, birth and maternal care. Chapters typically start with a brief historical account and review of key theoretical perspectives on their topic and then go on to use these perspectives in looking at aspects of current midwifery practice. Overall, this is a well written and engaging introduction to feminist 'ways of seeing' for midwives. It is aimed primarily at students and it should certainly be on the reading list of every undergraduate midwifery course. But the book will also appeal to a wider audience of experienced practitioners who are looking to understand their practice in its wider social, political and historical context. Reviewed by Mary Boulton, Professor of Sociology, Oxford Brookes University. [Full review on MIDIRS website]

20031003-19

The nurse-patient relationship: a consideration of its discursive context. Crowe M (2000), *Journal of Advanced Nursing* vol 31, no 4, April 2000, pp 962-967

This paper is a theoretical exploration of the discursive context that shapes the nurse-patient relationship. It represents a feminist poststructural consideration of the broader institutional and social context that influences the dynamics of that relationship. The characteristics of that relationship can be regarded as performances of subjectivity shaped by managerial, medical and nursing discourses. Both nurse and patient signify particular discursively constituted meanings to each other which shape the relationship. It is proposed that the discourses which inform how each should respond to the other encourage the utilization of disciplinary tactics by the nurse which relay to the patient what is expected of him/her. An effect of these disciplinary procedures is to rein in the caring potential of nursing practices. However, nursing's relationship with women's work and the social history of caring may provide it with a discursive context that recognizes the social significance of this work. (24 references) (Author)

20030814-42

Challenging the status quo. O'Brien M (2003), *MIDIRS Midwifery Digest* vol 13, no 3, September 2003, pp 316-318

A feminist approach to the present provision of maternity services. (23 references) (VDD)

20030729-2*

Unhappy endings: a feminist reappraisal of the women's health movement from the vantage of pregnancy loss. Layne LL (2003), *Social Science and Medicine* vol 56, no 9, May 2003, pp 1881-1891

This essay contrasts the rosy birth scenarios of the natural childbirth movement with reproductive disaster stories of members of pregnancy loss support groups and women from toxically assaulted communities in the US who have suffered pregnancy loss. I argue that both biomedical obstetrics and the women's health movement critique of it share a belief in the ability to control reproduction so that there will be a positive outcome. I show that this emphasis on happy endings (whether believed to be the result of medical intervention, or women's natural inborn powers to reproduce) exacerbates the experience of those whose pregnancies do not end happily. I show how the women's health movement's emphasis on the importance of women being in control of their own bodies is related to a broader 'culture of meritocracy' which contributes to maternal blame (and self-blame) when pregnancies are not perfect. (Author)

20030515-7

Woman-centered maternity nursing education and practice. Giarratano G (2003), *Journal of Perinatal Education* vol 12, no 1, 2003, pp 18-28

The purpose of this Heideggerian phenomenological study was to uncover the meanings of the clinical experiences of registered nurses working in maternity settings after they studied maternity nursing from a woman-centered, feminist perspective in a generic baccalaureate nursing program. Purposeful sampling was conducted to locate and recruit nurses who had graduated from this nursing program between the December 1996 and December 1998 semesters and were currently working in a maternal-newborn clinical setting. Each participant had taken the required woman-centered, maternity-nursing course during her/his undergraduate education. Data collection included an individual, open-ended interview that focused on the nurses' descriptions of their everyday practices as maternity nurses. Nineteen maternal-newborn nurses between the ages of 23 and 43 years who had been in practice from six months to three years were interviewed. The constitutive patterns identified from the interviews were: 'Otherness,' 'Being and Becoming Woman-Centered,' and 'Tensions in Practicing Woman-Centered Care.' Findings revealed that the nurses had a raised awareness of oppressive maternity care practices and applied ideology of woman-centeredness as a framework for providing more humanistic care. Creating woman-centered maternity care meant negotiating tensions and barriers in medically focused maternity settings and looking for opportunities for advocacy and woman-empowerment. The barriers the nurses faced in implementing woman-centered care exposed limitations to childbearing choices and nursing practices that remain problematic in maternity care. (30 references) (Author)

20030512-23

Step 50: sex discrimination. Dimond B (2003), *British Journal of Midwifery* vol 11, no 2, February 2003, p 86

