Women's Experiences of The Maternity Care in The Netherlands: A Study on Natural versus Medical and Its Effect on Agency

Arora, Sanchika

Leiden University Faculty of Social and Behavioural Science
Department of Cultural Anthropology and Development Sociology

Women's Experiences of The Maternity Care In The Netherlands: A Study on Natural versus Medical Birth and its Effect on Agency

An ethnographic study on the agency of pregnant and birthing women and how they navigate themselves through the unique and contentious Dutch birthing system.

Thesis by: Sanchika Arora (s3282996)
Supervisor: Dr Anouk de Koning

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Thank you to the wonderful, strong and courageous superwomen that trusted me enough to share the most intimate and vulnerable part of their lives.

Thank you to all the healthcare providers that found time in their busy schedules to speak with me about the work they spent a lifetime nourishing and cultivating. Your hard work doesn't go unnoticed.

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Cover Picture - This picture was taken during my fieldwork at the yoga studio where I volunteered. I took this photo of the mother and baby after a postnatal yoga class. In these classes, postpartum mothers bring their babies so they can fit in some exercises without having to leave their babies. The little stickers presented were to conceal the identity of other women in the class as they didn't want to be photographed.

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Chapter 1
An Introduction

1.1 The Issue

Childbirth is a transformative and deeply profound journey that greatly impacts the lives of women and raises important questions about women's autonomy in health and reproductive decisions in a particular place and country (Johnson & Simon, 2021). Maternity care in the Netherlands is based on the basic assumption that pregnancy and childbirth are natural and physiological processes that don't need to be medicalized until necessary and have long held the tradition to give birth at home (Johnson et al., 2007). Within the unique birthing system in the Netherlands, birth can be divided into primary care and secondary care. The gatekeepers of maternity care, the midwives, provide the primary care for low-risk births while obstetricians provide the secondary care (Wiegers & Hukkelhoven, 2010). The aim of this Dutch model of maternity care is to ensure that midwives provide prenatal care to women with low-risk pregnancies despite their decision to give birth at home, birthing clinic or in a hospital (Hermus et al., 2015). Additionally, in case complications arise during pregnancy, labour or postpartum, a woman is then referred to secondary care under an obstetrician (Hermus et al., 2015). Furthermore, the Netherlands has long been recognised as an ideal birthing model by countries all over the world due to the low intervention rates, home birthing options and interplay of healthcare providers such as midwives and obstetricians (Christiaens & Bracke, 2009). The system is regarded as a commemoration of women's empowerment and choice through pregnancy and childbirth.

Hence, maternity care is predominantly celebrated as a "women-centred" system with prominence on a woman's autonomy and agency (Amelink-Verburg, 2010). This ethnography aims to delve into the multifaceted experiences of women within Dutch maternity care while they explore the intricacies of the unique system. The "women-centredness" of the Dutch system has brought interest from a number of researchers to study the experiences of women in the field. However, there is a changing trend in women's choices of their chosen place of birth from home to hospital mainly for pain relief (Hermus et al., 2015). This rise is related to the fear of childbirth and the pain associated with it. Through my time in the field, I noticed that the differing opinions between medical professionals and women on what they should and shouldn't be doing with their bodies have caused tension within the system and ended up in damaging the experiences and the agency of women in an extremely crucial and vulnerable moment of their life. Further, I have come to an understanding that the concept on which the system is based is purely theoretical and actuality chooses to differ. In reality, there are many tensions that exist within this multifaceted system. These tensions range from between the mother and medical practitioners, among the medical practitioners (the midwives and obstetricians) and divided ideas and opinions of a natural versus medical birth.

The differing views each actor has on natural versus medical birth seem to cause a debate within the system and can have an effect on the experience and agency of women. Hence, my time in the field is aimed at interrogating the "women-centredness" of the system due to the ambivalent and divided view where each actor is involved with varying ideologies, perspectives and approaches to the care. Therefore, this ethnography undertakes an investigation into the experiences and agency of birthing women within the contentious field of maternity care in the Netherlands. To illustrate the complexities of this debate, let us recount a vignette from a candid conversation with a mother.

