Between Standards and Voluntariness: Midwives' Alignment Work in Antenatal Care

Jenny Gleisner

Linköping University, Sweden/jenny.gleisner@liu.se

Abstract

Antenatal care in Sweden is voluntary but offered to all pregnant persons. It is organised in accordance with a standardised programme where midwives do pregnancy check-ups and inform about pregnancy, childbirth and becoming parents. But a standardised programme can be difficult to apply to the varying individuals' wants and needs.

Through interviews with midwives and observation of parental education, the article attends to the tension that arises between standards and voluntariness in antenatal care and the often-invisible alignment work done by midwives to make knowledge attractive and palatable to parents-to-be. It does so by showing that the recipients wanting the knowledge becomes important for it to be moved with stability and integrity without losing meaning. The article contributes to ongoing discussions about how scientific knowledge is turned into practice by elucidating the affective dimensions of alignment work and how feelings may facilitate or hinder the movement of knowledge.

Keywords: Alignment work, emotion work, knowledge, standards, antenatal care, midwifery

Introduction

Antenatal care in Sweden is voluntary but offered to all pregnant persons. It is part of the public healthcare system and thus is expected to be offered in the same way regardless of one's geographical location, socioeconomic situation or language skills; antenatal care should be offered and be accessible to everyone (SOU, 2008: 131). These norms and values also mirror the Swedish healthcare policy as a whole (Lundberg, 2018); a policy that calls for "the need for common standards" (Star and Ruhleder, 1996: 112) that make "medicine more accessible, cost-effective, and democratic" (Timmermans and Berg, 2003: vii).

In a local medical context, such standards are encoded into formalised routines of how to plan patients' treatments based on their diagnosis and on how the medical staff's work is coordinated at the clinic. The standardised programme for midwives' work is encoded in a national report given by the Swedish Society of Obstetrics and Gynecology (2016) – referred to by midwives as "The Blue Book" because of its blue cover – and establishes routines for antenatal care.

Antenatal care, including pregnancy check-ups and parental education classes, has two aims: to monitor the normal pregnancy progression and detect divergences, as well as to offer knowledge and support that prepare the parents-to-be for going through pregnancy, childbirth and becoming parents (The Swedish Society

of Obstetrics and Gynecology, 2016; Bredström and Gruber, 2015). The knowledge and support offered by midwives in antenatal care is expected to empower parents-to-be and help them follow the pregnancy trajectory and prepare for parenthood.

The knowledge and support also reflect cultural expectations and sometimes idealised norms about 'normal birth' and 'good parents' (Gleisner, 2013). For example, a vaginal birth is explained as a better choice than a caesarean section for both mother and child, and breastfeeding as more beneficial than formula. Midwives also promote a healthy lifestyle including exercise, a balanced diet, no alcohol, a limited amount of caffeine, and gender equality in the partners' roles (The Swedish Society of Obstetrics and Gynecology, 2016; The Swedish Association of Midwives, 2018). Some of these topics are discussed during individual pregnancy check-ups, some in parental education classes, and some in both settings.

In this work, the standards in the Blue Book aim to make antenatal care and support to be accessible and equal to everyone by providing a programme, including pregnancy check-ups and parental education, to be implemented in all regions all over Sweden. However, while guidelines can be seen as a collective way of perceiving and handling various kinds of situations; ultimately, standards are constructed to be applicable to not just one specific situation, but to many.

This main characteristic condition of standards also constitutes their limits. Susan Leigh Star (1990) describes this vividly in her story about being allergic to onions and ordering a hamburger at a fast-food restaurant. In a fast-food restaurant, standards make it possible to speedily and reliably deliver 'the same' meal, that is, a hamburger of predictable taste and quality within a specified (very short) time frame, all over the world. In such a standardised system, any special orders, such as a hamburger without onions, becomes a disruption, as it requires the restaurant staff to make a time-consuming exception from the streamlined work at the restaurant. For the allergic customer, that means that their company will have finished their meals by the time the special order arrives, which is disruptive to a shared (and quick) meal. Star's solution was to order a standard burger and scrape "the offending onions" off (Star, 1990: 35), making the point that misfits inevitably occur when "individuals, organizations and standardized technologies meet" and that often invisible and continuous work needs to be done around standards (Star, 1990: 34).

Similarly, a standardised antenatal care programme does not easily apply to every individual's wants and needs. In antenatal care, there are no hamburgers to be delivered, of course, but knowledge. Still, I will argue, midwives are the ones who "scrape off the onions" in the form of making the standardised and voluntary antenatal care and the knowledge offered applicable and appealing to parents-to-be. By analysing material from interviews with midwives and observations of parental classes in Sweden, I explore how midwives reason about the following: their everyday encounters with parents-to-be, when individuals and the standardised antenatal care meet, and how emotions matter for knowledge to be moved. I will discuss how feelings towards knowledge and how it is communicated may be seen as hindering or facilitating its movement, and how handling both one's own feelings and the feelings of others are part of midwives' work.

This article contributes to ongoing discussions in Science and Technology Studies (STS) about the work associated with applying and maintaining standards to facilitate the movement of knowledge. STS scholars have, for example, pointed to the difficulties in maintaining standards (e.g., Latour and Woolgar, [1979] 1986; Mol and Law, 1994, 2001) and that work is needed continuously, and not only when misfits appear (Star, 1990). Further, that standards are used to facilitate knowledge to be moved with stability and integrity without losing meaning. However, the movement of knowledge between different contexts is not done easily and requires work (e.g., Bowker and Star, 1999; Kruse, 2016; Morgan, 2011; Star and Ruhleder, 1996). I contribute to this field in STS by further developing the concept 'alignment work', as developed by Corinna Kruse (2021). The concept broadens analytical focus; "[i]t aligns, for example, standards and specific circumstances or different understandings with each other" (Kruse, 2021: 10). I add a sensitivity to emotion work (Hochschild, 1979) that further develops the

concept by also including how emotions matter for the movement of knowledge, here exemplified through midwives' work in antenatal care.

Alignment work and the movement of knowledge

In her conceptualisation of alignment work, Kruse (2021) brings together Anselm Strauss' articulation work that emphasises the continuous and necessary but often invisible work that makes the 'real' work possible (Strauss et al., 1985) with Janet Vertesi's work on how actors align heterogenous infrastructures "to produce a shared experience of seamlessness" (Vertesi, 2014: 277f).

Invisible work, such as building relationships and offering emotional support, is often underpaid, low status and typically found in female-dominated and caring professions (Star, 1990; Allen, 2014; Björklund, 2004; Lydahl, 2017). Studies of invisible work also illuminate its complexities: that work can be more or less visible/invisible and that not all work should be made visible (Bowker and Star, 1999; Lydahl, 2017). Articulation work is about facilitating and coordinating others' work (Strauss, 1988: 164), such as making sure that patients do not have to wait too long between several appointments at a clinic (Jonvallen, 2009: 350) or preparing patients for medical examinations (Strauss et al., 1985: 156). Articulation work is carried out by different actors, but in health care, often by nurses.

