The Choices Before Us

Shifting attitudes towards childbirth and decision-making within the Netherlands

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Introduction

Childbirth is a unique experience examined within feminist studies as it is physically unique to women and affects women across all racial, economic and educational borders. However, differences in race, economic status and education deeply effect how each woman experiences giving birth. I arrive at this topic with an interest as to how experiences in childbirth are profoundly shaped by culture and location.

For my thesis I chose to examine two countries with very different attitudes towards childbirth and healthcare. The Netherlands and the United States stand out as two wealthy countries with similar medical technologies that have chosen very separate paths in maternity care. My decision to study each country is linked to my own experience as a dual citizen of both the United States and the Netherlands. I was born in the Netherlands at home with a midwife, but have grown up in the United States, surrounded by the notion of pregnancy as pathology. I embark on my research with experiences distinct to each country and an interest in how differently two countries have politicized the personal within childbirth.

As personal as childbirth is, a woman's decisions within childbirth are often influenced by how she internalizes her society (i.e., cultural norms, socioeconomics and political power relations). Changing rates of homebirths, hospital births and technological interventions reveal how often our decisions reflect the political changes in our respective societies. Reiger and Dempsy (2006) argue that western societies' are in the midst of an unsettling paradox in regards to childbirth and culture. As western women increase their social power and autonomy, their own trust and confidence in their bodies in childbirth has declined. This internal confidence has been replaced by an external confidence in a dominant western medical model. Decisions to undergo extra technological interventions such as extra ultrasounds or genetic tests are seen as the new empowerment. In an effort to exert control and authority, women are making decisions that have the ability to control risk (Zadoroznyj 1999; Lazarus 1994). Reiger and Dempsy suggest that this is inextricably linked to what they call "cultural embodiedment" (365). Women in western cultures are increasingly embodying a social landscape that places technology at the forefront of science and social life. An overall social trust in the medical industry and its'

hegemonic discourse has shifted how control is viewed and managed by women during childbirth.

Childbirth is a unique experience that has remained both constant and changing throughout history. It is constant by nature, yet also dynamic as it often mirrors sociopolitical changes within a culture. There are various examples of this in both the Netherlands and the United States. In the mid 19th century a cocktail of morphine and scopolamine known as 'twilight sleep' was introduced to American women to help them manage their pain. For first wave feminists it was seen as a powerful tool for women to minimize pain and thus control their childbirth. By the 1960s, many second wave feminists had publically denounced scopolamine as a drug that impeded women's responses and movements and was viewed as both debilitating and disempowering (Leavitt, 1980). Shifting feminist perceptions of control and empowerment changed how many women in the United States used pain medication.

In the Netherlands, this could best be seen in the dramatic shift from homebirth to hospital birth. In 1965, approximately 68.5% of all births were delivered at home. By 1978 the rate was down to 35.8% (Weigers et al. 1998). The introduction of short stay hospitals, access to hospital midwives and a functioning risk assessment system undoubtedly increased options for Dutch women. However such a large move towards the hospital may have also had implications for intervention free, women centered midwifery care as well.

Each culture perceives and reacts to childbirth in a different way based on its relationship to sex, gender, money and power. In the United States, capitalism produced a profit driven medical industry, and therefore childbirth became inextricably linked to the economy and access to health insurance. A 2013 New York Times article revealed that the average amount billed for a vaginal delivery is 30,000 dollars and 50,000 dollars for a cesarean. Commercial insurance companies pay an average of between 18,329 and 27,866 dollars, leaving many women with large bills (Rosenthal, 2013). Often costs are a product of individually billed procedures, ranging from a splash of disinfectant for the umbilical cord after birth ($20.00) to hundreds of dollars spent on having a technician read an ultrasound (Ibid). Both public and private health insurance companies encourage the use of expensive technologies to increase revenue. The result of this is that can often

lead to unnecessary medical interventions which do little for the mother, but a lot for the industry.

In the Netherlands, health insurance is universal and thus childbirth is less dependent on the market. There is importance placed on lowering spending and therefore "extras" (i.e., 'fun' 3D ultra sounds) in care is seen as excessive and costly. The average cost for a vaginal delivery is an average of 2,669 dollars and 4,435 dollars for a cesarean (Rosenthal, 2013). High rates of midwifery undoubtedly account for lower costs, as they are less apt to use expensive technologies within their practice. Unlike The United States, where women are forced to make decisions about their pregnancy and childbirth keeping cost in mind, Dutch women can more frequently receive the care that they want, when they want, and worry less about the bill.

Childbirth practices in the United States have mirrored the changes that have occurred during the 20th century institutionalization of society. Its place today within the hospital is both standard and customary. Pain medication is normative, and one of three babies is born via cesarean (OECD). The Netherlands, an equally wealthy and technologically advanced country in Western Europe, has a quite different approach. The majority of births are attended to by midwives, less than 12% of women use an epidural, and short stay hospital visits are both encouraged and normative (Christiaens, Nieuwenhuijze and De Vries 2013) . However, the once non-interventionist approach to childbirth is now shifting. Homebirth rates have steadily plummeted in the last fifty years, and cesarean rates have progressively increased. More women are opting for hospital care, and Dutch childbirth has been depicted in by various studies as more dangerous than in other European countries (Evers et. all 2011, Peristat I).

Childbirth, once a personal experience, has shifted into the public and thus inevitably political sphere of Western countries, where it is often dissected and scrutinized. In the shift from personal to political, I fear that women's voices, the most important voices, are being drowned out by economic incentives and an increasingly profit driven medical sector. My thesis will work to explore how healthcare policy has dramatically shaped how the United States conducts its childbirth practices and how similar attitudes may be slowly entering into women's decision making in childbirth in the Netherlands. Through examining the drastic shift from homebirths to hospital births

and the increased use of medical interventions within the Dutch delivery room, it is clear that maternity care in the Netherlands is changing. The comfort once traditionally reserved for homebirths is increasingly becoming replaced by the perceived safety of the hospital.

Why are more Dutch women increasingly opting for childbirth in a medical setting? How are they navigating their decision to do so? Is a shift towards an American model that perceives childbirth as pathology inevitable? Or will the Dutch governments' support of midwives ensure that regardless of location, women will continue to have quality care and autonomy in childbirth independent of economic incentives? Drawing from current literature and a standpoint epistemology using in-depth interviews with expecting or recent mothers, this thesis aims to explore how women navigate and compromise their childbirth decisions during a period of transition in Dutch maternity care.

Methodology

To understand how women navigate maternity care and childbirth within the Netherlands I chose to conduct a series of seven in-depth interviews with women currently living in the Netherlands as well as with a team of hospital midwives. My aim was to provide a "face" to the extensive research already done on childbirth practices within the Netherlands and to better comprehend the medical sectors' understanding of women's choices in childbirth. A lack of research (written in English) centered on women's voices and experiences in childbirth pushed me towards talking to women about how they were "living" their pregnancy or how they had "lived" their child's birth. My goal was to better understand the ways in which women were approaching pregnancy and childbirth in 2013, and to explore how perceptions of risk within childbirth manifested within each narrative.

Positionality and Process

Sandra Harding (1993) introduced the concept of "strong objectivity" to help researchers situate themselves within their research. (Hesse-Biber,131) To approach an issue, as an outsider requires a level of personal reflection and understanding of ones place in relation to the research.

Much of my interest in maternity care within the Netherlands and the United States comes from being both American and Dutch, and from having been born at home with a midwife in the Netherlands. My mothers' own memories of a wonderful low intervention homebirth ignited my interest in "alternative" forms of childbirth. These methods stand in stark contrast with the American attitudes of childbirth I have seen throughout my life. Today some friends have already declared their undoubted preference for epidurals when they decide to have children. In my experience American girls are socialized from any early age to believe that labor will be the most pain they will ever experience. I believe that this attitude towards childbirth creates fear, and takes confidence away from women their bodies. Thus I have arrived at my research with some pessimism and judgment of the current American medical model of childbirth. Therefore,

in my exploration of the Dutch maternity care system and its' changing trends, it is of utmost importance that I approach my research with an understanding of my own positionality and pessimism.

Hesse-Biber (2007) argues that in feminist research it is crucial to remain an active listener and be mindful of asserting too much of your agenda within the interview (134). Though I seek to understand why the Netherlands (a country which has prided itself on its' low intervention approach towards childbirth) is slowly moving towards a more medicalized, maternity care model, I realize my question is deeply embedded in my own judgments and fear. As it is difficult to isolate my sentiments from such a normative research question, I hope to utilize my interviews to understand more about how exactly women are exerting their agency and navigating their childbirths within this arguably shifting culture. To say that a shift towards an American model means a shift away from a positive birth experience implies that women are not exerting their own agency within childbirth. Therefore I intend to remain open to all sorts of decision making and step back from some of my own personal sentiments concerning the American model of healthcare and maternity care.

Though every childbirth experience is undoubtedly unique and non-generalizable, I believe that my thesis has led to some valuable insights. My research is most unique in its timing within Dutch history. It is a critical period for Dutch maternity healthcare and therefore more literature is needed to understand how such changes present themselves in women's childbirth decisions. These narratives that I present have shed light on the shifting perceptions of childbirth, comfort and risk. My research has made it clear that childbirth is a both personal and cultural experience. Each woman's experience will differ based on her internalization of her culture. As the Netherlands continues to shift its cultural attitudes and beliefs towards childbirth, women's own decisions will undoubtedly reflect this.