Summary of the legislation relating to sex discrimination. (7 references) (SB)

20030226-20*

Disrupting nurturance: authority and crisis in midwifery education. Van Wagner V (2002), In: International Confederation of Midwives. Midwives and women working together for the family of the world: ICM proceedings CD-ROM Vienna 2002. The Hague: ICM 2002. 7 pages

Conference paper in which the author reflects on her experience of teaching on the Midwifery Education Programme in Ontario, Canada. Her experiences are described in the context of feminist theories of teaching and learning and the paper explores issues of authority, power, and expertise. (13 references) (SB)

20030107-54

A cast of thousands. Bild E (2002), Ovarian Connection vol 1, no 2, November 2002, p 4

The author considers the various men whom aspects of pregnancy are named after. (SB)

20030102-86*

Reflections of inequality. Gomez A, Meacham D, editors (2001), Santiago: Latin American and Caribbean Women's Health Network 2001. 166 pages

Addresses issues relating to women's mental health, including the impact of gender roles, occupational hazards, gender-based violence, and body image. (SB)

20021220-45*

Addressing gender in maternal and newborn healthcare. Maternal and Neonatal Health (2002), Baltimore MD: Maternal and Neonatal Health [2002]. 2 pages

Gender - the roles and attributes that are associated with being female or male - influences every woman's decision to seek healthcare for herself and her family, and the opportunities and barriers she faces in the process of seeking care. (Author)

20021108-21

Midwives and human rights: dream or reality? TE Thompson (2002), Midwifery vol 18, no 3, September 2002, pp 188-192

Midwives as predominantly women caring for other women are subject to the same human rights violations and abuse that affect all the women of the world. They need to know and recognise these human rights violations before being able to take action that will reduce or eliminate such harmful practices. In this article, I address gender-based violations of the basic human rights of particular concern to women during their childbearing years, such as personal safety, respect for human dignity, fair and equitable access to health services, along with autonomous decision-making based on complete and unbiased information. The ethical and legal foundations of human rights are discussed in relation to viewing women as fully human, fully persons. Guidance for midwives taken from key documents of the International Confederation of Midwives are offered as midwives work together with women to end gender-based violations of one's human rights. (26 references) (Author) [Plenary paper presented at the 26th International Confederation of Midwives Congress, Vienna, April 2002].

20020911-38*

Determinants of women's choice of obstetrician/gynecologist. Zuckerman M, Navizedeh N, Feldman J, et al (2002), Journal of Women's Health & Gender-Based Medicine vol 11, no 2, March 2002, pp 175-180

Introduction: There has been a reported increase in women's desires to have female medical providers. It is unclear if this finding extends to obstetrician/gynecologists or how important gender is relative to other factors in choosing a provider. This study seeks to address these issues. Methods and Materials: In community locations in Brooklyn, New York, 537 women completed a questionnaire regarding demographics, gender of their current provider, and whether they considered age, gender, experience, location, or cost to be the most important factor in choosing an obstetrician/gynecologist. They rated their current experience and the importance of gender using a 10-point Likert scale. Results: Overall, 61% of participants preferred a female provider. The proportion did not vary with gender of the interviewer or participants' age. A female provider was preferred by 56% of Protestants, 58% of Catholics, and 58% of Jews and by 74% of Hindus and 89% of Muslims ($p = 0.02$). Regardless of whether a woman preferred a male or a female provider, 38% of participants felt strongly (7-10 on Likert scale) that gender was important. There was no difference in satisfaction with current provider between women who preferred a male or female provider. Gender was as important in choosing an obstetrician as experience or cost. Almost as many women with a female provider indicated a preference for a male (46%) as women with a male provider who preferred a female provider (54%). Conclusions: A slight majority of these women, particularly those who are Hindu or Moslem or currently use a female,

prefer female providers. Only a minority of these women feel strongly about their preference, and women with male providers are as satisfied as are women with female providers. Gender of provider was about as important as a physician's experience in choice of clinician. (12 references) (Author)

20020724-13

Midwifery power. Mander R, Reid L (2002), In: Mander R Fleming V editors. Failure to progress: the contraction of the midwifery profession. London: Routledge 2002. pp 1-19

Historical overview of the decline of midwifery power in the United Kingdom. (45 references) (RGW)