The concept of alignment work draws upon this body of research to think about the work of making standards work in practice while also recognising the work done to bridge the gap between different contexts that may hinder knowledge to be moved with stability. Kruse has developed the concept in the context of her research about the movement of forensic evidence, from traces at the crime scene to the laboratory and later as evidence in court. Alignment work, according to her, "is not always noticed or acknowledged as part of the primary work" and "is performed around interprofessional standards … supporting and complementing them" (Kruse, 2021: 4). She illustrates this with crime scene technicians' alignment work at the crime scene to make fruitful laboratory analysis of the traces they recover possible. Despite there being interprofessional standards in place that "are meant to resolve the tension between the laboratory and the crime scene" and to make traces move with stability (Kruse, 2021: 10), these standards are not always easily applicable to every individual crime scene. That is, the unstandardised and unstandardisable crime scene "must be harmonized with the laboratory" (Kruse, 2021: 10).

Alignment work therefore also brings a sensitivity to work done to bridge different understandings as part of making knowledge move with stability. These different understandings or epistemic cultures (Knorr Cetina, 1999) become more clear in another of her examples, namely crime scene technicians' being summoned to court to explain something in a crime scene report that may be self-evident to the technician but not to others. In other words, they perform (very visible) alignment work in court to facilitate evidence being understood in the intended way (Kruse, 2021: 11f). This alignment work mitigates the gap between the different epistemic cultures (Knorr Cetina, 1999) as it temporarily aims at "creating an experience of seamlessness between different sites in the criminal justice system" (Kruse, 2021: 5).

Kruse borrows the concept of seamlessness as the aim of alignment work from Vertesi's (2014) work on the interaction in and between heterogeneous systems. The gaps between them are what she calls 'the seams' that, perhaps similar to Star's (1990) misfits, cause tensions between different perspectives and understandings among the actors involved (Vertesi, 2014). When work is done to "produce a unified sense of digital space", that is, when the different systems can be made to work together in such a way that the gaps between them become invisible to the users of the digital space, it is experienced as seamless (Vertesi, 2014: 268).

In antenatal care, instead of aligning heterogeneous digital systems or different professionals' understandings of 'the same' evidence, alignment work is done to align a heterogeneous group of parents-to-be with the pregnancy care programme. The gaps, or the seams, can be recognised between the goals of antenatal care, the different check-ups, and parental education that

parents-to-be are supposed to move through while also being monitored and given advice and information. Thus, there are many different "edges" and "endings", where the seams may become visible (Vertesi, 2014: 269). That is, midwives perform alignment work to increase participation and to be able to present knowledge to parents-to-be in a way that makes it understandable and applicable to all of them without losing its meaning. Midwives aim at making national and regional guidelines work in the local context and in the encounter with the various parents-to-be – in other words, to resolve "*the tension between local and global*" (Star and Ruhleder, 1996: 114, italics in original) so that knowledge can be moved and moved with stability (Kruse, 2021).

However, Kruse's concept of alignment work alone does not sufficiently help understand the movement of knowledge when the recipients may not want it. In her work, someone not wanting the knowledge never becomes a matter of discussion – moving forensic evidence through its different professions is required of the criminal justice system and thus not a matter of individual choice. She however touches upon people's reluctance to share their knowledge since they may not "trust strangers with classified information" (Kruse, 2021: 13). As I will illustrate with my material from antenatal care, alignment work can, however, also include emotion work that aims at affecting others (cf. Hochschild, 1979, [1983] 2012; Driessen, 2018; Davis, 2019) into wanting the knowledge offered. How midwives reason about and manage the voluntary aspect of antenatal care offers a way to think about how and when feelings may hinder or facilitate knowledge to be moved. I bring work on emotions and emotion work to the concept of alignment work to make it possible to acknowledge and understand the affective dimension of alignment work and thus of the movement of knowledge.

Emotion work as part of alignment work

Emotion work, or emotion management, as Arlie Russel Hochschild also describes it, is about "trying to feel the right feelings for the job", i.e., to evoke or suppress feelings in line with job requirements but also to manage the feelings of others (Hochschild, 1979: 561). I focus on the second of these aspects, how midwives work to affect the feelings of parents-to-be.

Feelings can be recognised as being experienced and expressed in relation to someone or something else (Björk, 2017; Leavitt, 1996) while being context dependent, intertwined with normative understandings, and simultaneously an individual and collective process (Gleisner and Siwe, 2020; Gleisner, 2013; Cottingham and Erickson, 2020; Lindén, 2020).

In Hochschild's (1979) famous study of flight attendants, she shows how they both learn the skills of the profession as well as how to manage their feelings in line with expectations for their professional role: to be in control, to offer service, and to "be nicer than normal". The flight attendants' emotion work also aims at affecting the passengers' emotions in situations where problems may arise, e.g., making passengers who fear flying feel calm, safe and content, but also affect the passengers' will to follow rules and norms about how to behave, so that they do not cause troubles or disturb fellow passengers (Hochschild, 1979: 564). As pointed out by Hochschild (1979: 564), there is a direction to what emotion work aims at and an aspect of duration, as a continuous work carried out within a professional role.

Emotion work has been analysed in many different settings and particularly in health care and caring professions (e.g., Allan, 2001; Bolton, 2000; Gleisner and Johnson, 2021; James, 1992; Kerr and Garforth, 2016), showing that handling emotions is central to caring jobs but often invisible and that it includes both learning to maintain a professional approach and emotionally support the patients (Fineman, 2005; Hunter, 2001).

I also draw inspiration from Annelieke Driessen's (2018: 115) research on caregivers' work with residents in dementia care that shows that emotion work is also about affecting the will of others and that this work is done in sociomaterial interactions. She writes that "rather than coercing residents into doing whatever task is at hand, care workers attempt to align what residents' want with what they themselves want (for them)", rather than merely trying to convince or force them

(Driessen, 2018: 115). She further explains that what the caregivers want is not static and could also be aligned in relation to what is considered to be in the best interest of the residents.

I argue that it is productive to add a sensibility to emotion work as part of alignment work as it elucidates the relational aspects between midwife and parent-to-be and how emotions matter for the movement of knowledge, for example, to affect the recipients' willingness to receive and adhere to the knowledge offered (e.g., Hochschild, 1979, [1983] 2012; Gleisner, 2013; Björk, 2017; Cottingham and Erickson, 2020; Driessen, 2018; Davis, 2019).