In-Depth Interviews

Women's experiences with childbirth and maternity care can be best understood through personal narratives and experience. In-depth interviews seek to understand the

"lived" experiences within a certain phenomenon (Hesse-Biber,118). Therefore for the purposes of my research on women, risk and childbirth I conducted a series of in-depth interviews with women who were going through, or had already gone through the Dutch maternity care system. I also did one in-depth interview with a group of midwives to complement and better situate the lived experiences of women and childbirth. To better understand the current changes taking place in the Dutch maternity care sector, it was helpful to talk to midwives who were witness to changes in their own professional lives. Though its singularity makes its immune to generalization, it did provide some valuable insight through the eyes of one team of midwives.

Despite the fact that my paper examines the maternity care models in both the United States and the Netherlands, I chose to do my fieldwork in the Netherlands. As my thesis is primarily on how changes in Dutch maternity care are manifested in women's experiences, it seemed most suitable to only interview women living in the Netherlands. For a larger analytical piece on both countries, in depth interviews with American medical professionals and mothers would be needed. For the purposes of this thesis, the American system will be examined based on previous research, whereas the Dutch system will be complement with a small qualitative study.

Sample

Participants were found using a snowball sampling method via email. With my Dutch background, I already had access to a moderate sample size of recent mothers in the Netherlands. My cousin, who was pregnant at the start of my research, connected me to three other women. A family friend working as a nurse helped me make contact with a group of midwives practicing in her hospital outside of Amsterdam. This left me with a total sample size of nine. I interviewed three expecting mothers, four recent mothers and two midwives.

As I hoped to engage a variety of women's experiences within my research, I chose two limiting factors in order to focus my data. Participants were either pregnant, or had given birth in the last three years. In making this limitation, I hoped to accomplish two tasks. I chose a time limit to help ensure that the memories of childbirth were clear to

the participant. By examining childbirth in the last three years my understanding of the Dutch maternity care system would be current and thus relevant to my research. My decision to include a sample of women who had not yet given birth was aimed to better understand any preconceived notions, anxieties or concerns regarding childbirth within the Netherlands.

Participants in my study were professionally or academically educated, middle class, employed women all between the ages of 30 and 36. Women engaged in a variety of jobs including management, arts, and law. Participants were cohabiting or married to male partners and all were planning to (or already had) a hospital birth. Five participants were Dutch natives and two had migrated in the last ten years from Portugal and Poland.

Though my sample may not reflect a generalizable population within the Netherlands, it does allow me to look at how affluent middle-class women approach childbirth decisions within their place of privilege. This specific cohort has a wide range of options available by virtue of their education and opportunity. Therefore, I will look at how the shifting perceptions of risk have the ability to transcend social barriers such as class and education. Previous research suggests that in countries where homebirth is seen as more normative (such as the Netherlands,) societal factors rather than age or education were more predictive of women's decisions to give birth at home (Weigers, 1998; van der Hulst, 2004.) By looking at a group of relatively affluent women who chose to give birth in a hospital setting, I could explore how societal factors ultimately played out in their own childbirth decisions.

Structure

In-depth interviews were predominately taken place at participants' homes though three interviews were done at their convenience in their workplaces. My goal was to create an atmosphere of comfort in order to ensure fluidity and casual conversation. Therefore I allowed all participants to decide where they wanted to be interviewed. Interviews were both semi-structured and informal, following the belief that in maintaining a casual atmosphere, the conversation will flow freely, uninhibited by formality. The interviews generally lasted from 30 to 45 minutes; however we usually

talked much longer about my larger research goals and interests. I hoped to gain thorough answers to my general questions (see appendix) while also allowing participants to speak freely and make known what was most important for them in childbirth and maternity care. Therefore I took my queues from each participant and followed their direction, using my own specific inquiries as markers (Hesse-Biber 126-127)

I conducted my group interview with midwives in a hospital outside of Amsterdam in the main office for midwives. I arrived at my interview prepared to speak with one or two midwives individually. I was given access to this interview through a family friend and had limited information as to how the interview would be structured. My initial expectation of a more individualized interview quickly changed into a casual focus group, with two midwives at the center of the interview, and others periodically contributing to the conversation. Similarly to my interviews with mothers, I maintained a semi-structured interview style, allowing for flow while ensuring that certain questions were answered. While my interviews with women were done individually to better focus on each personal narrative, speaking with multiple midwives also had its' advantages. It gave me some evidence of a 'group opinion,' or an underlying message which all of the midwives seemed to agree with. However, there were also some consequences to this structure. Within the hour and a half one midwife did most of the talking while the other was much more distracted (she was tending to a delivery.) A, the older midwife, was also quite clearly opinionated which may have had some impact on E's testimony as well. In retrospect, I could have been more prepared for a potential group interview. Nonetheless, I was also fortunate to be given access to two midwives with completely different ages and work backgrounds.

A, had been practicing since the early 1970s, and E, since the mid 1990s. This was extremely helpful in understanding the various transformations the Dutch maternity care system has gone through within the last thirty years. As both midwives were seasoned professionals, they helped to situate some of the experiences I listened to within my other interviews. Though I was given much information on current midwifery practices in the Netherlands, I did not personally speak to anyone who had recently started their training. This may have been helpful to better understand how midwifery

training is approached today and to observe any changes in attitudes towards medicine and birth for new childbirth professionals.

In line with the format of a semi-structured interview, I arrived at each interview prepared with a set of approximately ten broad questions that I needed to cover. (Hesse-Biber, 115-16) Before I began I briefly introduced the purpose of my research and my interest in the Dutch maternity care system. I started each session with a few general questions regarding their profession, age and length of pregnancy or date of childbirth. I made sure that each following question was both clear and general enough so that participants could branch off onto other tangents. In this way I was able to garner a response while observing common themes that may have surfaced in each response. Participants were asked both general and specific questions such as "How are you currently feeling about your pregnancy?" or "When you look back to your pregnancy and childbirth what are your memories?" More specific questions included "What is your birth plan?" I wanted to both allow for open discussion while ensuring that I received all of the information I needed for my research.

As a feminist scholar, it is extremely important that research remains situated and thus special attention must be paid to the relationship between subject and researcher. I had a somewhat personal relationship with the majority of the participants in my study and therefore my interview style was perhaps less informal and more conversational. In order to maintain a certain level of uniformity I followed a similar structure in each interview and made sure my research aims were clear to each participant. However, it is difficult to determine how my relationship with each participant may have affected the amount of information they were willing to share. It was extremely important to set up an environment where all participants felt comfortable and willing to share personal information. By virtue of the subject matter and my initial email calling for participants, I expected that most participants would be willing to be open with their experiences. Nonetheless, it is safe to assume that participants with whom I shared some personal history with were perhaps more likely to reveal more personal information. Their own personal relationship and knowledge of me may have ensured a safer space; their experiences were not being shared with just "anyone." As some of the participants were

new to me, I worked to minimize some of this discrepancy by making sure to begin each interview with some small talk about my background and interest in childbirth.

In order to devote my full attention to each participant, I recorded all interviews (with the participants permission) using a smart phone dictation application. This helped me avoid any anxieties over capturing certain quotes or comments. In doing this I was able to pick up important reflective tones or repeats within responses that could later help with my analysis. For example, one expecting mother repeated "I don't know" multiple times within her responses, indicating her understanding of birth as unpredictable or variable. It also additionally allowed for an informal atmosphere where the participant could avoid the distraction of incessant note taking. I wanted to ensure that each interview felt more like a casual conversation than an interrogation. My instinctual feeling was that if I approached my interview with a series of formal questions, participants would be less inclined to elaborate and might feel that their experiences were being categorized rather than listened to.

Data Analysis

I began my data analysis using an informal coding process in which I discovered certain popular themes. Though my interviews generally followed questions within three categories — *preconceptions*, *birthing experience* and *reflections*— I finalized my data into three different specific themes. The first was "*safety, security and the unknown"* the second "*women's attitudes towards their bodies, pain and medication*" and the final "*standards of care; a comparison between doctors and midwives*." These sections were chosen because they best summed up the reoccurring themes drawn from all interviews. The first two were geared directly at women's perceptions of childbirth, risk and comfort, and the third was to best incorporate attitudes towards the maternity care system through the eyes of women and healthcare providers. As each interview contained a lot of information, I struggled to create categories that were specific yet inclusive of the varied responses I received in each interview. Though naturally there was variety in each participant's birth plan or experience, I found that safety, security, pain, self-confidence

and care were themes that repeatedly resurfaced. That said, I ultimately did not use all of the information collected from each interview. As my sample was quite small, I felt it most important to look at the reoccurring attitudes between interviews. In order to best situate my own research within previous research on the topic and to speculate further conclusions, it was imperative to analyze themes that came up most often. My categories reflect this.

All recorded responses were analyzed through a "close-read," in which I observed repeated words, tones and attitudes. This helped me to better understand the various anxieties concerning childbirth, something heavily associated with risk perception. I also conducted my analyses through a juxtaposition of responses and current cultural norms and expectations concerning motherhood and childbirth using my literature review. Based on previous research on Dutch maternity care, I conducted my own research with a general understanding and expectation. For example, research on the childbirth in the Netherlands has revealed that many mothers and midwives view childbirth as a non-pathological event (Johnson et. al 2007, van der Hulst et al. 2007, De Vries 1998**)** and therefore I wanted to see whether this was broad attitude was reflected within each narrative and if this attitude was shifting.

My intent was to both take women's personal accounts as independent and dependent from broader cultural trends revealed within current research. This is also why I chose to conduct my interviews in a semi-structured environment, allowing women to speak freely about their experiences without too many constraints. However, the goals of my research are present within my questions, and therefore each response is somewhat filtered by my aim to understand how women perceive risk, security and comfort within childbirth and how they navigate their decision making. It is important to note that my research is geared towards uncovering information about specific phenomenon within childbirth and therefore may exclude other equally important pieces of information. However, for the purpose of creating a niche for my research it was important to make a decision to filter my questions and thus some of the experiences.

