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Working fulltime throughout pregnancy – The Norwegian women's perspectives. A qualitative approach

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ABSTRACT

Objective: the purpose of this study was to gain a deeper understanding of aspects that influence healthy women's ability to work fulltime throughout the pregnancy, considering women's experiences and individual perspectives, as well as understanding health resources available to them.
Design/Setting: a qualitative approach was selected for the data collection, and the data presented is derived from in-depth interviews. Ten pregnant Norwegian women with uncomplicated pregnancies, aged 24–40, working fulltime throughout their pregnancies with no sick leave, were interviewed during pregnancy week 37–39. All participants had their regular check-ups at six local public health clinics. The transcribed interviews were analysed through systematic text condensation.
Findings: the findings included two main themes: *Supporting environment* and *having a positive mindset*. Feeling good about oneself and feeling appreciated at work provided these women with the supporting environment they needed. All the respondents had coped with different challenges that they found important when working throughout their pregnancies while facing the difficulties of a pregnancy. They emphasised that their positive attitude and coping skills contributed to normalising the pregnancy and motivated them to go to work.
Conclusions: having a positive mindset and a balanced perspective on the pregnancy and bodily changes are important factors in being able to work throughout pregnancy. Support, in various arenas, might positively influence pregnant women´s positive mindset, having a favourable effect on their health resources and ability to continue working when bearing children.

1. Introduction

The majority of the pregnant population is part of the workforce in developed countries. In recent decades sick leave in this group has increased, and the primary focus has been on disease and risk factors. Approximately 60% of the Norwegian pregnant population takes some sick leave during the pregnancy (Kristensen et al., 2008). Increased sickness absence among pregnant women is not explained by higher age among the first-time pregnant population (Ariansen and Mykletun, 2014). Rieck and Telle (2012) describe increasing sick leave during the past twenty years and observed that as the pregnancy progresses there is an increase in sick leave absence. 75.3% of 2918 Norwegian women reported being on sick leave at some point during pregnancy. Factors associated with sick leave varied according to pregnancy trimester (Dørheim et al., 2013). Alstveit (2012) studied the reproductive health of employed first-time mothers, and how they combined work and family life. Becoming a mother and being at work is associated with a challenge to maintain previous work performance, and pregnancy can pose a threat to some women's professional identity (Bailey, 2000; Millward, 2006).

The World Health Organisation states that knowledge about the occupational health of pregnant employees is needed (WHO, 2001). In Norway the health of pregnant women is considered as good, and for most women continuing physical activity and work during pregnancy is safe (The Norwegian Ministry of Social and Health Services, 1999; The Directorate for Health and Social Affairs, 2005). Work and health are intimately connected, and the working situation affects both mental and physical health (Ettner and Grzywacz, 2001). Employment fosters and protects health (Ross and Mirowsky, 1995), and full-time jobs relate to better health than all forms of non-employment (Popham et al., 2012; Minelli et al., 2014). Being in paid employment increase the likelihood of an uncomplicated pregnancy (Jansen et al., 2009; Chappell et al., 2013).

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Pregnancy is a normal physiological state including normal bodily changes (Dørheim et al., 2013). However, pregnancy is a transition phase as the woman prepares to become a mother, and becomes aware of the changes in her body and the growing fetus (Blåka, 2002). The health of expectant mothers is a determinant of the health of the infant (WHO, 1998), however a woman's genetic makeup, physiological and psychological condition could affect the outcome (Blåka, 2002). One important aspect of the midwife's care is promotion of a normal pregnancy and birth (ICM, 2011). Future health care should focus on salutogenesis and, as a contrast to disease and risk assessment, this will emphasise health promotion (Downe, 2008).

Antonovsky (1987) salutogenic question 'What is it that keeps individuals' healthy despite stress and critical events in life?' emphasise the fact that stress management may be decisive for whether the outcome will be pathological, neutral or improved health. This illustrates ways of sustaining and promoting health. Health is dependent on the individual's generalised resistance resources (GRRs) and sense of coherence (SOC) strategy. GRRs are considered the individual's health resources, meaning the potential for health and current health status on the continuum of health. Antonovsky (1979) explains that the individual's health resources are any individual characteristic that can simplify tension management. GRRs can support well-being in the context of major life events, and are grounded in biological, social, cultural, and historical dispositions. A person's capacity to use resources, in order to improve and maintain health, is described as SOC. SOC includes the three components: meaningfulness, comprehensibility and manageability (Antonovsky, 1987; Lindström and Eriksson, 2005). The first concept, meaningfulness, describes the individual's way of finding meaning in situations, both mentally and emotionally, to shape outcomes and cope with difficulties in the best possible way, thus including the individual's attitude to responsibility, and the belief that managing tension is worthwhile and meaningful. The second concept, comprehensibility, describes the person's understanding of challenges, i.e. seeing the world as ordered, and having structure, compliance and clarity in the information he/she needs to confront challenges. Lastly, manageability entails how individuals use resources adequately, including load balance, mastery and control, participation and decision-making (Antonovsky, 1987; Lindström and Eriksson, 2005).