That the relationship between midwife and parent-to-be is one between expert and layperson also affects the movement of knowledge and the emotion work carried out. In this relationship, the midwife becomes a mediator of scientific knowledge while also being the caregiver. On the one hand, the expert's training and their professional role give them a degree of professional discretion, but on the other hand she still has to conform to the standards and guidelines that govern her profession (Cook et al., 2020). However, while midwives are obliged to inform about certain matters prescribed by the standardised programme (The Swedish Society of Obstetrics and Gynecology, 2016) parents-to-be can choose whether or not to participate or listen. That is, the relationship between midwife and parent(s)-to-be is regulated for the midwife but voluntary for parents-to-be. What is at stake in antenatal care, in the midwives' view, is the parents-to-be resisting the expert knowledge and perhaps endangering their child.

The relationship is further shaped by quite overt power aspects. Being in the expert role puts the midwife in a position to promote normative understandings about, for example, the normal (vaginal) birth, a healthy lifestyle, and breast feeding. In addition, if the midwife suspects that a child is at risk of neglect or abuse, she is obliged to notify the social services (The National Board of Health and Welfare, 2022), which parents-to-be may perceive as a constant threat hanging over them. As STS studies have shown, the tensions of the complex expert position "[shape] the relations between medical professionals and patients" (Åkerman et al., 2020: 4) as well as the mediating role of the expert (Egher, 2020).

Material and methods

I apply an ethnographic approach, which means striving towards capturing actions, reflections and perspectives as they enable analysis of meaning in work practices as well as emphasising the importance of their contexts (Emerson et al., 2011). I have aspired to capture midwives' perspectives on their work, and their reasoning on how to make knowledge and guidelines accessible and palatable to parents-to-be.

The empirical material for this article was gathered in 2018-19 and includes in-depth interviews of midwives and shorter observations of their work. I conducted thirteen semi-structured interviews with midwives working in three different regions in Sweden and observed four parent education lectures in two of these regions. These specific regions were chosen to include a variety of catchment areas including smaller -, midsize- and large cities. The midwives interviewed had 2 to 39 years of work experience in different regions or clinics. The selection of regions and participants aimed at gaining a rich material on midwives' perspectives on how antenatal care and parental education are organised, as well as on their reflections on meeting parents-to-be with different backgrounds. The empirical material also includes documents, such as national guidelines and reports that guides midwives' work (The Swedish Society of Obstetrics and Gynecology, 2016; SOU, 2008:131; The Swedish Association of Midwives, 2018).

The interviews were conducted at the midwives' workplaces and lasted between 60 and 90 minutes. The interviews included open-ended questions about the midwives' everyday work, its organisation, meeting with parents-to-be, and introducing and talking about different subjects. I aimed to get insight into their reasoning about how to present research-based knowledge to parents-to-be, and which knowledge to include in the parent education classes in relation to organisational guidelines and to parents' feelings and requests. All interviews were audio recorded and transcribed.

While on site, I wrote fieldnotes that I soon after rewrote into rich descriptions (Geertz, 1973). In my notes, both from interviews and observations, I included not only what was said and done, but also how and in which context (cf. Agar, 1996).

During my observations of parent education classes – mainly offered to first-time parents and lasting approximately two hours at a time – I focused on how the midwives presented knowledge to parents-to-be. During classes they spoke of this as recommendations, information, research-based or evidence-based knowledge. Calling it information I believe to some degree underestimates the complexity of it and why it may be difficult to mediate, which is why I refer to it as knowledge.

I have been inspired by Grounded Theory (Charmaz, 2014) throughout the research process, from formulating research questions, gathering data, and coding to analysis, looking for patterns as well as contradictions, and basing theoretical work on them.

In an earlier study of mine I conducted extensive fieldwork at a midwifery education programme in Sweden and carried out two shorter periods of fieldwork at a delivery ward, studying midwifery students' learning and how guidelines and institutional- and cultural contexts shape norms and emotions in everyday practice (Gleisner, 2013). The midwifery students described working with parent education classes as sometimes challenging and frustrating and I became curious of why. This was not what I focused on then, but the topic stayed with me and informed this project. Early on, a theme that caught my attention was how midwives reasoned about different obstacles or challenges that may prevent or hinder how knowledge is moved throughout antenatal care – from midwife to parents-to-be. In particular, they highlighted these challenges or obstacles when talking about what they described as potentially sensitive subjects, such as a pregnant person's weight or attitudes towards breastfeeding.

Aligning parental education

According to the midwives I interviewed, essentially all pregnant persons register at a midwifery clinic and participate in the programme consisting of approximately six to ten check-up visits and one or two ultrasound scans. Even though antenatal care is voluntary, regularly seeing a midwife for pregnancy check-ups becomes "the normal way", and not attending the pregnancy care programme becomes a choice that deviates from that norm. Attendance at parental education, however, does not seem to be as self-evident. Thus, even though both pregnancy check-ups and parental education are voluntary, the voluntariness – or the willingness to participate – differs between the two. This voluntariness, however, seems to be perceived as a little problematic by midwives. As one of them said, "With first-time parents, we probably think that they should go even though it is voluntary". This opinion was voiced in all of the interviews: even though parental education is voluntary, first-time parents really should participate. In the midwives' eyes, the parents-to-be exercise of their voluntariness becomes a problem as individual check-ups and parental education are developed in relation to each other. In other words, what the midwives conceptualised as a package of knowledge that needs to be moved in its entirety will only move in this manner if (first-time) parents choose to take part in both.

Accordingly, midwives strive to get parents-to-be to want to participate in parental education – in other words, they perform alignment work to align parents-to-be and their wishes with the programme in its entirety. When discussing this alignment work, I will argue that adding a sensitivity to emotion work to the notion of alignment work makes it possible to capture how alignment work can be a matter of affecting others to *want* to align themselves with what may not originally have been their choice (cf. Hochschild, 1979: 564; Driessen, 2018: 115). Adapting the format of parental education is one way of doing this.

Midwives continually study and discuss how to organise the parental education, which content to include in them, and how to improve participation (Jordemodern, 2016; Fabian et.al., 2005; Andersson et. al., 2012; Alhdén et. al., 2008, 2012; Bariami et. al., 2015). That also means that the activities they offer may vary between different places as well as over time.

Traditionally midwives organise parental education during pregnancy in smaller discussion

groups that meet on one or several occasions. This group model builds on the participants being active and interacting with each other, sharing experiences, fears and expectations. The midwives named as the benefits of smaller groups that they allow parents-to-be to share their experiences and to get to know the other participants. This was also the incentive when introducing parental education in Sweden, besides providing information about pregnancy, birth and caring for the new-born baby (Fabian et al., 2015). There is, however, nowadays often one lecture about giving birth as an addition to the group-based activities, which is run by midwives working in delivery care. This group model was applied in two of the regions in my study.