Exploring Risk, Security & Childbirth

The research of a cultural phenomenon requires going beyond lived experiences, and exploring the previous research done within the field. As my sample size was relatively small, it was important to rely on research already done on childbirth and decision-making. Though the aim of my thesis is to understand how women navigate childbirth and the shifting attitudes towards Childbirth in the Netherlands, some of these changes may be linked to the pervasive childbirth practices of the United States. Therefore I chose to do an in-depth literature view on both countries and their relationship to childbirth and maternity care. I established the United States as an example of a western country with an "extreme" pathologization of childbirth. Inversely, I looked at the Netherlands as an example of a western country with a minimal pathologization of childbirth.

To organize the excess of information I found on childbirth, I created categories that could better help answer my initial research question and provide some background to some of the responses found within my interviews. In my literature review I sought to understand why two countries with highly technologically developed medical sectors could view childbirth so differently in regards to risk, safety and cost. To begin to answer this I divided my content analysis into three major parts. I first examined the United States and the inextricable link between risk, the U.S. healthcare economic model, and the power of authoritative knowledge. Next, I focused on how the Netherlands approaches childbirth and risk through its own risk management system. I chose to explore the ways in which oversight both helps and threatens midwifery and its' more non-interventionist approach towards childbirth. Finally I conclude with a comprehensive look into the transformation from the home to hospital that has occurred in the last half century. I complimented this section with two figures. One details statistical changes in birth indicators within the Netherlands and the other is a comparison between both countries. My literature review provides a juxtaposition of both countries' and their relationship to risk, maternity care and healthcare. It furthermore looks at how the Dutch maternity care system is potentially on the cusp of a major shift towards a more pathologized approach to childbirth.

To explore my topic, I utilized a variety of journal articles and statistical reports procured through online databases with a gender, sociological or anthropological focus. Childbirth practices differ within each culture, thus it was crucial to narrow my search down to mostly international social science journals concerning childbirth, obstetrics and midwifery. With a thorough literature review, I could not only increase my own understanding but draw conclusions from common themes expressed later within my personal research. Fortunately much has already been written on childbirth and how both countries handle maternity care. (This was unfortunate too, as it brought up many other important themes that I could not add)

An analysis of Dutch and American policy concerning issues of maternity (i.e., hospital practices, midwifery, maternity leave) will help to understand the official position in which the government has taken in regards to maternity in both countries. A government's attitude towards childbirth can have either strengthening or debilitating effects for women's health and childbirth. In the Netherlands midwifery system operates successfully based on the evaluation of risk. In the United States, midwives have been publically denounced at points in history by various American medical organizations in an effort to increase revenue for physicians and hospitals **(**Goodman 2007**).** I sought to find information which detailed how the U.S and Dutch governments approached maternity care policy-making and what implications this had for women.

Research Approach

Within this thesis I will rely on standpoint theory to guide my research. I will use this epistemology in response to what prior research has failed to do. Previous research has mostly relied on statistical data on rates of birth indicators. Therefore, in regards to the shifting cultural perceptions of childbirth and risk within the Netherlands, there are major gaps within the research. Such spaces cannot be filled in by statistics alone. Personal narratives must be utilized to fully understand how shifting cultural perceptions are influencing childbirth decisions. The rise of hospital births and obstetrical

interventions in the Dutch birthing room is relatively recent, and has not been fully explored through personal narrative. Using feminist standpoint theory, my research will not only seek out historically marginalized voices in medical discourse, but also give evidence to how childbirth is changing within the Netherlands.

Standpoint theory suggests that in order to provoke change and or better knowledges, it is important to look through the eyes of those oppressed and understand the experiences that are often overlooked. In feminist standpoint theory, Brooks (2007) states "women's concrete experiences provide the starting point from which to build knowledge (56)." Historically, women's own personal narratives of childbirth have been largely left out of the medical discourse on maternity. I believe that to ensure higher quality care and an overall better childbirth experience, such narratives must be made available to inspire future policy change.

Much of the previous research done on the Netherlands and childbirth has also emphasized a clear hospital versus home dichotomy. A mere juxtaposition of the home and hospital does not tell us how women are experiencing childbirth and navigating their decisions. As childbirth is both profoundly personal and individual, polarizing the "home" or the "hospital" does little to inspire change within any birthing room. Therefore standpoint theory is increasingly useful in understanding how individuals experience childbirth so that their experiences become the base for discourse and potential policy change. Though shifting homebirth and hospital rates can tell us about broader cultural norms and expectations, statistics can easily become detached from bodies. Thus for the purpose of my research, standpoint theory best gives attention to individual voices and lived experiences.

By including narratives from women who have given birth between 2010 and 2013, I can better see how current cultural changes are manifested and rooted in each personal narrative. I do not see my personal data as something self-standing, but as experiences produced from a shifting Dutch culture. My goal is to put women's voices at the center of the discourse to understand how women are embodying specific changes and shifting norms within Dutch maternity care. I also strongly believe that by placing narratives at the forefront of my research, I can better reveal the unique experiences that quantitative data cannot illustrate. In this, I can contribute to a growing field of research.

[Different] Choices in Childbirth: A cross-cultural comparison between the United States and the Netherlands

In this literature review I will examine the different attitudes towards maternity care in the Netherlands and the United States. I will begin with a discussion of risk and its' role in maternity care, and explore how it is socially and institutionally managed within both countries. I will examine how the United States' profit driven healthcare system is tied to risk and women's choices in childbirth, as well as how midwifery care in the Netherlands both expands and limits choices for women based on risk management systems. I will conclude with some discussion on the dramatic shift from home to hospital in the Netherlands and the possible consequences of location.

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Modern western healthcare is risk-averse. It defines and implements its decisions, suggestions and warnings through careful risk evaluation. Beck (1992) suggests that there is an inextricable link between modernity, capitalism and the production of risk. As we have progressed into an increasingly modern and technological world, there has also been an increase of risk associated with nuanced technologies. Beck argues that in order to deal with these emerging risks a certain set of questions was asked:

> "How can the risks and hazards systematically produced as part of modernization be prevented, minimized, dramatized or channeled? Where do they finally see the light of day in the shape of 'latent side effects', how can they be limited and distributed away so that they neither hamper the modernization process nor exceed the limits of that which is 'tolerable' – ecologically, medically, psychologically and socially?" (Beck, 19)

How can we manage the risks associated with modernity without the disposal of certain innovations? How can we ensure that the technologies are safe for consumers? If we

apply this rational to healthcare we can ask, what technologies can we use to minimize health risks that have arisen alongside modernity? For example, an increase in skin cancer (melanoma) is linked to global warming and exposure to damaging ultra violet rays. Global warming is a product of modernity and the major increase of carbon emissions it creates. Carbon emissions break down the atmosphere and allow harsh ultra violent ray's in. (Diffey, 2003) We are increasingly told to wear sunscreen everyday to avoid the risk of melanoma, thus we manage the risks that we have "created" or discovered.

Beck's risk management theory is easily applicable to American maternity care in that modernity has created a medical industry where billions of dollars are invested to make childbirth efficient and complication free for both mother and baby. There is a constant influx of new information regarding childbirth. Today we know more than ever before. However, an increase in knowledge can also mean an increase of perceived risk. The relatively new knowledge that many things can "go wrong" has spawned a new reliance on technologies to prevent and protect the patient and the medical industry. For example, in America approximately 1 in 3 babies are born through cesarean section. (OECD) This number has drastically risen with the introduction of new technologies and the normalization of the procedure. However, research has shown that though cesarean sections are sometimes needed, often they are not necessary and are done because they are a quick (and thus a desirable) procedure for doctors and patients (Zhang et.al. 2010, Wendland 2007, Beckett 2005) C-Sections are also often done as a preemptive measure to prevent any problems from occurring through a vaginal delivery (i.e., breached delivery). Invasive technological procedures are thus utilized to manage any possible perceived risk.

How healthcare institutions choose to manage risk often reflects larger sentiments towards patient rights, medical costs and how much power interest groups can wield. Thus I will begin my literature review with an examination of the American maternity care system and the deep intersection between cost and the delivery room. I will look at how hegemonic medical knowledge has had major consequences for midwifery and has changed how the United States approaches childbirth.

"The power of authoritative knowledge is not that it is correct but that it counts"

– Bridget Jordan

Maternity Care in the United States: Doctor as Expert, Midwife as Obsolete

In the United States, maternal healthcare radically shifted as the country moved towards a profit driven healthcare model at the turn of the 20th century. While childbirth once centered on a woman's body as the source of knowledge (i.e., a woman's' body *knows* when to push) modernity created a new reliance on technology and the expert knowledge of the physician. This ultimately meant that women's authority was pushed towards the background. A new hospital and healthcare industry that viewed doctors as experts also meant that alternative health practitioners, such as midwives, were deemed unsafe or unreliable (Dawley, 2000). To put this into perspective, in 1900 midwives attended to approximately 50% of births in the United States. In 2009 the rate had dropped to 8.1% (Dawley, 2000. Declercq, 2012). Some scholars have argued that there was a deliberate campaign to end midwifery in order to propel a capitalist agenda that promotes licensed physicians and hospitals as the ultimate sites of safety (Dawley, 2000; Goodman 2007). Trust in the medical industry means that more women (with uncomplicated pregnancies) are attending a physician throughout childbirth, which dramatically increases out-of-pocket spending and ultimately only profits the healthcare industry. This was best highlighted in a 2013 New York Times that revealed that the cumulative cost of approximately four million annual births is over 50 billion dollars (Rosenthal, 2013).