20020620-12

Naomi Wolf's 'Misconceptions' - is it relevant to the UK? McCabe A (2001), Association for Improvements in Maternity Services (AIMS) vol 13, no 4, Winter 2001-2002, pp 8-9

Misconceptions (1) - feminist writer Naomi Wolf's expose on US childbirth practices - was received with unusual positivity by the UK press. Why did it take a rich and beautiful - if somewhat confused - media personality writing about birth practices in a foreign country to get the message across in the UK? 1. Wolf N. Misconceptions: truth, lies and the unexpected on the journey to motherhood. London: Chatto and Windus, 2001. (Author, edited)

20020207-43*

Our bodies, our babies: the forgotten women's movement. Reiger K (2001), Carlton Australia: Melbourne University Press 2001. 335 pages

This book traces the struggle of Australian women and others to change approaches to childbirth, to claim their right to choices in childbirth, and to educate themselves about birth and breastfeeding. The author explores the movement which radically changed our maternity care practices, allowing fathers to participate in the birth of their children and babies to 'room-in' with their mothers. The story draws on interviews with mothers, midwives and doctors, and on archival material from relevant women's organisations. It shows how the childbirth and breastfeeding movements are relevant to feminism and women's rights. (Publisher, edited)

20020107-13

Technology: is it killing the art of midwifery?. Crozier K (2001), RCM Midwives Journal vol 4, no 12, December 2001, pp 410-411

Society has embraced the technological era and everyday life abounds with technology such as mobile phones, home computers and the internet. There has also been a rapid growth of technology in medicine and there are now many devices that midwives might reasonably be expected to use in the course of their work on labour wards. This paper will seek to explore some of the feminist arguments that surround the use of labour ward technology and clarify issues for further examination. (18 references) (Author)

20020103-9

Women's health care: a new paradigm for the 21st century. Klima CS (2001), Journal of Midwifery & Women's Health vol 46, no 5, September/October 2001, pp 285-291

Oppression based on gender exists in all aspects of women's lives and transcends contemporary cultures, economic systems, and even health care services. Radical feminism provides an alternative philosophic framework of health care that is based on a women-centered viewpoint, with the experiences of women as its unifying philosophy. Midwifery is a means to apply this new philosophic approach to the health care of women. A partnership between midwifery and feminist philosophy will allow women's voices to be heard, while guiding research in women's health care in new directions, and illuminating new approaches to current health problems. The new millennium provides an opportunity to explore an alternative framework and philosophy that will change the current paradigm of women's health care. (47 references) (Author)

20011031-47*

Misconceptions: truth, lies and the unexpected on the journey to motherhood. Wolf N (2001), London: Chatto and Windus 2001. 282 pages

Whether you are a midwife, a parent or are about to experience childbirth, this book provides a fascinating personal view on 21st century maternity care and the transition to parenthood. Whilst the author's experience is predominantly North American, there are many aspects that are pertinent to the United Kingdom (UK) and other

countries. I must admit to approaching the book with a set of pre-conceived ideas about United States (US) based maternity care which I found were initially borne out in the book and reflected certain stereotypes. However, I found the same issues of medical power underpinning the US structure and experience of women which also exists in the UK and this brought me to view the book with respect. Even without my own nagging doubts, the book is well enough researched to give examples of experiences of maternity care in the UK which confirms that all is not always as one would hope here. However, the UK is also cited for providing many good examples of woman-centred care. The author has widely researched maternity care, particularly in the USA, and provides some shocking statistics, for example 'if the 50% of unnecessary caesareans were avoided, American hospitals would lose \$1.1 billion in revenue a year'. As Naomi Wolf's profile informs us, the author 'lectures widely on women's issues, gender and politics'. This is a personal account and the view of one woman's experience of a maternity care system but there are many aspects of it that I am sure will resonate for many women. For any professional concerned with providing women with maternity care that is sensitive to her needs, this book provides valuable insight into the vulnerability and dependency of pregnant women and the impact that unfriendly and uncaring attitudes can have on women at this time. The author takes us on a journey through her first pregnancy, she describes the loss of confidence she experienced following the joy of discovering her pregnancy. This confirms for me that this theme of losing confidence is common to all women regardless of socio-economic status or cultural background. But her criticisms are not just for the medicalisation of childbirth as she describes 'naturalists' as being equally as rigid. As midwives, we know what a minefield antenatal screening is for women. Here the author makes the reality of the soul-searching women do when making decisions about antenatal screening painfully clear. How well do antenatal classes really prepare women for the childbirth experience? Not well enough was the author's experience. She came to the conclusion that women are 'not prepared for the courage you need to tap into during labour'. The only reason the classes could be described as woman-centred were because the women there were the centre of everyone's attention once a week! Her criticism is that there was not enough realism, which is food for thought for midwives preparing to give childbirth classes. I could cite many examples pertinent to midwifery practice which is why this is a book that deserves to be read by midwives. Reviewed by Ann Remmers, Head of Midwifery, Southmead Hospital, Bristol.