In the third region, parents-to-be can pick and choose from a so-called smorgasbord of lectures on different topics. The different lectures are based on PowerPoint presentations and focus on the following areas: being pregnant and having a healthy lifestyle during pregnancy, as well as exercise and food recommendations; giving birth, pain relief methods, breastfeeding and how to care for the new-born baby; and parenthood and relationships. The subjects discussed in the group model are consistent with the content of the lectures in the smorgasbord model but are introduced in a less structured way.

Organising parental education as a smorgasbord of lectures was described by midwives working in the third region as an incentive to increase attendance by them fit more easily into people's presumably busy lives and thus making attending them more appealing. That is, time, or rather the expectant parents' lack of time, makes frequently offered single lectures more accessible. The smorgasbord model was also thought to be reaching groups that partake less in parental education, such as young people, people who are not comfortable in social gatherings where they are expected to interact with strangers, and people with immigrant backgrounds (e.g., Bredström and Gruber, 2015; Fabian et.al., 2004). I however, focus on the content of the lectures and how it relates to experiences and knowledge accessed. The midwives' point of departure for the lectures was, as one of them explained, "When we started planning these lectures, we thought about what women need to know and what they want to learn."

The midwives working with the smorgasbord model then highlighted the lectures by often referring to them when a topic or question was raised by the parents-to-be at a pregnancy check-up, telling them that it would be discussed thoroughly there. This may create a sense of exclusiveness, that knowledge presented at the lectures cannot be gained elsewhere (cf. Davis, 2019) and thus making the lectures more attractive. In this way, the midwives do emotion work by affecting the willingness to participate in parental education (cf. Björk, 2017; Leavitt, 1996). Once the parents-to-be are in the class, the midwives can present what the parents-to-be ask for, what they as midwives perceive as necessary knowledge as well as inform about matters that they are obliged to. In other words, by seemingly encouraging parents-to-be to pick and choose, the midwives hope to entice them to pick the package of knowledge in its entirety.

In my interviews, the midwives also pointed out another benefit of the large lectures in the smorgasbord model: through the lectures, they could be sure that everyone is receiving the "same information".

Group-based parental education allows, to a degree, variation in what is discussed based on the interests of or questions posed by the participants or on what the individual midwife chooses to emphasise. But the midwives seemed to worry about failing to inform group participants about something or framing things differently. "You could never be sure that everyone got the same information since there were so many of us involved", a midwife said about her old workplace with group-based parental education. Since these groups are rather small, there are also several midwives involved in leading them. Holding lectures, on the other hand, meant that "We know that if they went to the lecture, they got the same information as everyone else." Similarly, another midwife working with the smorgasbord model explained: "Because we have these lectures that are run by this small group of midwives who show this PowerPoint, I can be certain that this specific piece of information has been given." Both midwives emphasised the necessity of everyone

receiving the same information, implying that knowledge can be delivered in a stable way. Thus, stability is imagined to be maintained by the PowerPoint presentations and by a limited number of midwives running the lectures.

This raises the question of why it is so important for everyone to receive the "same information". I trace this importance to the normative dimensions in maternity care, that care and support should be equally and equitably accessible to everyone from the public health care system, including antenatal care (cf. Bredström and Gruber, 2015). There were, however, also doubtful voices about the lectures among the midwives: "It takes two hours. You go there, receive the information you need, and then you're done. … Whether it is a good thing or not, that I don't know." She pointed out that even though this way of organising parental classes may facilitate the movement of knowledge, the effects were not known. This has been acknowledged as a problem also when assessing the outcome of parental education on a general level (Brixval et al., 2015; Ferguson et al., 2013). Another midwife explicitly criticised this model of large lectures:

> It's a lecture and not an exchange between people. The interaction was the reason to start up parental education back in the seventies, and for the parents to be strengthened in their role as parents. As it is now, it's a lecture about how to behave at the delivery ward. Yes, I mean "First, you will come here, then we will put on an ID wristband, and then this and that will happen. And these are the different kinds of pain relief methods available." So, there is not much said about parenthood.

In other words, the midwife seemed to feel that the interaction between people and the focus on preparing for parenthood have been lost in the smorgasbord model of parental education. But she also pointed out what is gained, even though she did not present it as something unquestionably good; namely the very practical matter of the lecture of explaining to parents-to-be "how to behave at the delivery ward". When I observed lectures about preparing for giving birth, the midwives explained where to park the car, what to bring to the delivery ward (a snack, baby clothes, nappies), knowing when it is time to go – and most importantly, to call first before coming to the delivery ward. They also discussed the kind of support a midwife can provide during birth, such as pain relief and helping with breathing techniques, as well as what the midwife cannot do. Such limitations referred to, amongst other things, when certain pain relief is not appropriate and the midwife's lack of time since she often cares for more than one birthing person at the same time.

However, parents-to-be who do participate and receive "the same information" may not necessarily embrace the information offered to them, or interpret it as intended. As I have shown in an earlier study (Gleisner, 2013) the midwife's perception of normal birth may not always correspond with the expectant parents' understanding. But the midwives want to align the parents' expectations and attitudes towards the birth with that of midwives. They want the pregnant person to be in active labour when arriving at the delivery ward, not, as a midwife put it, "dilated only one centimetre". If the latter is the case, they may be sent home again (and will probably be disappointed). Hence, these lectures include instructions that are meant to shape the behaviour of the parents-to-be but also their expectations so that they know what they can request and expect when giving birth.

Even so, while the lectures enable the same knowledge to be presented with stability it simultaneously undermines the stability of how knowledge is understood by the recipients. To the midwives, presenting knowledge during lectures that follows a PowerPoint presentation and a script enacts stability through making sure that everything they agreed to include will be addressed.

However, the kind of mutual alignment work that captures misunderstandings or ambiguity through back and forth questions and answers so that "understandings are in alignment" (Kruse, 2021:12) is not possible during the lectures with their very limited time for questions, only during individual pregnancy check-ups.

Even though pregnant and birthing persons are expected to follow a prescribed trajectory (Gleisner, 2013), they are all different. Some of them fit into the standardised antenatal care and some do not. While standards make equal care

over time and in different places possible (cf. Bowker and Star, 1999), it is the midwife's job to handle the limitations of standards (cf. Star, 1990) and to make the journey through antenatal care as smooth as possible. Or, as discussed here, to make parental education appealing to attend so that as many as possible choose to participate, which would resolve the tension between standards and voluntariness in antenatal care. This is why adapting parental education is a form of will-work (Driessen, 2018); emotion work that is done to increase the willingness among parents-to-be to embrace the knowledge embedded in the programme and thus a part of midwives' alignment work.