It is thus first important to discuss the economic incentives the medical sector had in devaluing the midwife as a trained professional. Unlike many of its European counterparts which offer universal healthcare, United States citizens rely either on a private or public healthcare policy based on their economic bracket, age, disability or other status. Healthcare is market driven and is reliant on the soaring costs for pharmaceuticals, innovative technologies and standard procedures. For midwifery, a profession that traditionally practices minimal intervention, it is increasingly difficult to

keep up. As many midwives prefer *not* to use highly technological tools (and are often unlicensed to do so anyway), they ultimately make less money for their place of practice. One midwife in a study by Goodman (2007) stated –

> "What midwives do when they are working in a hospital is not billable. They would rather not use IVs, fetal monitors, and medications. What the hospital looks at is 'What is this going to get us in billables?'…So the hospital is going to lose money they could have had. They can't bill as much. They don't like that." (614)

The tension between midwife and healthcare system is often disguised as a concern for the safety and well-being of mother and child. One hospitals response to suspicions of having had economic incentives for closing down their midwifery center said –

> "The decision stemmed from an analysis showing that 85% of its pregnant patients have some risk factor. We needed to move to a model that would have our deliveries being performed by obstetricians." (ibid, 614)

Despite the fact that a comprehensive 1996 report by the World Health Organization (WHO) concluded that 70-80% of pregnancies are low risk and *without* complication, this hospital still used safety as a reason to over-medicalize and thus over-utilize expensive technologies. Consequently, midwives have been forced into private practice professions, where they operate independently of the hospital. Because of this, many midwives become inaccessible to women based on geography or insurance that refuses to cover a "non-traditional" childbirth. Additionally, a lack of support from the authoritative medical power means that midwives are seen as less able or responsible than physicians.

By encouraging all low-risk pregnant women to give birth in hospitals with *physicians*, two results emerge; childbirth is considered inherently medical and high costs become unavoidable. Wendland (2007) discusses how capitalism has changed how we have come to view and normalize technological interventions such as unnecessary caesarean sections.

> "I believe that two other core cultural values can be seen in the evidence-based calls for cesarean: safety, which trumps "selfish" concerns of subjectivity, and market capitalism, in which long-term complications of consumption are notoriously underestimated when they are imagined at all. Safety and consumer ideology interpenetrate with the veneration of technology, the institution, and

> patriarchy in such a way that that they become located in the hospital and embodied in the doctor, whose tools and technological expertise become the safe fetal space to be purchased by expectant mothers." (225)

Thus maternity care has become capitalistic in its nature through an understanding of the hospital as the only safe place. The hospital meanwhile profits off of this ideology and can influence the childbirth decisions that generate the most profit. American culture has effectively embodied a blind faith in technology and views the doctor as always "knowing best." The doctor in turn is influenced by a medical industry that promote excess medical spending and treatments. This ultimately translates into higher rates of interventions in childbirth. If a woman is having a breached delivery, a cesarean section is presented in research as the safest and most efficient method. However much of the research does not discuss maternal subjectivity and the emotional ramifications one may experience through after a surgery (Wendland 2007). When research is presented in a positivist way, and supported by the medical industry it is understandable as to why birthing mothers would trust their doctors to make the "right" decision. This is best exemplified in a comparison of cesarean rates between the United States and other OECD countries. The most recent data suggests that for every 100 live births, 32.3 are delivered through cesarean. In the Netherlands the rate is 14.3 (OECD). In two wealthy, modern countries, how can we account for such a discrepancy? Are Dutch women's bodies *that* different?

Every year approximately 2.3 trillion dollars is spent on health care, and some of the biggest costs are on relatively minor procedures. It is also notable to add that 18% of Americas GDP is spent on healthcare, almost twice as much as most other developed countries. (NYTIMES) Because there is so much revenue involved in the medical sector, it is natural that the physician who can prescribe costly medications and procedures has become an authoritative figure. Power is often achieved when there is economic value attached to an entity. Jordan (1996) discusses the ramifications of this –

> "In many situations, equally legitimate parallel knowledge systems exist and people move easily between them, using them sequentially or in parallel fashion for particular purposes. But frequently, one kind of knowledge gains ascendance and legitimacy. A consequence of the legitimation of one kind of knowing as authoritative is the devaluation, often the dismissal, of all other kinds of knowing.

> Those who espouse alternative knowledge systems then tend to be seen as backward, ignorant, and naïve, or worse, simply as trouble makers" (56)

The consequence of devaluing other types of knowledge is that we ignore modes of caretaking that may benefit the patient in very different ways. When knowledge is so closely connected with profit, important perspectives are lost. Midwives pride themselves on being advocates for pregnant women. The goal of the midwife is to help create a safe, comfortable and empowering environment for a woman to give birth in. In fact, for low uncomplicated births, midwives have shown to be as effective, if not more, than a physician when accounting for emotional wellbeing, health and childbirth satisfaction (Blanchette, 1995, Greulich et al., 1994**,** Thachuk 2007.**)** In the United States many women may be missing out on important care as traditional midwifery cannot fit into its' capitalist healthcare system.

A Risky Business: Midwifery and Maternity Care in the Netherlands

Whereas midwives in the United States have been stigmatized as alternative healthcare providers, in the Netherlands the midwife is the first health care professional a woman will see when she becomes pregnant. The Dutch medical system has embraced midwifery as a safe, effective and low cost system for low-risk pregnant women (De Vries, 1998). This attitude is most salient within health insurance policy. Health insurance is both mandatory and universal within the Netherlands. Unlike the United States, there are fewer third parties interested in profiting from patients choices in healthcare. In maternity care, women who have low risk-uncomplicated pregnancies must stay in primary care or the *eerstelijn (*first line) in order for costs to be covered by their health plan. For low risk women who decide to give birth in secondary care (*tweedelijn)* with an obstetrician, costs are paid out of pocket. If at any moment a women encounters complications, she is switched to secondary care (De Vries, 2004). Financial pressure to remain in primary care may play a large role in the rate of midwife attended childbirths in homes and hospitals in the Netherlands. In many ways the reverse of what is happening in the United States is happening in the Netherlands. In order to keep costs down, more

women may be using midwifes and thus fewer interventions are encouraged (unless needed.) Dutch healthcare ultimately encourages an ideology of childbirth as a normal and natural occurrence rather than a pathology requiring various medical treatment.

The Dutch maternity care system is unique in its ability to deconstruct the pathologization of childbirth while insuring that women have quality care pre- and post-childbirth. However, health insurance policies that financially penalize low risk women who chose physician based care, shows us the potential limitations of such a system. While low risk pregnant women in the Netherlands have the unique privilege to decide whether they would like to give birth at home or in a hospital setting, they can still be financially limited in their childbirth choices (i.e., pain medication, interventions etc.) A woman's ability to navigate her childbirth choices is ultimately based on how the medical sector defines her in relation to "risk."

While the notion of risk has had negative consequences for American midwives, it has become the basis of how maternity care is organized in the Netherlands. In fact, scientific risk evaluations have allowed midwives to practice without the homeopathic or outdated stigma that American midwives carry today (Bryers et. al. 2010). The Netherlands established its List of Obstetric Indications (LOI) in 1974 as part of an attempt to cut healthcare costs. It has since been updated three times and has served as a resource for healthcare providers when deciding whether a pregnant woman is high risk or low risk. (Amelink-Verburg and Buitendijk 2010) Women are categorized within a specific risk category when they become pregnant. If they are deemed low risk (i.e., good health, uncomplicated pregnancy) they continue their pregnancy with their midwife. If at any point a woman has some sort of complication (high blood pressure, sickness) she is referred to secondary care; an obstetrician or gynecologist. For women who have transitioned into secondary care at the onset of labor, childbirth is automatically held in a hospital setting. Low risk women have the option to deliver at home with a midwife or in a hospital with a midwife.

The underlying message behind such an organizational structure is that pregnancy and childbirth need not be inherently risk laden. In fact, the rational reflects the conclusion made by the WHO in 1996 that states that the majority of pregnancies are low risk and lead to uncomplicated childbirths. By viewing the majority of pregnancies as low

risk, childbirth is not immediately pathologized and designated to the hospital. The use of midwives may help explain why the rate of medical interventions is also significantly lower in the Netherlands (*See figure 1)* Additionally, whereas women who give birth in a hospital in the United States often stay for at least a night, many Dutch women utilize short stay hospitals and are often required to go home within twenty-four hours. By measuring a woman's risk in pregnancy and childbirth, women and their health provider can best determine the most effective and comfortable system of care.

While the categorization of risk has undoubtedly helped midwifery flourish and remain a normalized system of care, risk is still variable by nature. Bryers and van Teijlingen (2010) note that by closely evaluating risk and weighing its assorted consequences women can become doubtful or worried about the normalcy of their pregnancy (493). They state

> The assessment of risk in maternity care is a continuous process, women labeled as 'low risk' may develop problems and many deemed to be high risk will have no problems. Women move between risk categories: for example, a woman with raised blood pressure may be moved to a higher risk category but then moved back to a low risk category if her blood pressure returns to normal. Thus, risk assessment allows movement between risk levels. For a woman this creates uncertainty and concerns that can affect her equilibrium throughout the pregnancy and, when it comes to birth environment, can interfere with 'nesting instincts.' (493)

The same system that provides scientific legitimacy to midwifery can also threaten the use of midwives and especially the frequency of home births. Due to its' variable nature, risk can create some uncertainty for a pregnant woman. Bryers and van Teijlingen (2010) also note that risk systems often do not differentiate between what they call a social model (i.e., 'natural childbirth, emphasis on woman, etc) and a medical model (safety, medication, interventions.) For an example, a woman who delivered her first child through cesarean may want to deliver her second child vaginally. However, a VBAC (vaginal birth after cesarean) is a heavily debated issue and a midwife may be torn between a medical risk model and a social risk model. Though the medical model may encourage a cesarean, a midwife also wants to promote the autonomy of her patient and thus is torn between two conflicting healthcare models. At the risk of any complication,

some midwives may then still choose to transfer the woman into secondary care. My personal interviews with midwives revealed that often variation in decision-making is based on a midwives confidence or own experience with handling certain complications.