It had already been a long day at work, I came in at 6:30 AM on a warm morning to The Cosmos, a beautiful yoga and pilates studio hidden in a nook of Amsterdam West where I volunteered through the summer. I got free classes for all the times I went in to check in guests and lay the mats down, it was a great deal! Coincidentally, it was also one of the only yoga studios around Amsterdam that held prenatal classes and postnatal classes where new mothers could bring their babies in to fit in a workout on their postpartum days. As the clock struck 12:45 PM, mothers started to walk in with their strollers. They checked into the class with me and made their way into the back of the class where they dropped their stroller and then moved onto their mats where they got comfortable with their babies. I joined too and made myself comfortable at the back of the class. Lily, the teacher, starts the strong pilates class. Mothers picked up their giggling babies while they moved in lunges and squats. Soon after the class, some mothers had a cup of tea and started to make their way out. Two mothers, Salima and Lieke breastfed their babies in the waiting room, while I started to finish my task in order to close the studio. I initiated a conversation with them, first starting with small talk and then moving on to their birthing experience.

While Lieke had a natural birth in a birthing centre, Salima explained how she wanted and had a medicalized birth. While her overall experience was good and she had a healthy baby girl, she complained of her long recovery but was pleased with the care provided by doctors and nurses during the birthing. However, before her birth, she recalls defying all odds thrown her way with all healthcare providers warning her of everything that could go wrong. "I don't understand why they tried to scare me off everything that could go wrong during the birth, I know what can go wrong and I would've been more scared without doctors around me" Salima recalls. Later she adds "All births are natural no matter how the baby comes out, so I don't understand why they make it such a big deal"

This short vignette can clearly highlights the following tension that exists in the system between a natural and medical birth. Furthermore, it also briefly looks into conversations with medical professionals and how Salima makes decisions for her own birthing body to protect her agency and feel in control of her birthing situation. While Salima stood strong and did have a powerful birthing experience, there are instances of other women in this ethnography that didn't have a good experience like Salima. The unpleasant experiences were a result of certain decisions these women made about their own bodies and birth that went against the system's recommendations and ended up having scarring experiences, with no control over the situation and experiences a loss of agency due to the

workings and tensions present within the Dutch birthing system. This ethnography is a discourse on natural versus medical birth and the opinions of medical practitioners within the system that have an effect on women's experiences and agency. Therefore, it constitutes a feminist perspective on women's autonomy since women's bodies have been an object of study with regard to power, control and regulations (Feeley et al., 2020).

1.2 My Motivation

As an avid advocate for women's reproductive health and rights, my motivation to study the experiences and agency of birthing women is driven by my belief that every woman deserves to have her voice heard and choice respected during the most life-changing moments of her life. In my time in the field, a number of women told me how they never felt heard about their birthing experience until I interviewed them and their story felt irrelevant ultimately since they had a healthy baby and a healthy body. To me, Anthropology is about telling a story of an individual and validating each of their experiences no matter what they may entail. Moreover, it's about studying their ideas, values and beliefs that are formed through life experiences. Spending time in the field and speaking with a number of involved actors, I aimed to navigate the issues in maternity care by sharing the stories of the women and validating their experiences that caused them to feel empowered or disempowered during their birth. The sacred journey of pregnancy and birth is deeply profound and I hope to shine a light on the experiences, both challenges and victories that a woman encounters within the healthcare system. The mere understanding of learning the entanglements of women's experiences and agency during childbirth is key to forming a fair and respectful healthcare system that aims to give tailored care to the preferences and beliefs of these women. Ultimately, this ethnography isn't just a scholarly pursuit but a step to make an impact in the lives of these birthing women and honour their voices. With a deep sense of purpose and passion, I hope to write an empathetic and informed ethnography that honours these women's stories and experiences with the utmost reverence and respect for them.