Aligning the feelings of parents-to-be

The alignment work midwives do, is not only about parents-to-be accessing the knowledge offered through participating in parental education but also about managing their feelings so that they *want* to adhere to it. I will illustrate the complexity of this work through discussing midwives' work around affectively charged issues.

I asked the midwives if they found certain topics as difficult or sensitive to talk about. All of them mentioned breastfeeding and weight issues. One of the midwives working with the smorgasbord model described both why weight may become a sensitive topic and the difficulties in approaching it like this:

> I think it is easier to talk about it [weight issues] now since we got the PowerPoint presentation, compared to before. Then, during the first individual meeting, we were expected to talk about their lifestyle. If it was a woman with a BMI of 35, it was much more difficult because I don't want to step on anyone's toes. Some of them made clear that "I know my weight. You don't have to inform me about it. I know about the risks. I don't want to hear it". Well, because antenatal care is voluntary, we can't inform them about something they don't want to be informed about. But during the lectures, we have information written down, showing statistics and research saying, "This is a normal weight gain during pregnancy, in relation to your BMI". We can talk about it in an easier way. I don't look at specific individuals when I say, "This is important to think about because this and that". And then, you tell them about the risks.

The other midwives interviewed similarly described weight as "not only about weight" but often linked to affectively charged experiences that an individual may carry with them, such as a history of eating disorder. While there are normative perceptions of normal weight in broader society, there are also medical risks for the progression of the pregnancy and for the health of the mother and foetus in relation to overweight, underweight and excessive or insufficient weight gain during pregnancy (Chang et al., 2013; de Jersey et al., 2018).

In the quote, the midwife compared talking about health-related issues during individual pregnancy check-ups with discussing them during lectures in the smorgasbord model. To talk about weight in terms of statistics and research-based knowledge during the lectures with many people in the audience made the topic, in the midwives' view, less personal and thus easier to inform about.

The midwives I interviewed also spoked about developing strategies for talking about breastfeeding during the check-ups and based on the individuals' wants and needs. "You have to be flexible", a midwife said when explaining to me how she introduced issues to discuss depending on the person in front of her. When I asked another midwife to describe how she introduces a potentially sensitive topic in a conversation during pregnancy check-ups she laughed and said,

> I have worked out this strategy when it comes to breastfeeding. The first time we talk about it I ask, "Is it ok with you if I tell you about the positive health-related effects of breastfeeding?". If they say no, I have to respect that.

In this rather cautious approach, the midwife described the first step in her (assumingly at least to some degree successful) strategy towards informing parents-to-be about the benefits of breastfeeding. Another midwife had also put a lot of thought into introducing breastfeeding as a topic to discuss in group-based parental education:

> I begin by asking them what they have read and heard about breastfeeding and any questions they may have. Then we talk about that, and I give them some facts. It is always good to have some facts. But it is their choice, and we have to be sensitive to that. But we also have to … we are obliged to talk about the benefits of breastfeeding, and also the benefits in the long run. Meanwhile, we are not supposed to demand anything from them. We are supposed to inform, and then it will be an informed decision where they can decide what they want to do.

That is, she first asked the participants to present what they know about breastfeeding so that she thereafter could relate it to what she mentioned as "facts".

The midwife also addressed the tension between midwives' being obliged to inform while listening is voluntary. When she talked about the parents-to-be making "an informed decision", she implied that, to her, the choice whether to breastfeed should be made in a particular way: It should also be "informed", that is, be grounded in a certain kind of knowledge – research-based knowledge. This was mirrored by another midwife:

> I think it depends on the person's attitude and if her decision is based on ignorance. It also matters if she has already decided what she thinks is good, or what she has heard her mother say was good. I find it hard to respond to that.

She illustrated her words with the example of a woman who wants to breastfeed but brings a bottle and formula to the delivery ward to give the baby during the first days before breastfeeding has been established: This is rather discouraged if the mother wants to breastfeed as it is considered to make breastfeeding more difficult (e.g., Häggkvist et al., 2010; Melin et al., 2018). In this example, the midwife's expertise about how to best stimulate and establish breastfeeding stands in conflict with what she perceived as the knowledge and attitude of the parent-to-be. In the light of the other midwives' strategies and experiences, one might suspect, however, that the midwife may find it difficult to address the topic with the parent-to-be, fearing that they would not want to listen to or follow her advice.

Another factor is that midwives are obliged to aim for increased levels of breastfeeding at a general societal level. They are expected to do so by informing about the practical and health-related benefits of breastfeeding (for both mother and child) based on recent research, as well as by supporting women through establishing breastfeeding and through any problems that may arise (The Swedish Society of Obstetrics and Gynecology, 2016: 76ff). Through access to such knowledge and support, from the midwives' perspective, parents-to-be will be able to make "an informed decision".

It might seem like the expected outcome of that decision is a given; after all, the midwives make it clear what is considered as "best" for the baby, the mother, and the family as a whole – the Blue Book presents research-based knowledge that supports breastfeeding and promotes motivational interviewing (MI).[1] However, the Blue Book also emphasises that individual experiences affect choices and the importance of the midwife and midwifery care being supportive without being judgemental (The Swedish Society of Obstetrics and Gynecology, 2016: 77). In addition, some babies cannot breastfeed, and sometimes breastfeeding is not recommended – and a midwife ought always to work in the best interest of the mother and baby (The Swedish Society of Obstetrics and Gynecology, 2016: 30, 64, 67). Hence, the midwives are to support those who want to breastfeed – for their own sake and as well as for their babies' – but recognise the individual choice of whether or not to breastfeed.[2]

Rather than ignore or dismiss the expectant parents' wants and needs, the midwives create conditions for them to adhere to the knowledge offered. One of the midwives working with the smorgasbord model explained that she finds parents nowadays rather demanding because they "have read so much", which has affected how she thinks about how they as midwives talk about different topics. She said,

> If you're passionate about breastfeeding, you should be the one lecturing about it. Because then you will deliver it in a completely different way… If you're not certain, then you can just go home because they won't trust you at all.

That is, offering knowledge, encountering different knowledge claims and attitudes are done simultaneously with striving to appear reliable and convincing. Offering research-based, reliable and stable knowledge – in the midwife's words "facts" – is given importance for the movement of knowledge. But it is also important to speak of breastfeeding with passion to be able to affect the feelings of parents-to-be so that they will want to breastfeed. Such affectively charged topics may affect the relations between midwife and parent-to-be in a negative way and may cause tensions that hinders the movement of knowledge (cf. Davis, 2019; Hillersdal et al., 2020; Egher, 2020).

Thus, the midwives' alignment work is not merely about "getting the job done" (Driessen, 2018: 113), it also matters *how* they get it done; in other words, the midwives' emotion work is a central part of their work and their alignment work.