In this we see how risk changes based on situation, healthcare provider and woman's body. While a risk evaluation system has successfully worked to dismantle certain pathological ideologies of childbirth, its' natural inability to be generalizable or even stationary means that childbirth under this system is prone to shifts in attitudes and perceptions. The last fifty years in the Netherlands has explicitly shown how such changes have manifested within childbirth decision making.

From home to hospital: shifting attitudes in the Netherlands

One of the most noted changes that has occurred in the Dutch maternity care sector is the dramatic decrease of home births in the last half decade. The sharpest decline occurred between 1965 and 1980 when the homebirth rate started at 68.5 and decreased to 35.8. (Weigers, 1998) There are many explanations as to why this happened. One major reason was the introduction of short-stay hospitals and newly granted hospital access for midwives (ibid). Therefore a woman could receive care from her personal midwife in a setting with access to medical interventions. A shift towards the hospital did not mean an automatic medicalization of childbirth however it arguably did set the stage for other changes in maternity care. Once in a hospital, a wide range of medical interventions become available that were unavailable within the home. Between the 1960s and 1970s prenatal diagnostics such as ultrasounds and electronic fetal monitoring were introduced as a way to various monitor risks. Such diagnostic technologies were initially only offered in secondary care with a specialist. Therefore, any woman who was interested in using these technologies was immediately transferred into secondary care, regardless of her risk level (Weigers, 192). As with most western countries practicing modern medicine, the introduction of innovative technology was both exciting and desirable. The ability to monitor a fetus throughout pregnancy provided a new level of assurance that simply did not exist before the technology existed. The use of advanced fetal monitoring technologies may also induce greater feelings of control and predictability (i.e., I know there is a heartbeat because I can see it) (Petchesky, 1987).

Though the rate of midwifery for low risk pregnant women has remained somewhat stable, rates of interventions such as cesarean sections and episiotomies have increased in recent years (*see figure 2).* While this may in part be due to an increase of women in hospitals, it may also be linked to a pervasive fear that has spread the Netherlands since a 1999 report done by the European Peristat Project. The 1999 European Peristat-1 study measured various birth indicators throughout several countries in Europe. It found that the Netherlands had one of the highest fetal mortality rates in Europe. This came as a shock to a country with a reputation for such high quality maternity care. Though follow up reports in 2004 and 2010 have shown decreasing fetal mortality rates, the Netherlands still has a relatively high rate compared to other European countries. Media outlets became enthralled with these statistics, and immediately homebirth was seen as a plausible answer for such high rates. This ultimately may have contributed to an increase of women utilizing hospital care and various technologies to avoid any potential risk in childbirth.

A recent journal article published by the British Medical Journal (BMJ) by Evers et al. (2010) prompted a new wave of concern in regards to the safety of home births. The study examined a cohort of women who gave birth between 2007 and 2008 in a central Dutch city. The data ultimately found that infants of pregnant women at low risk whose labor started in primary care (midwife) had a significant higher risk of delivery related perinatal death than did infants of pregnant women at high risk whose labor started in secondary care (with an obstetrician) (Evers et al. 2010). The data indicated that midwives were unsafe compared to obstetricians. Not only did this study suggest the inability to have a safe home birth, (as a low risk woman) it deemed obstetricians as the "better" birth attendant. Various other studies have been done on the Netherlands which dispute the findings by Evers. A 2009 nation wide study by de Jonge et al. found that there was no difference in outcomes between home births and hospital births for low risk women (de Jonge et al. 2009). Scholars immediately responded to the Evers study citing a non-generalizable data pool and various problems with the sample selection (de Jonge et al. 2010).

Though the study was critiqued, it still garnered international attention to midwifery and the prevalence of home births in the Netherlands. Such an article

exemplifies how quickly perceptions of risk in childbirth can change within a population that relies on a fluctuating risk management system. As I will note later, my own data revealed that this study entered into some pregnant women's decisions about childbirth.

While it is still unclear whether the Netherlands will adapt a more Americanized outlook towards birth, statistics do tell us of some interesting changes occurring in the birthing room. In order to better understand the lived experiences and go beyond the numbers, I sought to talk to women who had gone through the Dutch maternity care system or were currently within it. Through examining individual narratives we can come to a better understanding of how the political is effecting and impacting the personal.

Telling it like it is:
Childbirth as told by mothers, pregnant women and midwives

Previous research suggests that women in the Netherlands are making different decisions in regards to childbirth. While we can speculate the various motivations behind such decisions based on a pervasive American healthcare culture or persuasive journal articles, the only way to truly understand decision making is to examine lived experiences. To add on to what is lacking in the current research, I chose to interview a set of seven women and a small group of midwives. While my sample size is relatively small, it helps to provide some tangible evidence as to what is changing in the Netherlands and why. It additionally provides some of the personal reasoning behind changing trends within the Dutch birthing room.

Demographics

Of the seven women I interviewed, three were pregnant and four had given birth within the last two years. All were pregnant for the first time, or had given birth to one child. Those that were pregnant had just begun their maternity leave and were due to give birth in the following 6-8 weeks. All participants who had already given birth gave birth in a hospital, and all pregnant participants were planning on having a hospital birth. Two participants intended to give birth at home but were then moved to the hospital. Participants were in their early thirties, and had lived in the Netherlands for at least five years. Five out of seven women were Dutch natives and two had immigrated to the Netherlands from Portugal and Poland. All women were in heterosexual relationships and lived with their partners.

Changes within: Midwifery within the Hospital

My discussion with Dutch midwives provides a personal perspective to changes occurring in maternity care within the Netherlands. As all of my participants gave birth within the hospital, it was suitable to include the stories of hospital midwives as well who were witness to hospital based childbirth. Both A and E, two seasoned midwives who had

attended both home and hospital births throughout their careers, were skeptical of current practices in hospital midwifery. Thus I begin my research and analysis with detailing how midwives view the current Dutch maternity care system.

A, who began working as a *vroedvrouw (*direct translation: wise woman) or midwife, in 1971, discussed some of the major changes that have occurred in the Dutch maternity care system within the last thirty years both on a personal and medical level.

> "When I started, [*sic]* I'm from the period with the wooden stethoscope, nothing else. And after several years they got this big machine and we could let them [women] hear the heartbeat of the baby but that was maybe after seven or eight years.. We had nothing, but we had less complications, we had no complications because they [women] trusted their bodies, they trusted us, and everything went smoothly."

Her own experience as a midwife in the 1970s revealed that birth was rarely pathologized and predominately needed little to no intervention. While her own experiences of complication free childbirths are clearly personal, it reveals her skepticism of the increase in what she called "unnecessary interventions" in childbirth. As it seems statistically impossible to have had no complications after an estimated 4,000 (!) deliveries, her memory seems to reveal more sentiment than fact. *A,* seemed to believe that a rise in the use of technological interventions was in fact creating more problems for women in the delivery room.

E, a younger midwife discussed how women's personal decision making processes had dramatically changed in the last five years. She noted that there has been a dramatic change in how both women and hospitals approach pregnancy and childbirth. She told me that in her experience women had become more fearful, had spent much more time using the Internet to 'self diagnose' and requested pain medication more frequently. Hospitals have also industrialized more, looking for the most efficient way for women to give birth. She told me –

> "It is business. And that's what sometimes frustrates me as a hospital midwife…that you are in a business and uh, sometimes you just say okay let's break the membranes because then it goes quicker and as a midwife at home I had more patience…but you can't blame us because the ob/gyns, our bosses, also say time is money…'

Such systematic changes can be compared to the United States where maternity care procedures are done preemptively to be more time or cost-efficient (Goodman 2007;Beckett 2005, Davis-Floyd 1987). Both midwives seemed equally upset with the current hospital practices within the Netherlands. It was clear that they viewed childbirth as a natural physiological occurrence, rather than a sickness, which needs to be hospitalized. The conflict between midwife and institution was put most aptly by E, who struggled with new midwives who were taught differently in medical school.

> "…we think a woman is healthy when she is giving birth – they think a woman is ill when she is giving birth and that's the difference."

This was especially applicable for A, who began her midwifery in a time where homebirth was seen as more normative. It was clear that she was struggling with a new industrialized system of childbirth within the Netherlands. However, she also told me that her age and lengthy experience often gave her seniority over other midwives and obstetricians in the hospital. I found this to be quite compelling. Her experience and confidence with childbirth had the ability to override some of the new modes of maternity care which were being introduced within the hospital. Nevertheless, she noted that the traditional "*vroedvrouws*" were getting older and retiring, being replaced with younger midwives with different educational backgrounds. Therefore it was becoming more difficult to maintain a specific traditional form of low intervention midwifery. For new midwives training in hospitals, their experience would be within a medical framework and therefore their approach might be more pathological than midwives who learned through apprenticeship in the home.