20010726-30*

The impossibility of motherhood. DiQuinzio P (1999), New York: Routledge 1999. 275 pages

Critical review of feminist writing on motherhood. Chapters cover issues of feminism and individualism, mothering and the emergence of feminism, mothering and difference feminism, the body as situation, maternal thinking, embodiment and discourse, mothering and psychoanalysis, and mothering and women's experience. (SB)

20010110-05*

The politics of reproduction: beyond the slogans. Albury RM (1999), St Leonards, Australia: Allen and Unwin 1999. 209 pages

In both public and private life, women's fertility is always the focus of strong passions. Why are some women willing to undergo invasive medical treatment in order to become pregnant? Why are others willing to use backyard abortionists if clinics are not available? Why is everyone else so quick to judge them? The author looks beyond the slogans that dominate the debate to explore the contexts in which women make decisions about fertility and raising children. Drawing on the experiences of younger and older women, she looks at the changing ways in which women have negotiated fertility, contraception, abortion, assisted reproduction, adoption and motherhood. She analyses the ways in which the media, the medical profession, public policy and the law constrain and shape women's experiences. She examines the role of the women's movement and argues that we need to look beyond the commonsense understandings of motherhood, heterosexuality and family formation which shape policy debates.

20010101-11

Evidence-based care. Part eight: perineal care should be a feminist issue. Walsh D (2000), British Journal of Midwifery vol 8, no 12, December 2000, pp 731-732, 734-737

A significant body of robust research exists to inform perineal care but it is almost all about process and outcome variables reflecting practitioner's interests. It is scandalous that women's concerns and priorities have been largely sidelined apart from a few notable exceptions discussed in this article. This reflects the largely patriarchal culture that exists within hospital-based maternity services. We can learn much from feminist research principles that can assist us in redefining the research agenda so that what we study and how we study it is more woman-centred. (42 references) (Author)

20001118-42

Is motherhood good for women? A feminist exploration. Kirkley DL (2000), JOGNN: Journal of Obstetric, Gynecologic and Neonatal Nursing vol 29, no 5, September/October 2000, pp 459-464

Motherhood as biologic destiny for women, has been long assumed. As nurses who aid women struggling with the demands of career and motherhood, we need to question this assumption. An exploration of feminist theory offers nurses ideas (and perhaps permission) to question the purpose and effects of mothering and the effects of mothering on women in our culture. Additionally, parallels between motherhood and the nursing profession are drawn. (18 references) (Author)

20001101-01

The gender agenda. Salvage J (2000), Nursing Times vol 96, no 26, 29 June-5 July 2000, p 26

One of the most emotive subjects within midwifery and obstetrics is the continuing gender debate regarding male involvement with maternity care. The author presents her personal view that men must accept they belong to a gender with a shameful record of abuse of women, and belong to a profession which afford many opportunities to repeat such abuse. (JAL)

20000906-40

Marginalizing women: images of pregnancy in Williams Obstetrics. Smith SA, Condit DM (2000), Journal of Perinatal Education vol 9, no 2, 2000, pp 14-26

This research analyzes the historical development of the medical construction of the pregnant body in 17 of 20 editions of Williams Obstetrics, an obstetrical textbook published continually from 1904 to 1997. Examination of the visual imagery of these works produced three key findings. First, depictions of the healthy or 'normal' pregnant body are virtually absent throughout the series. Second, visual depictions of women's full bodies adhere to a race-based hierarchy of presentation. Finally, the fundamental discourse about pregnant and female bodies communicated to physicians (primarily) by these images is one of pathology and fragmentation. We conclude that the resulting social and medical construction of the pregnant and female body presented in the Williams series is one of disembodiment, abjection, and ultimately marginality. These findings support recent feminist research that criticizes both the increasing erasure of the person of the women from the medical interpretation of pregnancy and the concomitant decrease in women's perceived sense of empowerment as pregnant beings. (26 references) (Author)

20000713-18*

Access to maternity information and support: the experiences and needs of women before and after giving birth.