Their emotion work is reminiscent of the caregivers in Driessen's work who do what she calls sociomaterial will-work in order to get the residents out of bed or into the shower by "sculpting moods and emotions" (Driessen, 2018: 118). By smiling and being cheerful, the caregivers encourage the residents to want to get up, instead of coercing them. In Driessen's words, this constitutes as "… the relational nature of will-work: if a care worker gets along well with a resident, aligning wanting becomes easier to do" (Driessen, 2018: 223). This specific form of emotion work that Driessen focusses on aims at aligning the will of others to get the job done. Likewise, in Hochschild's (1979: 564) study of flight attendants, they manage the feelings of passengers by inducing trust, and by calming those who fear flying or are concerned about delays by making them feel calm and safe. The smile was presented to the flight attendants as the "biggest asset" to manage many kinds of situations and troublesome or worried passengers (Hochschild, [1983] 2012: 105).

The emotion work that appears in different ways in the examples presented show that trust is important in making knowledge appealing to parents-to-be. Inducing trust in the knowledge offered and in midwifery and its expertise appear as a prerequisite for aligning the feelings of parents-to-be and thus for the movement of knowledge in antenatal care (cf. Davis, 2019).

To parents-to-be, successfully aligned antenatal care and parental support appear seamless. They do not see the work midwives do in reorganising parental education to make it more accessible, or the many ways midwives work to present information about e.g., breastfeeding or weight issues. Nor do they see the flexibility in how midwives introduce these subjects during the individual pregnancy check-ups, adapting to the pregnant person's knowledge, experiences and emotions. Midwives work to make the seams between the Blue Book's standards and their personal situation invisible by providing information in such a way that the parents-to-be engage in the different activities and adhere to the information given to them in the expected way and are prepared for the subsequent steps of the journey, such as knowing when labour has started, how to care for the new-born baby, and how to become good parents.

In Driessen's work, will-work becomes visible when what a resident wants stands in opposition to what a care worker wants. The care workers' will-work aims at encouraging – not forcing – residents in dementia care to do what the care givers believe is best for them (i.e., getting out of bed if it means they will eat better even though the resident may not want to). In other words, will-work addresses the "tension between opposing desires" that aims at aligning the will of residents with the care givers' wanting so that "good care" can be provided (Driessen, 2018: 111f). In her example, just as in the case presented by one of the midwives, the caregiver/midwife engages in will-work by explaining how breastfeeding is stimulated and established in "the best way", according to research.

In other words, the Blue Book's standards have to be complemented by (alignment) work: applying, maintaining and adapting standards to each and every person a midwife meets where there is a tension between the goal of antenatal care and the wants and needs of individual parents-to-be. As Star (1990) has argued, this is a common problem with standards: to make them work smoothly, this often-invisible work must be done – over and over again.

Conclusion: Emotion work as part of alignment work

In this article, I have built upon STS literature about the work associated with applying and maintaining standards to facilitate the movement of knowledge. I have attended to the tension that arises between standards and voluntariness in antenatal care and analysed the often-invisible alignment work done by midwives to make knowledge attractive and palatable to parents-to-be. I have shown how emotions matter within antenatal care and the relation between alignment work and emotion work.

The importance of and rationale behind the shared standards in midwives' work reflects the goals and values of Swedish health care policy: equal care should be accessible to everyone, no matter where one lives, one's socioeconomic situation, or language skills (Lundberg, 2018; SOU, 2008:131). However, while standards in medicine make equal and accessible care possible (Timmermans and Berg, 2003), there are also limitations to these standards.

The midwives themselves often spoke of knowledge as *information* or in terms of an action – of *informing* parents-to-be. They also spoke of advice – all of it based on research and turned into standards for antenatal care. But as discussed by Kruse (2021), when knowledge is moved between contexts, recipients may not understand it in the way they are expected to. In my study, gaps between different knowledge cultures (Kruse, 2021: 11f) appeared when parents-to-be brought their own experiences and what they have read or heard from others into parental education. Their understandings of (valid) knowledge differed from those of the midwives, which makes the stable movement of knowledge challenging (Kruse, 2021: 2). In addition, not only can parents-to-be choose whether or not to see a midwife or to join the parental education, they can also choose whether or not to adhere to the knowledge offered to them. Hence, even when parents-to-be participate in the pregnancy programme, this does not necessarily mean that they will embody the information offered to them or interpret it in the intended way.

This article adds to research on the stable movement of knowledge by further developing the concept of 'alignment work' (Kruse, 2021) that emphasises the work of making standards work in practice while also recognising the work done to bridge the gap between different contexts. I argue that adding a sensitivity to emotions (Hochschild, [1983] 2012; Davis, 2019) elucidates that the recipients *wanting* the knowledge becomes important for it to be moved with stability and integrity without losing meaning (Kruse, 2021).

My analysis shows that the midwives' obligation to inform and prepare pregnant persons and their partners in becoming parents in a voluntary form of support creates a tension, perhaps best described in Bowker and Star's (1999: 15) words as "… the slip between the ideal standard and the contingencies of practice". As illustrated through the empirical examples in this article, the midwives are the ones scraping off the onions (cf. Star, 1990). If the antenatal care does not easily match an individual's wants and needs, it is the midwives' job to manage this. They are the ones continuously doing alignment work, bringing together the global and the local, making global standards fit in the local context (Star and Ruhleder, 1996) and aligning parental education, the knowledge offered there, and the wants and needs of individual parents-to-be. The parents-to-be are constantly replaced by new ones, which means that the midwives' continuous and often invisible alignment work never stops (cf. Bowker and Star, 1999). In other words, midwives are the experts who mediate knowledge to individuals from all over society, with one thing in common: they are parents-to-be.

My analysis also shows that midwives' work to align the feelings of parents-to-be includes how they introduce knowledge and themselves as reliable experts (cf. Driessen, 2018: 113; Egher, 2020). I have discussed how midwives induce parents-to-be to attend parental education by talking about the knowledge being offered there as exclusive and impossible to be gained elsewhere. I have also discussed how they present themselves as reliable and their knowledge as trustworthy by referring to research and statistics. They furthermore engender trust and shape expectations by familiarising parents-to-be with the practicalities of their local delivery ward. Hence, the midwives align standards with the specific circumstances and understandings (cf.

Kruse, 2021: 10) of each set of parents-to-be, but also with their feelings.

To conclude, I argue that alignment work includes emotion work that aims to align the feelings of others in line with the goals of antenatal care (cf. Hochschild, [1983] 2012; Driessen, 2018; Björk, 2017; Leavitt, 1996) to create, at least temporary, moments of alignment to make standards run smoothly (cf. Kruse, 2021; Vertesi, 2014). This, I claim, is important for understanding the affective dimensions of alignment work and that feelings may facilitate or hinder the movement of knowledge, which may be useful also in other contexts, especially in caring practices and when experts and laypersons meet.