Previous research indicates that midwives in the Netherlands play a crucial emotional role for women in childbirth while also affirming an ideology of birth as a natural and non-pathological process (Johnson et al 2007; Van der Hulst et al. 2007). Overall, both A and E exemplified the traditional Dutch midwife. They strongly believed in a non-interventionist approach and in the notion that most women were capable of delivering babies without too much help. E revealed her own "golden standard" for midwifery –

> "You are a good midwife, [*sic]* for example a home birth, if you just sit in a corner, just watch, coach if the woman needs that, but let the partner coach. If they are a team it's the most beautiful thing to watch I think. And interact if its necessary, if it's needed to do an intervention…then you are a perfect midwife."

Both midwives held on to a somewhat romantic approach to midwifery. A told me that she began working as a midwife because of the romantic notion behind delivering a child. She found it incredible to be the first human a baby saw when it opened its' eyes. However, both noted that this ideal was rapidly fading, replaced by a systematic, regulated system which relies more on technology and less on a midwifes' confidence and experience.

The changes illustrated by the midwives I spoke with mirrored some of the changes I observed in my interviews with women who were pregnant or had given birth. For some, a fear and anxiety towards childbirth often led to their decision to give birth within the hospital. Though some participants discussed their desire for an intervention free childbirth, many framed their decisions around the notions of safety, security and being prepared for the unknown.

Security, Safety and the Unknown

Birth Location Preferences

Previous research has indicated that Women's childbirth preferences in the Netherlands are often dichotomized as two opposing models; the natural or medical (Kleiverda et al. 1990,Van der Hulst 2004, Borquez and Weigers, 2006). A natural model usually indicates a birth under the care and supervision of a midwife, in a home setting and without pain medication. A medical model usually implies a birth attended by a midwife or obstetrician, in a hospital or birthing center and with access to pain medication and other medical interventions (if necessary.) The trouble with such a dichotomy is that it ignores how women navigate difficult decisions within childbirth and instead creates two opposing methods. To categorize one form of childbirth as natural, presupposes that there is an "essentialist" childbirth, and that any other form of childbirth is "un-natural." As childbirth is deeply imbedded within culture and norms, it is impossible to reduce

childbirth to "natural" or "un-natural," because in each location it may differ. Thus, as the debate between "natural" and "medical" could produce an entirely new thesis, I ultimately chose to re-categorize these terms into "non-intervention" childbirth or childbirth "with medical intervention."

Women's decisions to give birth in a home setting (and thus without medical intervention) were predominately linked to feelings of comfort, ease, relaxation and control, whereas preferences towards a hospital birth were associated with safety, preferences for 'expert' knowledges, and recognition or fear of the "unknown" (Kleiverda et al. 1990, Weigers 1998, Bryers and van Teijlingen 2006, Johnson 2007). Homebirth rates have steadily plummeted in the Netherlands since the mid 20th century. In 1965, approximately 2/3 of all births were delivered at home. Today this has more than reversed (Weigers et al. 1998, De Vries et al. 2012). Contrary to recent national statistics that reveal a current homebirth rate of approximately 23% in the Netherlands, my sample size consisted only of hospital births. My sample is not representative of the general population and therefore it is impossible to explore the differences between homebirths and hospital births with my data alone. However, two of the participants (S and K) in my study indicated strong initial preferences towards a home birth before being moved to a hospital. Therefore I can analyze some of the motives behind the desire to deliver at home. Nonetheless, I do believe that in understanding how a small sample of women living in the Netherlands navigate their childbirth decisions can give me insight to changes currently taking place in the country.

Preferences towards a hospital birth

One reoccurring theme throughout my research was the preference towards hospital births based on an uncertainty about childbirth. The hospital was seen as a place with extensive knowledge and superior safety. M, a native Dutch manager living in Amsterdam told me –

> "I think that giving birth is something medical, and yeah, and uh, being at a place where the expertise is sounds like the best thing to do…I also think its very messy to be at home you know? Things can go wrong..."

M's own understanding of the hospital as a site of safety corresponds with all of the research I found on authoritative knowledge and maternity care (Bryers and van Teijlingen 2010, Goodman, 2007, Davis-Floyd 1998). The majority of all participants explained their decision to give birth in a hospital with feelings of safety and security. Many women emphasized the element of the "unknown" several times throughout each interview and the hospital seemed to grant a level of assurance, even though the majority did not view birth as inherently pathological or medical. Though some expressed confidence in their bodies ability to give birth, childbirth outside of a hospital posed too many risks. F, a 30 year old Dutch lawyer who had just begun her maternity leave told me –

> "I guess for me, I'm kind of risk averse, so even though until now everything is going really well and I don't have any reason to assume that it wouldn't go well if I did it at home, it's just the idea of not being able to access medical care when you really need it, that just.. I don't know, I don't feel comfortable with that."

F recognized a woman's desire to give birth at home, but stated that there was always a "what-if" factor that unsettled her. The chance of any complication outweighed any of the other birthing options. Her own decision to give birth in a hospital reflects prior research done on tolerable and absolute risk by Bryers and van Teijlingen (2010). The authors suggest that risk in maternity care is broken into two arenas, absolute and tolerable. Absolute risk is based on statistical data (i.e., morbidity rates) whereas tolerable risk is defined as 'a willingness to live with a risk to secure certain benefits in the confidence that it is being properly controlled' (490). For F, her decision was based more on absolute risk, the notion that no matter her risk level, her best outcomes would ultimately be within the hospital. Tolerable risk (i.e., homebirth with a midwife) was outweighed by absolute risk.

Women's own feelings towards comfort may also be in a state of transition. For the majority of women I interviewed, the comfort of the home was replaced by the comfort of the hospital. Though many understood the notion of the "gezelligheid" in having a home birth, any sense of risk undermined this. Therefore feelings of safety were seen as more comforting the familiarity of the home. The safety of the hospital provided assurance and ultimately increased their comfort in their birthing environment. This contradicts many notions of ultimate comfort being in the home and provides an

alternative perspective to understand women's decision to shift from home to hospital in the Netherlands. In this we also can see just how subjective comfort is for each woman.

In multiple interviews, the 2010 article by Evers et. al. was brought up. The article which ultimately concluded that it was safer to give birth in a hospital with an ob-gyn as a high risk pregnant woman than to give birth at home with a midwife as a low risk pregnant woman was often mentioned when I asked them why they thought there was an increase in hospital birth rates. As this study garnered a lot of media coverage, it is easy to understand why women would be weary to deliver at home. Reports like these become the new "common knowledge," and provide a "scientific" backing to certain preexisting doubts or anxieties about childbirth. The implications are real – by issuing a report that claims it is safer to have a high-risk childbirth in secondary care than have a low-risk childbirth in primary care, birth becomes fully pathologized. In this report there is no concept of an uncomplicated birth. Instead, all deliveries are seen as risky and thus needing to be medicalized. As this report was released in 2010, at the time or before the time that most of my participants gave birth, it could have easily filtered women's perceptions of childbirth and risk.

Kleiverda et al. (1990) found that women who indicated a preference towards having a homebirth centered their decisions around an internal feeling of control (i.e., my birth will be on my own terms, I'll make every decision) whereas women who wanted to give birth in a hospital spoke of an external loss of control (i.e., I don't know how I'll react, something might go wrong"). (4) This both positively and negatively corresponds to my own research. Women who had a strong preference towards a hospital birth were more likely to consider this external loss of control whereas those who initially wanted a homebirth did not mention this. However, women also indicated that by choosing to have a hospital birth they were exerting a certain amount of control. Their own response to uncertainty was to make the autonomous decision to give birth in the hospital. This reflects previous research done on the transition from home to hospital in modernity. Miller and Shriver (2012) note that American women who relied on their physicians felt that they were exercising agency because they were doing whatever they could to have the healthiest baby. (712). For J, a 30 year old entrepreneur, it was important to separate

her home and childbirth, thus also exerting some control over her environment. She told me –

> "I don't know if I would like to connect my own bed that I sleep in to the moment of giving birth. Maybe. I don't know, if it is really painful and traumatic, I'm kind of happy that it happened in another room that you can just leave and then go on with your life, at home."

Therefore women who were more uncertain about their childbirth were more likely to want to give birth on sites of "absolute" safety; places where, if needed, all available help could be given. For them, this was a deeply personal decision based on what felt comfortable for them. Inversely, my interviews revealed that the two women who had strong preferences a homebirth were much more confident in the physiological process of childbirth. Their initial homebirth plan was tied to an absolute confidence in their bodies and their midwives.

Preferences towards a homebirth

Most of the participants I interviewed did not have any desire to give birth at home. However it is important to note that though many women indicated their hospital preference they *understood* the desire to give birth at home. They used words such as "relaxed," "special," "comfortable" and "romantic." However, almost always, these words were followed with a "but..." indicating that their own feelings towards minimizing risk outweighed all of the positivity associated with having a home birth. In fact, the only two participants who were quite positive about homebirths were ones who had immigrated to the Netherlands. S and K, from Portugal and Poland, (respectively) began their pregnancy very interested in giving birth at home though home births in their countries of origin were seen as dangerous and unpopular. They were both disappointed that they ended up in a hospital setting. S wanted a homebirth but lived on a street that was inaccessible to the hospital. It was thus recommended that she move to the hospital at the onset of labor. In retrospect S notes –

> "I really would like to have had a home birth, but I didn't know it [the labor] would be so fast. If I knew it was so advanced I would have said I want to stay

> home. But I didn't know it. In the end nothing went as I expected but it was very, very good and also according to the midwife opinions I had a 'dream labor.'"