1.3 Problem Definition and Theoretical Framework

I will now embark on a comprehensive exploration of various concepts and theories that lay the groundwork for our later discussions. To begin, I will delve into the intricate landscape of Dutch maternity care, recognizing the multitude of elements that contribute to the complex division of care. Understanding this context is crucial for grasping the basic dynamics that influence women's experiences and agency within the birthing system. Next, I will delve into the dichotomy between natural and medicalized birth, and the differing opinions of mothers and doctors that can underpin women's decision-making during childbirth. Another crucial aspect to explore in this thesis is the experience of pain during childbirth, a phenomenon which can closely be connected to the medicalization of birth and the fear surrounding natural birth. Examining the relationship between pain and childbirth allows us to understand its impact on women's birthing choices and experiences

and how it may relate to broader societal perspectives on birth. Lastly, I undertake an in-depth exploration of the complex notion of agency, acknowledging how agency might look different for everybody due to its personal and context-dependent nature. To operationalise the concept of agency in this study, I employ the notion of knowledge, power and control. Through dissecting these elements we can gain insight into how women navigate their childbirth experience and assert autonomy within the healthcare system. Through this multi-dimensional approach, I aim to contribute to a more encompassing and inclusive discourse on maternity care in the Netherlands and all the actors involved in the care.

1.3.1 The Dutch Maternity Care

Based on a country's organisational model of birthing care, diverse professionals may be involved in the care of a mother during her pregnancy and labour (Amelink-Verburg, 2010). This organisational model usually regulates which professional will be involved in each process of pregnancy and labour. Furthermore, each country has their unique division of roles amongst the professionals that determine the responsibilities of each of them in the care of a woman during her pregnancy and labour (Amelink-Verburg, 2010). While childbirth in many Western countries is seen as a highly technical and medicalized process that is filled with complications, this isn't the case in the Netherlands (Johnson et al., 2007). The Dutch organisational model of maternity care has long been regarded as a cogent system where the autonomy of midwives promotes natural, normal and satisfactory birth, free from all medical interventions that otherwise may be found in other high-resource countries (De Vries et al., 2013). The midwifery care includes a selection of preventative methods, detection of complications and overall tends to promote a natural birth without medical interventions (Amelink-Verburg, 2010). Further, the World Health Organization finds the knowledge and skills in assisting a low-risk pregnancy and childbirth as the core of midwifery ability in successful births (Amelink-Verburg, 2010). Moreover, midwives are recognised as "women-centred caregivers" where their tasks issue the optimal health of a woman through all stages of her pregnancy and birth with the use of low technology in her presence (Amelink-Verburg, 2010).

The Dutch midwives are considered independent practitioners and are legal medical professionals with knowledge of physiological pregnancy and birth that work independently, in duos or in groups (Wiegers & Hukkelhoven, 2010; De Vries et al., 2013). The midwife is the primary care provider and gatekeeper, however, some general practitioners may still provide part of the care during pregnancy and childbirth (Wiegers, 2009). A healthy woman with an uncomplicated and low-risk pregnancy and birth is assisted by her primary caregiver, the midwife and can choose to give birth at home, birthing clinic or hospital (Wiegers, 2009). The Dutch maternity care system is renowned for the high rates of home birth without pain medication or medical interventions compared to other developed countries (Logsdon & Smith-Morris, 2017). However, the rate has fallen drastically over the last few years, decreasing from 30% in 2005 to 13% in 2016 (Logsdon & Smith-Morris, 2017).

Most women I spoke with who visited midwifery practices worked in groups and were referred to as caseload midwives. During their prenatal appointments, women manage to meet almost all of the midwives, giving them a chance to get to know themne of these midwives will be present when the pregnant woman is giving birth and takes a shift to help assist in the processes depending on the labour length.

In addition, there are clinical midwives who are certified midwives that provide specialised care in a hospital or clinical setting for women that don't want to give birth at home (Wiegers & Hukkelhoven, 2010). However, suppose there is an increased risk of complications that makes the pregnancy or birth high risk, women will need specialist care and consultancy from an obstetrician in secondary care (Wiegers, 2009). Medical interventions such as pain medication during labour, continuous fetal monitoring, induction of labour or pain relief such as an epidural can only take place in secondary-led care (Klomp et al., 2016). The aforementioned indicates that, if a woman with a low-risk pregnancy wants any form of medical intervention to manage pain or reduce anxiety related to natural childbirth, she will automatically be moved to secondary care. Further, despite the free, high-quality care and collaboration of healthcare professionals, the perinatal morbidity and mortality rates in the Netherlands remain relatively high compared to other European countries (Schölmerich et al., 2014).