Acknowledgements

I would like to thank the midwives who participated in this study. I am most grateful to the programme *The Long-Term Provision of Knowledge to Society* for funding this project. A special thank you to my project colleagues Corinna Kruse and Hannah Grankvist, to the *Bodies, Knowledge, Subjectivities* group, and to the *Centre for Medical Humanities and Bioethics* at Linköping University, for discussions across disciplines. I would also like to thank the anonymous reviewers for critically engaging with my work and for their extremely helpful comments.

References

Agar MH (1996) *The professional stranger. An informal introduction to ethnography*. San Diego: Academic Press.

Åkerman M, Taipale J, Saikkonen S, Kantola I and Bergroth H (2020) Expertise and Its Tensions. *Science & Technology Studies* 33(2): 2-9.

Alhdén I, Alehagen S, Dahlgren LO and Josefsson A (2012) Parents' Expectations About Participating in Antenatal Parenthood Education Classes. *Journal of Perinatal Education* 21(1): 11-17.

Alhdén I, Göransson A, Josefsson A and Alehagen S (2008) Parenthood Education in Swedish Antenatal Care: Perceptions of Midwives and Obstetricians in Charge. *Journal of Perinatal Education* 17(2): 21-27.

Allan HT (2001) Nursing the clinic and managing emotions in a fertility unit: findings from an ethnographic study. *Human Fertility* 4(1): 18-23.

Allen D (2014) *The Invisible Work of Nurses: Hospitals, Organisation and Healthcare*. London: Routledge.

Andersson E, Christensson K and Hildingsson I (2012) Parents' experiences and perceptions of group-based antenatal care in four clinics in Sweden. *Midwifery* 28(4): 502-508.

Bäckström CA, Wahn, EIH and Ekström AC (2010) Two sides of breastfeeding support: experiences of women and midwives. *International Breastfeeding Journal* 5(20): 1-8.

Bariami M, Oxelmark L, Johansson SE and Hylander I (2015) Support and continuity during the first 2 weeks postpartum. *Scandinavian Journal of Caring Sciences* 29(3): 409-417.

Björk S (2017) Emotions and empathic imagination: Parents relating to norms of work, parenthood and gender equality. *Families, Relationships and Societies* 7(7): 171-186.

Björklund P (2004) Invisibility, Moral Knowledge and Nursing Work in the Writings of Joan Liaschenko and Patricia Rodney. *Nursing Ethics* 11(2): 110–12.

Bolton SC (2000) Who cares? Offering emotion work as a 'gift' in the nursing labour process. *Journal of Advanced Nursing* 32(3): 580-586.

Bowker GC and Star SL (1999) *Sorting Things Out – Classification and Its Consequences*. Cambridge: MIT Press.

Bredström A and Gruber S (2015) Language, culture and maternity care: 'Troubling' interpretation in an institutional context. *Nordic Journal of Migration Research* 5(2): 58-66.

Brixval CS, Axelsen SF, Lauemoller SG, Andersen SK, Due P and Koushede V (2015) The effect of antenatal education in small classes on obstetric and psycho-social outcomes – a systematic review. *Systematic Reviews* 4(20): 1-9.

Chang T, Llanes M, Gold KJ and Fetters MD (2013) Perspectives about and approaches to weight gain in pregnancy: a qualitative study of physicians and nurse midwives. *BMC Pregnancy and Childbirth* 13(47): 1-7.

Charmaz K (2014) *Constructing Grounded Theory*. 2nd edition. London: Sage Publications.

Cook WC, Turnhout E and van Bommel S (2020) Learning to Become an FSC Auditor: Objectivity, Interpretation, and Mastery. *Science & Technology Studies* 33(32): 32-48.

Cottingham MD and Erikson RJ (2020) The Promise of Emotion Practice: At the Bedside and Beyond. *Work and Occupation* 47(2): 173-199.

Davis SR (2019) Science Communication as Emotion Work: Negotiating Curiosity and Wonder at a Science Festival. *Science as Culture* 28(4): 538-61.

de Jersey SJ, Tyler J, Guthrie T and New K (2018) Supporting healthy weight gain and management in pregnancy: Does a mandatory training education session improve knowledge and confidence of midwives? *Midwifery* 65(1): 1-7.

Driessen A (2018) Sociomaterial Will-Work: Aligning Daily Wanting in Dutch Dementia Care. In: Krause F and Boldt J (eds) *Care in Healthcare. Reflections on Theory and Practice.* Cham: Palgrave MacMillan, pp. 111-133.

Egher C (2020) Online Expert Mediators: The Rise of a New 'Bipolar' Stakeholder or Going Beyond Interactional Expertise in the Blogosphere. *Science & Technology Studies* 33(2): 10-31.

Emerson R, Rachel M and Shaw LL (2011) *Writing ethnographic fieldnotes*. Chicago: University of Chicago Press.

Fabian HM, Rådestad IJ and Waldenström U (2004) Characteristics of Swedish women who do not attend childbirth and parenthood education classes during pregnancy. *Midwifery* 20(3): 226-35.

Fabian HM, Rådestad I and Waldenström U (2005) Childbirth and parenthood education classes in Sweden. Women's opinion and possible outcome. *Acta Obstetricia et Gynecologica Scandinavia* 84(5): 436-443.

Fabian HM, Sarkadi A and Åhman A (2015) Challenges and benefits of conducting parent classes in Sweden: Midwives' perspectives. *Sexual & Reproductive Healthcare* 6(4): 236-242.

Ferguson S, Davis D and Browne J (2013) Does antenatal education affect labour and birth? A structured review of the literature. *Women and Birth* 26(1): 5-8.

Fineman S (2005) Appreciating emotion at work: paradigm tensions. *International Journal of Work Organisation and Emotion* 1(1): 4-19.

Geertz C (1973) *The interpretation of culture.* New York: Basic Books.

Gleisner J (2013) *Negotiating the Normal Birth. Norms and Emotions in Midwifery Education.* PhD Thesis, Linköping University, Sweden.

Gleisner J and Johnson E (2021) Caring for affective subjects produced in intimate healthcare examinations. *Health*. Epub ahead of print 27 May 2021. DOI 10.1177/13634593211020072.

Gleisner J and Siwe K (2020) Differences in teaching female and male intimate examinations. A qualitative study. *Medical Education* 54(4): 348-355.

Gustafsson I, Nyström M and Palmér L (2017) Midwives' lived experience of caring for new mothers with initial breastfeeding difficulties: A phenomenological study. *Sexual & Reproductive Healthcare* 12(12): 9-15.