K, from Poland, planned on a home birth but became physically ill and dehydrated from her labor contractions. She ultimately wound up in the hospital in case her sickness worsened and warranted an IV. Both experiences exemplified some of the anxieties other women had about transitioning from the home to the hospital. However, neither K nor S was negative about this. Prior research done by van de Hulst et. al. (2004) found that women who intended to give birth at home were less likely to use obstetric interventions. While K used Demerol (a narcotic), neither women used an epidural. S experienced her childbirth without any obstetric intervention. Their initial choice to give birth was part of a larger choice to avoid medical intervention unless needed. This was ultimately reflected in their hospital births. Additionally, while both women ended up in hospitals, their interviews did not reveal any of the same concerns or anxieties that the Dutch natives spoke of. Instead, both emphasized how their own research into childbirth and the physiological processes involved helped prepare them for their labor and to offset any anxieties about the unknown.

Women's attitudes towards their bodies, pain and medicine

In each interview I discussed attitudes towards pain medication and the concept of a "natural birth" (free from obstetric intervention). I looked to see whether attitudes towards pain and medication were linked to culture, or if they were personal. None of the women I interviewed had planned on using medication for their childbirth, though none were fully against it. Though obstetric interventions have increased in the last fifty years, pain medication usage does not parallel that of the United States. Recent data suggests that the Netherlands has an epidural rate of less than 12% (Christiaens, Nieuwenhuijze and De Vries 2013) versus the United States, which had a rate of 67% in 2011 (Listening to Mothers III).

Of the women I interviewed who had already given birth, three had used pain medication, one of which used an epidural. Only one woman had followed her initial plan

and given birth without obstetric intervention. Attitudes towards pain medication generally followed a need-based mentality; "if it becomes really bad, I'll take it." This followed the general theme of recognition of the unexpected and unknown. Medication was regarded neither as negative nor positive but was also not seen as an automatic option. J discusses this:

> "Somehow I feel that if I don't need it, I don't want it. I also feel that this whole process of being pregnant and giving birth is something that you share with so many women all over the world and I don't know if I'd like to kill that pain and the whole sensation…but as the same time if it's really horrible [the pain] and if it's really making me like stressed or somehow it helps me to be more relaxed than I don't have anything against it but it's not that I'm afraid of the pain and that I have already decided that I really want it."

A previous study done by Christiaens et al. (2010) compared Dutch and Belgian women's attitudes towards pain medication in childbirth and the usage rates in hospitals. They found that a personal control of pain (i.e., through acceptance, or anticipation) often led to lower rates of usage thus indicating that some initial acceptance can create a higher pain threshold. All three of the pregnant women I interviewed reflected some sort of understanding of labor pain, but were not quick to plan to alleviate it with medication. Participants generally followed a rational line of thinking, such as F who said -

> "I'm not principally opposed to pain killers… you just don't know what will happen, so I don't know, maybe it's so bad that I can't take it, I mean we are going to try it without but you know, you have to be realistic... At some point if you think 'you know this is just a level I cannot go over and it's not doable anymore' than you have to be realistic and maybe face the music and say 'ok guys this is just it for me, give it [the medicine] to me' (laughs) I'll just wait and see, go into it open minded, it's a big unknown."

Though all women did not initially plan on using medication, some welcomed it with open arms. Y, who had believed in having a natural childbirth during her pregnancy experienced a very prolonged labor at home and received an epidural on her arrival at the hospital.

> "I was really like 'ehh it's a medical thing, its not really good, you should do the natural thing,' but oh my god it was fantastic (laughs). I have to tell you, I was so pleased with it because I could really easily give birth, it gave all the space for

> her, I knew when to push, I had energy because I slept the night before, so I had all the energy to help her...I felt so good, so yeah that was a good epidural, I didn't have any problems with that, though something could have happened."

This again reveals how circumstantial and personal each decision was for each woman. Y may have had an initial plan for her childbirth, but then switched it once she went into labor. Her ability to look beyond her "plan" put her at ease with her decision. In retrospect she was still thankful that she received an epidural. Here we can clearly see that women's own satisfaction in childbirth is quite often linked to the amount of agency they felt that they had during the process. This transcends the home/hospital or intervention/non-intervention dichotomy as well, because women can exert agency in both locations. Y's happiness with her epidural was based on her personal choice to have it, and this can make all the difference.

Another common response to pain and childbirth was the practical knowledge that so many women had already given birth before them. Often women experienced a moment of panic in their pregnancy but an acknowledgement of how "normal" childbirth was, acted as a positive reinforcement. M revealed that remembering that a "zillion" women had given birth before her helped to calm her nerves while pregnant. Y also repeated this sentiment, her own confidence stemmed from an understanding that she was not unique in the process; her mother and grandmother had all done this before her. Thus, by viewing childbirth as both routine and normal, women were less likely to experience anxiety.

As expected from previous research, those who had intended to give birth at home were also more prepared for the pain and were quite confident (Christiaens et al. 2010). Such confidence was also associated with having a good understanding of the physiological elements of childbirth. S spoke about the importance that education played in her pain medication free childbirth.

> It helped a lot. Being prepared for it…and not being afraid mostly, and knowing what's going to happen because I remember my sister when she had her first kid it was quite difficult and she had no idea what was going to happen and she was not informed either of the whole stages and I was aware of everything that was happening 'oh now we are here, now it's that.' I was aware of how it should feel how it shouldn't feel so I think that helps but it depends again on who you are because I'm so scientific, I'm thinking of chemicals and physical situations so

> that helps me into it. And that helps me cope. With other people its support from the father, other people it's a lot of doctors… It's really personal.

Being educated and self-aware was extremely important to both participants who intended to give birth at home. This seemed to offset some of the anxieties which the women who intended to give birth in a hospital felt. Generally, each woman I interviewed viewed pain medication as something unnecessary, unless it becomes necessary. This follows the general attitude within the Netherlands towards pain medication and a mentality that one should only use it if they *really* need it. Though they may or may not believe it in it, women want to be able to make the decision to receive pain medication. This corresponds with an ultimate desire to preserve agency throughout childbirth and that women reflect more positively on their childbirth when they felt that they had choice and control.

Standards of Care

Midwives and other medical practitioners played a crucial role in all women's childbirth or pregnancy experiences. They provided emotional support, nurtured women's feelings of birth as a normal occurrence, and fostered an encouraging and supportive environment. All of the women interviewed expressed genuine satisfaction with the prenatal care they received as well as their care (if applicable) during childbirth. Midwives were described as comforting, supportive, organized and relaxed. K reflects on her daughters' birth with great enthusiasm because of the care she received.

> "They (the midwives) were actually really good. And I think it's one of the big reasons I am so positive. I think they are extremely relaxed and treat pregnancy as a natural (which it is of course) state of being so to speak and that pregnancy should not be followed up in regards to some sort of pathology but as a complete experience that is mental and physical and focused on a woman and her well-being and her choices and how she wants to deliver..."

K's experience with her midwife directly echoes how midwives A and E discussed their own midwifery practices in the hospital. Women in my study who used a midwife throughout pregnancy and childbirth were quite satisfied with their emotional support and

rational approach to childbirth. Though most women visited a series of midwives within a practice, they still felt satisfied and supported at each visit.

Midwives were viewed as advocates or partners. This corresponds with previous research that indicates that midwives act as a unique support system during childbirth (Johnson 2007, Goodman 2007). In an allied position, midwives helped advocate for women's birth plans. K, who had discussed a specific birth plan previously with her midwife, told me how important this was when she went into labor.

> "...you could really see the different approach between the midwife there and the midwife in the hospital. For example I had spoken to the midwife and said I wanted to try different positions and not lie in bed because I don't think it's a good position for myself and in the hospital they lay me in the bed and she was the one who kept reminding me, oh but maybe you want to try different positions and she had remembered what I wanted because you usually at that point forget what you wanted"

The hospital midwife suggested alternative methods from what K had previously discussed, thus her own midwife helped navigate the preferences which may have become more difficult to assert during child birth. Here we see the importance of the personal relationship established between woman and midwife and how critical this can become within the birthing room. Midwives also acted as "cheerleaders" for women, talking them down from anxieties or worries. Research has shown that prenatal fear or stress can lead to adverse outcomes in childbirth (Schetter 2011). Thus, midwives played a crucial role in helping to relieve stress and answer questions and concerns.

Midwives also made sure that their care was mother oriented, something which F hinted was crucial for her care.

> "...they were all generally really nice and the good thing is that they always paid attention to the personal aspect so they were always start off by asking how are you feeling, you know, how's it going at work and trying to approach it from that angle, so I think for lots of women that's really comforting."

By treating the woman as the first patient, and the baby as the second, F suggested that a level of empowerment is restored to the pregnant women. If an appointment begins with an ultra sound and no inquiries as to how the woman is feeling, feelings of isolation may occur.

Attitudes towards midwives reflect previous research indicating high levels of satisfaction in the Netherlands (Weigers 2009; Johnson 2007; Janssen and Weigers 2006). However, Jannsen and Weigers (2006) found in their study that Dutch women were less satisfied with the amount of information they received from midwives. This reflects the sentiments expressed by Y, who was concerned that her midwives were too focused on a "natural" birth that they did not give priority to the potential adverse outcomes in childbirth.

> "Only when I looked back do I feel like they didn't prepare really for the worst case scenario. They only prepare you for the ideal scenario, natural birth, taking care of you, being a mom, you know, the mother earth idea. Which was great, and I really love it, but you weren't prepared properly for the 'what if?' They say like 'yeah, then you go to a hospital..' okay, but then what happens?"