Additionally, it is important to understand the health insurance coverage for maternity care that is in line with the support of the midwifery model since they play an important role in influencing the landscape of maternity care (He, 2011). Basic health care insurance is compulsory for all people living in the Netherlands and covers the care of both primary and secondary care in the Netherlands (Warmelink et al., 2017). For low-risk pregnancy and birth, the insurance will only cover care from a midwife or general practitioner that falls in the primary care and only women with a high-risk pregnancy and birth can be covered for care by the secondary care under a gynaecologist (He, 2011). As mentioned earlier, if a woman requests any medical interventions - she is transferred to secondary care under the supervision of an obstetrician and insurance will not compensate the birth for women who could've had a "normal" pregnancy (He, 2011). Women and their families will need to pay out of their pockets in order to incorporate any form of care that falls away from the normal workings.

The *kraamzorg* or maternity care assistants are part of the postpartum care that provides care for the mother and child in the early weeks following the birth. The aim of postpartum care is to ensure the physical health of both mother and baby and detect any complications in the early stage but to also help parents cope in the first few days, especially if they are first-time parents (Wiegers, 2006). The well-organised maternity care in the Netherlands provides postpartum care for all mothers and babies with the *kraamzorg* for a minimum duration of 24 hours and a maximum of 64 hours for 8-10 days following childbirth and in case there were complications that arose, the care can extend to 80 hours (Wiegers, 2006). The *kraamzorg* care has been covered by insurance since the 1960s (Wiegers, 2006). Their responsibility lies in monitoring the health of both the baby and mother, assisting with

breastfeeding, helping around with household tasks such as cooking and cleaning and providing support to the parents while they develop a new routine (Wiegers, 2006). Even though the mother will have 4-5 follow-up checkups with their midwife or obstetrician following birth, the personalised help that a *kraamzorg* provides in the fragile days after birth is unique to the Netherlands and to lighten the midwife's workload after birth.

There is also a more recent introduction to Dutch maternity care, the doula. A doula is a woman who isn't medically trained but aims to provide emotional and physical support to the birthing woman and her family (He, 2011). They assist in a smooth labouring process and essentially supplement the support that medical professionals such as midwives, doctors and nurses might need to provide (He, 2011). Doulas mainly act as an advocate for the birthing woman and ensure that her wishes are respected in situations that could become dire or stressful (He, 2011). Studies report that mothers supported by doulas have a better perception of their body, labour and their newborn (He, 2011) However, their care is considered private, expensive and is completely separate from that of any of the involved medical providers, hence, insurance companies do not compensate for the services of a doula (He, 2011).

1.3.2 Natural Childbirth

According to MacDonald (2011), when asked to define a natural birth, midwives and mother described natural birth as a physiological birth that is drug-free, free of medical interventions and completely demedicalised. It is essentially the opposite of hospital birth and allows the body to move through labour and delivery without medical interventions and instead focuses on the body's natural potential and power to give birth, allowing it to unfold as naturally as possible. Natural birth has long held a celebratory status within the midwifery and alternative birthing movement around the world and continues to challenge the medicalisation of childbirth and the dominance of biomedicine (MacDonald, 2011). During a natural birth, medical and technological interventions such as continuous fetal monitoring and pain relief medication are almost always steered clear of or used moderately (Klomp et al., 2016). Instead, pain management strategies include, breathing methods, water birth, hypnosis and freedom of movement, as well as, position change while labouring (Logsdon & Smith-Morris, 2017; Simkin & Bolding, 2004). The most important part of natural birth is creating a safe, encouraging and empowering environment for the birthing woman (Berg et al., 2012). Women usually have their partner or family member as well as their midwife. Some women even choose to hire a doula, who is a person that provides emotional and physical assistance to the birthing woman and her family through labour. The support helps a woman recognise and exercise her power and control during her birth, her body and surroundings without her losing her agency in any manner.