Singh D, Newburn M, editors (2000), London: National Childbirth Trust July 2000. 142 pages

Results of a survey conducted in the United Kingdom in 1998 by the National Childbirth Trust to examine the types of antenatal care, information and support which women receive, and to identify strengths and weaknesses of services provided. A total of 1188 responses were analysed from women of different parities, ages, and social and ethnic groups. A follow up survey conducted 6 months later examined women's experiences of care in labour and postnatally. (KL)

20000704-29\$

The concept of 'care' in midwifery practice. Davies L, Wickham S (2000), Midwifery Matters no 85, Summer 2000, pp 8-9

Language has the ability to empower or disempower a woman. The authors argue that the woman can become the passive recipient of the process described as 'care' rather than being an autonomous person making her own childbirth decisions. Alternatives to the word 'care' are considered, and the implications of this for the future of autonomous midwifery are highlighted. (8 references) (RGW)

20000504-22\$

Midwifery activism and the feminist agenda. Hanna, C (2000), Midwifery Today no 53, March 2000, pp 32-33

How does the feminist agenda fit into plans for midwifery activism? The author explains how support and encouragement from two previously unrelated groups made all the difference to her promotion of midwifery in California. (JAL)

20000501-24*

Feminism, the state and social policy. Charles N (2000), Basingstoke: Macmillan Press Ltd 2000. 245 pages

Feminist social movements of the 1960s and 70s demanded radical change and an end to women's oppression. They aimed their demands at the state, thereby recognizing that the state had the power to change policies. Twenty-five years later, it seems that everything and nothing has changed. Women now make up half the workforce of advanced capitalist societies but they still do the bulk of the cleaning, washing and cooking at home. So have feminist social movements been effective in bringing about change? Has their engagement with the state led to changes in social policies? Have they made any difference to the lives of ordinary women and men in the industrialized west? This book provides some of the answers. It explores how policies have changed and how much of this change is due to social movement activity. It looks at the engagement of feminist social movements with different states in different societies, the way states influence the emergence of feminist social movements and the form they take. In some areas of policy, there have been huge changes and in others, change has been almost imperceptible. This book explores why it is easier to bring about change in some areas than others. It also asks whether these changes would have happened anyway. Are they a result of feminist social movements or of changes in economy and society? Or does the answer to this question depend on the society being studied? These issues are explored by comparing feminist social movements, states, and social policy change in Britain, Europe and North America in the last three decades of the 20th century. (Publisher).

20000501-02*

Reading birth and death: a history of obstetric thinking. Murphy-Lawless J (1998), Cork, Ireland: Cork University Press 1998. 343 pages

The issue of who should control childbirth remains one of the outstanding problems for the women's movement, despite almost four decades of campaigning for change. This continuing relevance suggests that exercising choice and personal agency remain political struggles for each woman who faces an institutional maternity care system. Since the eighteenth century, obstetric discourse has had a decisive impact on women's experience of childbirth. Using historical records from Irish hospitals and the writings of Irish doctors, this book analyses the core beliefs and practices of obstetric science. It reveals a belief in the incompetence of women with regard to childbirth and traces the effects on women of such a radically gendered notion. The author argues that the problem of exercising personal agency which women face stems directly from the way the science has worked. (325 references) (Publisher)

20000313-25\$

Research in midwifery - the relevance of a feminist theoretical framework. Barnes M (1999), Australian College of Midwives Incorporated Journal vol 12, no 2, June 1999, pp 6-10

As midwifery develops as a discipline and new models of care are introduced within maternity services, research activity and inquiry into practice and professional issues will be required. This paper suggests that an appropriate theoretical underpinning for research in midwifery is one that is based on feminist theory. It is argued that by adopting this approach, midwifery practice will focus on the needs of women and change in the provision of services for childbearing women will be in response to women's evaluation of existing services. By addressing the needs of women it is argued that the profession will also benefit, as the role of midwifery in the health care of childbearing women will be defined. (33 references) (Author)