Y, who ended up requiring medical intervention, felt as though she was not prepared for the very real risks of childbirth. While she felt as though her midwives were supportive and caring, they only prepared her for the best scenario. This positively corresponded with my interview with the midwives who were quite adamant about the ability for women to give birth "naturally." This was especially true to A, whose own low intervention history helped reinforce her understanding of childbirth as natural and low risk. Though Y respected what she called "the intuitive knowledge" of midwives, once she was under the care of her obstetrician, she felt more safe and confident. She told me –

> "The midwives do have a lot of knowledge, but a lot of it is what we might call intuitive and that's very valuable because they can really be with you, but at a certain moment you want certainty and then you want the thing that works like an epidural..."

This positively correlates with previous research on authoritative knowledge and the notion of doctor as expert. As midwives still operate with a low interventionist approach, their work is seemingly thought of as less medical and thus less reliable in an emergency (Goodman 2007). Y's relief in having "certainty" is a reflection of a western faith in medical technology and the hospital the hospital as institution. E, who was overdue and had her pregnancy induced, described her dissatisfaction with the medicalization of her birth. She described how quickly her experience quickly went from natural to medical upon her arrival at the hospital.

> "Its strange because you felt really healthy and okay I mean I could have gone by bike but then you are a patient from one moment to another... you have to be in a bed with the other sick people and that felt kind of strange and that's of course not very nice so they gave me oxytocin and an IV and then I couldn't go out of bed anymore so all the things that you learn in a course from walking around and giving birth on a special chair was not an option anymore."

She described her experience as unsettling because her initial plan was changed from having little intervention to being hooked up to IVs and remaining stationary in a hospital bed. Though she planned to give birth in a hospital, an induced labor meant that she had to be under constant surveillance even though she felt completely healthy. Her own agency felt somewhat taken away as she became a patient and her childbirth became overly medicalized, and thus her comfort level went down. In her case, a transition into the hospital for an induced childbirth meant that she had to follow a different procedure than if her son was born early. Her inability to move around meant that her agency within the process was quite limited. However, she also recognizes that if her son was born earlier and didn't need to be induced, the entire experience would have been less medical and thus perhaps more comfortable.

Generally all participants in my study were satisfied with both the care they received from the midwives, and if needed, the care they received from doctors. Though midwives provided a strong emotional support for all of the women, the doctors provided a greater assurance. This hints at the hospital/midwife dichotomy, often discussed in literature on homebirths and hospital births. While most attitudes towards midwives and medical personnel were positive, a few women experienced various moments in which they felt less comfortable, or dissatisfied. Most women's narratives revealed that a shift towards the hospital did not impact how they experienced autonomy, high quality care and choices in childbirth.

Conclusion

I began my thesis with some apprehension as to the changing trends in western childbirth practices. Recent research done on the United States has revealed a problematic healthcare industry that has robbed many women of decision-making and autonomy in the delivery room. The cost of birth has never been higher. It may not be surprising then, that rates of cesarean sections and interventions have increased in the United States where profit drive its healthcare system. However, the Netherlands supports a maternity care system that approaches childbirth rationally and as independent of cost. Therefore I found it surprising that similar statistical trends were occurring in the Netherlands. A dramatic shift from the home to the hospital in the last half-century raises the question - did a shift towards the hospital ultimately enable the increased use of interventions in childbirth?

I posed a series of questions in my introduction, namely, "why are women in the Netherlands choosing to give birth in hospitals and how are they navigating the decision to do so?" In my small sample I found that women's own comfort in childbirth was more related to feelings of safety and security than to feeling connected to the familiar or the "gezelligheid." Most women made the instinctive decision to give birth in the hospital, where safety seemed to be guaranteed. While my sample is far from generalizable (all participants were similarly educated, middle class, first time mothers) it was still clear that the decision to give birth in a hospital setting was linked to greater feelings of control and safety. The landscape may be changing in the Netherlands, but the women I interviewed were still all satisfied with the level of care they received. Previous research suggests that women are most satisfied in childbirth when they experience high levels of autonomy and control (Goodman and Mackey, 2004, Green et. Al., 1990). This indicates to me that it is crucial to look beyond location in childbirth and refocus future research on how best promote the midwifery care within hospital settings.

My research into childbirth is far from complete. The Netherlands is home to many different cultural groups, and future research would be wise to focus on how socioeconomic and cultural background influence childbirth decision-making. The Netherlands has a unique approach to childbirth; does this clash with first generation

immigrants? How do women, who want physician-only care, fare in a society that economically forces women into midwifery care for low-risk pregnancies? Childbirth in the Netherlands is multi-faceted, and I realize that my thesis focuses on some of the larger shifts occurring in the country, and pays less attention to the smaller cohorts of women who may be navigating the maternity care system in entirely different ways.

There will continue to be shifts in childbirth as societies change, progress and transform. Future research in childbirth must go beyond location politics and focus on how women can be best enabled to make decisions in any place, be it the home *or* hospital. This can better promote policy change so that we can increase satisfaction in any location. An emphasis on the home/hospital dichotomy is easy to develop in the Netherlands, where home birth is still quite popular. I hope that future research will move beyond this dichotomy. As more women are choosing hospital care our focus should shift to how best we can provide quality care and autonomy within this "new" medical space.

The Netherlands is at a pivotal moment in maternity health care. This is the first time in its' history in which hospital births outnumber home births but where midwifery and a woman centered approach to care is still the norm. At this point, we can only hope that the increasing trend of hospital births will do little to shift costs for women.

After five months of interviewing, researching and writing, I can allow myself more optimism about changing childbirth trends in the Netherlands. While it is clear that more women are choosing to give birth in a hospital setting, I realize that this is not problematic in itself. It only becomes problematic when a choice of location means a change in cost, access and quality care. Fortunately, this is not yet the case in the Netherlands, thanks to a government that formally supports midwifery and universal health insurance.

While it undoubtedly remains an open question, I am confident that while attitudes may shift and locations may move, maternity care in the Netherlands will still hold onto a uniquely Dutch attitude towards childbirth and quality care.

Appendix

Data Figures

Figure 1: Medical Intervention Rate in the United States and the Netherlands (Most recent data available, see sources[1])

Indication	The Netherlands	The United States
Cesarean	17%	31%
Induced Vaginal	21.4%	30%
Episiotomy	30.3	17%
Epidural	>12%	67%
Narcotics Pain Medication	Unavailable	16%
Vaginal Instrumental (Forceps)	10%	40%

[1] Cesarean rates: OECD, Pain Medication and Episiotomies in the US: Listening to Mothers III, Rates in the Netherlands: Peristat 2010, Christiaens et.al. 2013

Figure 2: Changes in birth indicators in the Netherlands 1999-2010 (Peristat Report unless cited)

Indication	1999	2004	2010
Homebirth	Unavailable	30%	16.3%
Vaginal Instrumental	Unavailable	10.6%	10%
Episiotomy (in vaginal birth)	24.5% (1995[2])	24.3%	30.3%
Cesarean	8% (1990 data[3])	15.1%	17%
Use of Assisted Reproductive Technologies (ART)	Unavailable	2.5%	3.5%
Infant mortality (per 1000 births)	Unavailable	4.6 p	3.8
Fetal Mortality (per 1000 births)	4.6	7.0	5.7
Early Neonatal Mortality (per 1000 births)	3.5	3.0	2.8

[2] Graham, Carroli Et. Al. 2005 "Episiotomy Rates Around the World: An Update" in Birth Vol. 32 No. 3 (pp.219-223)

[3] OECD Library (http://www.oecd-ilibrary.org/sites/health_glance-2011-en/04/09/index.html?itemId=/content/chapter/health_glance-2011-37-en)

Interview Questions

Midwives

1. When did you become a midwife?
2. Why did you chose this profession? Was there a moment when you realized "THIS IS WHAT I WANT TO DO?"
3. What was the educational process like to become a midwife? How long did it take, did you enjoy it?
4. Can you describe where we are? In specifics
5. Describe a typical day at the hospital
6. Do you think that midwifes have a certain reputation in the Netherlands?
7. Do you feel supported by the medical "world?' and the government?
8. Has the midwife practice changed since you started? How?
9. Have childbirth trends changed for women in the Netherlands?
10. How common is the use of medication? Has this changed?
9. Why do you think midwives are so commonly used in the Netherlands compared to the United States?

Current Mothers

1. When you look back on your pregnancy in the Netherlands, how do you remember it?
    a. What was your relationship like with your midwife?
    b. How did you choose a midwife?
    c. Did you have a complicated pregnancy?
    d. Did you generally feel supported?
2. Before giving birth what were your expectations for your childbirth experience?
3. Describe the actual birth of your child –
    a. Where were you?
    b. did it confirm or go against your expectations?
    c. Pain medication?
    d. Did you have the same midwife throughout pregnancy AND birth?
4. If there was something you wish you could have changed about the process what would it be? (i.e., different location, with doctor, medication, etc.)
5. Do you feel satisfied with the current Dutch model for childbirth?
6. Why do you think that there has been a shift (in the younger generation) to give birth in hospitals versus at home?
7. What do you think of home-births?

Expecting (pregnant) Women

1. How far along are you, due date, where will you give birth (birth plan?)
2. What was your attitude towards “birth” as a process before getting pregnant?
3. Has it changed throughout your pregnancy?
4. How did you decide where to give birth? What influenced that decision?
5. Who have you been dealing with in the medical profession? i.e., midwife?
6. Where are you receiving your information on childbirth/pregnancy from?
7. What are your current feelings towards giving birth? I.e. Excited, nervous
8. Do you feel satisfied with your maternity experience so far, the doctors/midwives you are working with?

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