Häggkvist A-P, Brantsäter AL, Grjibovski AM, Helsing E, Meltzer HM and Haugen M (2010) Prevalence of breast-feeding in the Norwegian mother and child cohort study and health service-related correlates of cessation of full breast-feeding. *Public Health Nutrition* 13(12): 2076-2086.

Hassel H and von Rahden O (2007) Training for midwives in motivational interviewing. *Journal of Public Health* 15(6): 441–445.

Hillersdal L, Jespersen AP, Oxlund B and Bruun B (2020) Affect and Effect in Interdisciplinary Research Collaboration. *Science & Technology Studies* 33(2): 66-82.

Hochschild AR (1979) Emotion work, feeling rules, and social structure. *The American Journal of Sociology* 85(3): 551-575.

Hochschild AR ([1983] 2012) *The managed heart: commercialization of human feeling*. Berkeley and Los Angeles: University of California Press.

Hunter B (2001) Emotion work in midwifery: a review of current knowledge. *Journal of Advanced Nursing* 24(4): 436-444.

James N (1992) Care = organisation + physical labour + emotional labour. *Sociology of Health and Illness* 14(4): 488-509.

Jonvallen P (2009) Compliance Revisited: Pharmaceutical Drug Trials in the Era of the Contract Research Organization. *Nursing Inquiry* 16(4): 347–35.

Jordemodern (2012) Theme: Breastfeeding (Tema amning). Journal by the Swedish Association of Midwives (Svenska barnmorskeförbundets tidskrift). March, No. 3.

Jordemodern (2016) Theme: Parenthood education (Tema föräldragrupper). Journal by the Swedish Association of Midwives (Svenska barnmorskeförbundets tidskrift). January-February, No. 1-2.

Kerr A and Garforth L (2016) Affective Practices, Care and Bioscience: A study of Two Laboratories. *The Sociological Review* 64(1): 3-20.

Knorr Cetina KD (1999) *Epistemic Cultures – How the Sciences Make Knowledge.* Cambridge: Harvard University Press.

Kruse C (2021) Attaining the Stable Movement of Knowledge Objects through the Swedish Criminal Justice System: Thinking with Infrastructure. *Science & Technology Studies* 34(1): 2-18.

Kruse C (2016) *The Social Life of Forensic Evidence*. Oakland: University of California Press.

Latour B and Woolgar S ([1979] 1986) *Laboratory Life: The social construction of scientific facts*. Princeton: Princeton University Press.

Leavitt J (1996) Meaning and feeling in the anthropology of emotions. *American Ethnologist* 23(3): 514-539.

Lindén L (2020) Love and Fear? Affect, Public Engagement and the Use of Facebook in HPV Vaccination Communication. *Science & Technology Studies* 33(3): 2-18.

Lindhardt CL, Rubak S, Mogensen O et al. (2015) Healthcare professionals experience with motivational interviewing in their encounter with obese pregnant women. *Midwifery* 31(7): 678-684.

Lundberg O (2018) The next step towards more equity in health in Sweden: how can we close the gap in a generation? *Scandinavian Journal of Public Health* 46(22): 19-27.

Lydahl D (2017) Visible persons, invisible work? Exploring articulation work in the implementation of person-centred care on a hospital ward. *Sociologisk Forskning* 54(3): 163-179.

Melin A, Björklund P and Zwedberg S (2018) Pediatricians' experiences of working with breastfeeding: An interview study. *Sexual & Reproductive Health* 16(16): 218-223.

Miller W and Rollnick S (1991) *Motivational interviewing. Preparing people to change addictive behaviour*. New York: Guilford Press.

Mol A and Law J (1994) Regions, networks, and fluids: Anaemia and social topology. *Social Studies of Science* 24(4): 641-671.

Morgan MS (2011) Travelling Facts. In: Howlett P and Morgan MS (eds) *How Well Do Facts Travel? The Dissemination of Reliable Knowledge.* Cambridge: Cambridge University Press, pp. 3-39.

SOU (2008) Parental support – benefits all. National strategy for society's help and support to parents in their parenting (Föräldrastöd – en vinst för alla. Nationell strategi för samhällets stöd och hjälp till föräldrar i deras föräldraskap). Stockholm: Ministry of Health and Social Affairs (Socialdepartementet) 2008:131.

Star SL (1990) Power, Technologies and the Phenomenology of Conventions: On Being Allergic to Onions. In: Law J (ed) *A Sociology of Monsters – Essays on Power, Technology and Domination.* London: Routledge, pp. 26-56.

Star SL and Ruhleder K (1996) Steps Toward an Ecology of Infrastructure: Design and Access for Large Information Spaces. *Information Systems Research* 7(1): 111-134.

Strauss A (1988) The Articulation of Project Work: An Organizational Process. *The Sociological Quarterly* 29(2): 163-178.

Strauss A, Fagerhaugh S, Suczek B and Wiener C (1985) *Social Organization of Medical Work*. Chicago: University of Chicago Press.

The National Board of Health and Welfare (Socialstyrelsen) (2022) For those who are legally responsible to report concern for a child's welfare according to chapter 14§ 1 of the Social Services Act. Available at: www.socialstyrelsen.se/orosanmalan (accessed 10 October 2022).

The Swedish Association of Midwives (Svenska barnmorskeförbundet) (2018) Description of expertise for midwives (Kompetensbeskrivning för legitimerad barnmorska). Version 1.0 Available at: www.barnmorskeforbundet.se (accessed 2 May 2021).

The Swedish Society of Obstetrics and Gynecology (Svensk förening *för* gynekologi och obstetric) (2016) Maternal, sexual and reproductive health (Mödravård, Sexuell och Reproduktiv Hälsa). Report No. 76.

Timmermans S and Berg M (2003) *The Gold Standard – The Challenge of Evidence-Based Medicine and Standardization in Health Care*. Philadelphia: Temple University Press.

Vertesi J (2014) Seamful Spaces: Heterogeneous Infrastructures in Interaction. *Science, Technology & Human Values* 39(2): 264-284.

Notes

1 The method, initially introduced by Miller and Rollnick (1991), aims at facilitating changes of behavior and is developed to accomplish this even when time is constrained (Lindhardt et al., 2015). Through this conversation technique the midwife step-by-step guides the parents-to-be through the process, from introducing a topic, for example the risks with smoking during pregnancy, to supporting a change of behavior. Specific for this method is that the parents-to-be will be the ones taking the initiative to formulate the problem, present solutions and take responsibility for their lifestyle changes (Hassel and von Rahden, 2007).

2 This complexity of midwives' work with, for example breastfeeding, is continuously discussed and researched among midwives (Jordemodern, 2012; Bäckström et al., 2010; Gustafsson et al., 2017). It also resonates with how Cook, Turnhout and van Bommel (2020) discuss how experts must follow societal goals and be objective and simultaneously recognizing subjective dimensions of expertise.