20000203-06*

Social perspectives on pregnancy and childbirth for midwives, nurses and the caring professions. Kent J (2000), Buckingham: Open University Press 2000. 251 pages

How do pregnancy and childbirth affect women's lives? How do we understand the connections between the biological social processes that shape experiences of pregnancy and childbirth? What influences contemporary approaches to maternity care and midwifery education? This book explores contemporary issues around pregnancy and childbirth using a feminist sociological approach. Becoming pregnant and giving birth are seen here as complex social processes. The book therefore goes beyond biological amounts of pregnancy and childbirth to examine these social processes. The biological and the social are seen as linked together. Knowledge, power, identity and the body are key concepts in the book and important for understanding the relationship between the biological and social. Written in a clear, accessible style the text will assist nurses, midwives and the caring professions to use sociological ideas and theories. It is divided into four parts that look at ways of knowing, the professionals, constructing identities and women's bodies. In the conclusion the author discusses the implications of adopting a feminist and sociological approach to health care practice. Social Perspectives on Pregnancy and Childbirth for Midwives, Nurses and the Caring Professions has been designed for use as a key text on a range of pre-registration and post-registration degree

courses for nurses and midwives, and is suitable for use on a range of undergraduate programmes in social science and health studies. (558 references) (Publisher). MIDIRS review: The title of this book is rather wordy, but don't let that put you off. Julie Kent has put together a remarkable text, that sets pregnancy and childbirth within a sociological context, and explores how the world in which we work as midwives can be explained and affected at every level by the social world in which we live. Kent has a gift of explaining complex theories in a lucid and accessible fashion, and uses these theories to conduct a detailed examination of knowledge, professionalisation, motherhood, midwifery, reproductive technologies and more. The book draws on many of the 'classic' sociological texts, often referred to in the 'further reading' section of each chapter, giving readers who are not familiar with these a thorough introduction to the authors and ideas that underpin current thinking. The references used throughout the book are extensive, giving an opportunity to explore a catholic mix of theory, research and, on occasion, personal opinion. The book is very user-friendly. I particularly liked the way that terminology that might be new to the reader is highlighted in bold, and each emboldened word is included in a glossary at the back. Each profession has its own vocabulary. Trying to make sense, as an outsider, of that vocabulary, whether sociological or midwifery can, at best, lead to a sense of alienation and, at worst, to a complete lack of comprehension. Each chapter ends with a summary of key points, followed by a series of discussion points. These encourage the reader to reflect on what they have learned and could, if used as the basis of a reflective essay or literature search, form part of a midwife's PREP requirements. The discussion points are also creative. For example, in the chapter *Imaging Bodies*, the reader is encouraged to consider how pregnancy and childbirth are represented in popular magazines. Such a simple suggestion, yet with the potential of such a powerful impact, for popular magazines seem to suggest a world that is peopled almost exclusively by white, able-bodied, slim, attractive and apparently heterosexual people. Kent creates a powerful argument for including sociological perspectives on pregnancy and childbirth into every aspect of midwifery education, practice, research and management. I constantly found myself thinking 'Yes, midwives really need to know this', and yet, sadly, too much of our time and focus is on the biological and medical. While these are also vitally important to practice, they need to be balanced in equal measure by an understanding of how society shapes our understanding and interpretation of the world. The scope and breadth of the book are remarkable, in line with the aim of the book 'to show how the very meanings attached to biology, to being a woman, to having a baby, are the products of social processes'. It is perhaps inevitable, then, that the depth is sometimes wanting. For example, within the chapter *Educating the Professionals*, a discussion about the relationship between midwives and nurses is limited to one paragraph. However, this is a small gripe, and the reference list at the back of the book is so extensive that there are ample pointers for readers who want more detail. I think midwives at all levels will find this a thought-provoking read. It may make you challenge your own assumptions about men, women, and families and it may make you reflect on, and possibly change your practice. Kent ends by urging midwives to engage in theoretical debate and to develop research that includes a sociological perspective on pregnancy and childbirth. Reading this book demonstrates why this is so vitally important for women, families and midwives. Reviewed by Mary Stewart, midwifery lecturer.

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