During the childbearing process one can, by using Antonovsky's salutogenic theory as a foundation, focus on the woman's internal and external health resources to promote health. Furthermore, the combination of pregnancy and work require problem-solving skills (SOC). There is minimal evidence about a woman's internal and external resources, based upon Antonovsky's salutogenic theory, applicable to the promotion of health during pregnancy, including employment. This study will attempt to address this knowledge gap.

1.1. Aim

The purpose of this study is to gain a deeper understanding of aspects that influence fulltime working women's ability to stay gainfully employed throughout the pregnancy, considering the women's experiences and personal perspectives. The research questions were: *What are the characteristics of these fulltime working women's ability to work throughout the pregnancy? How can their health resources be understood?*

2. Methods

The study had a qualitative, explorative, descriptive design (Polit and Beck, 2014), as investigating a phenomenon that is rarely described.

2.1. Participants

The participants in the study were purposively selected, to best contribute to the phenomenon in study (Malterud, 2011). In qualitative research the principal for selection of a sample is to ensure that the participants have experienced the phenomenon to be studied, and that they are able to articulate what it is like to have lived that experience (Polit and Beck, 2014). The inclusion criteria were: Healthy pregnant women with uncomplicated pregnancies in fulltime employment throughout the pregnancy, without sick leave. The women in the study had to master the Norwegian language. The midwives at six major local public health clinics were contacted and requested to distribute an invitation to pregnant women in their communities. The women received requests to participate in the study by their midwife during their regular check-ups in pregnancy week 35–37. Ten women participated in the study. Three interview appointments were cancelled due to these women not having met the criteria during the recruitment process. One interview was cancelled because of the onset of labour before the period of data collection started.

2.2. Data collection

A qualitative approach was chosen for data collection (Schneider et al., 2012). The data presented is extracted from in-depth interviews, conducted during pregnancy week 37–39. Out of convenience eight interviews were conducted at the local hospital and two interviews at the women's homes. The interviews took place between June and November 2015, they lasted approximately 50 minutes each, and were conducted by two researchers (A.K.S., S.T.S.). Both researchers participated in all interviews, in both interviewer and observer roles. An interview guide with open-ended questions was prepared in advance (Table 1). The questions derived from a literature review on the topic, and from professional knowledge and experience. This guide was used as a foundation for keeping the conversation within the chosen subject, rather than asking specific questions (Malterud, 2011). After eight interviews, data saturation was achieved. The researchers suspected that sampling more data did not lead to additional information related to the research question. Meaningful themes and useful interpretations emerged after eight interviews; however, the researchers chose to conduct two additional interviews to confirm the findings and strengthen credibility (Schneider et al., 2012). The collected data was rich in content, as all the women spoke freely and provided detailed descriptions of their experiences and reflections on the topics.

The women were aged 24–40 years and were in full-time employment. They were all ethnic Norwegians, lived with their partners and had both higher and lower education. They worked in different organizations, both private and public, as well as in large and small companies. Three of the women had jobs that included physical work. A description of the women's occupations is presented by using International Standard Classification of Occupations (ISCO, 2013) (Table 2). Both first-time mothers and multiparous women were included. Mostly midwives but also general practitioners administered their regular check-ups.

2.3. Data analysis

The interviews were digitally recorded and transcribed verbatim, and were analysed carefully by using the method systematic text condensation. This method was developed by Malterud (2011) and,

Table 1
Interview guide.

1. How did you experience pregnancy? Describe your thoughts of being pregnant.
2. How do you experience coping with challenges in your life in general?
3. How did you experience care from those closest to you during pregnancy? Describe how you have been cared for by your partner, family and friends.
4. How did you experience being pregnant and working? Describe how you have been cared for by your employer and colleagues during pregnancy.
5. Describe your experience of being cared for by health professionals during pregnancy.

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