The Netherlands has always stood by keeping birth as natural as possible and giving women an opportunity to understand, experience and reclaim natural birth (Johnson et al., 2007). In fact, even

through pregnancy, midwives don't conduct unnecessary tests for the mother and baby, unless there is already a risk present at hand. The Dutch have always understood birth to be nothing but a physiological process and choose to treat it as that, a natural process rather than an illness (Johnson et al, 2007). The system promotes women to give birth naturally in the comfort of their homes and a birthing centre and if the birth is medicalised, the women give birth in a hospital (Johnson et al, 2007). This aspect of Dutch maternity care where care under midwives as well as birthing in a safe, supportive and non-medical setting can result in slowdown of medicalization and is essentially considered the safest option for both mother and child (Johnson et al., 2007). This is why the Dutch maternity care model is acknowledged as a women-centred model that continues to focus on women-centred ideologies (Christiaens & Bracke, 2009). However, the fear and anxiety revolving around natural birth with regard to its safety and unbearable labour pain are leading more and more women in the Netherlands, including some of the women I interviewed to draw away from natural birth and move toward a more medicalised birth, which is what the the system is designed to handle.

1.3.3 Medicalization of Childbirth

Medicalization be defined as "defining a problem in medical terms, usually an illness or disorder, or using a medical intervention to treat it" (Van Dijk et al, 2016, p. 619). According to Van Dijk et al. (2016), while medicalization itself is not by definition a negative phenomenon and medicalising certain situations can have various benefits. However, medicalization examines diagnoses that are based on a vast understanding of human circumstances and where one usually benefits from the diagnosis. In the context of childbirth, childbirth has become increasingly influenced by modern medical technology and consists of medical interventions in most Western countries (Johnson et al., 2002). Johnson et al. (2002), even argue that a possible natural birth has become too medicalized. A medicalised birth in general insinuates the childbirth process that is heavily impacted and controlled by medical technology and procedures (Johnson et al., 2002). It consists of various interventions during labour and childbirth, however, the degree of medicalisation may vary depending on the healthcare provider present, the particular situation of the pregnancy itself and also what the mother demands.

The type of medical interventions that are frequently used in medicalized births are continuous fetal monitoring, induction or augmentation of labour using pharmaceuticals, epidural (anaesthesia used for pain relief), episiotomy (a surgical cut to open up the vaginal opening), delivery aid with vacuum extraction and forceps and a cesarean section (surgical delivery) (Hermus et al., 2015). While these interventions can be life-saving for both the baby and mother in a particular situation, the main issue with hyper medicalizing a birth is the introduction of unnecessary interventions where one intervention leads to another, increasing likelihood of danger and stress for both the mother and baby, longer recovery time for the mother, potential emotional and psychological impact on the mother, possible non-consensual acts or obstetric violence from medical providers

which results in reduced agency of the birthing person (Perrotte et al., 2020). During my time in the field, I noticed that opinions on childbirth vary among cultures, individuals - their backgrounds and life experiences and the workings of healthcare systems. While some women I spoke with had/planned a medicalised birth due to medical conditions, personal preference or fear of pain, other women preferred a more natural and less-invasive approach to their birth. Due to their decision, they sometimes faced opposing views from their doctors or midwives which ended up shaping their negative experiences and lack of agency during their birth.

1.3.4 Fear Around Childbirth

According to Rodung et al., (2016) over 80% of birthing women indicated worry and fear of childbirth. Labour pain was a considerable fear and concern for most women, their partners and maternity healthcare professionals (Klomp et al., 2016). Logsdon & Smith-Morris (2017) explain that even though pharmacological and instrumental interventions have been included with natural birth, most interventions during childbirth have to do with pain control. The pain levels are dependent on a variety of factors such as fatigue level, position of baby and intensity of contractions (Logsdon & Smith-Morris, 2017). Further, multiple studies show that the need to request an epidural is closely related to higher levels of fear and anxiety with regard to childbirth (Smorti et al., 2020). However, the Netherlands has long had a reputation for traditional natural birthing without the use of pharmacological pain medication such as epidural (Klomp et al., 2016). However, in the recent past, the number of women using epidurals has taken a rise. In 2012, 17.6% of women used epidurals as compared to 5.4% in 2003, 11.3% in 2008 (Klomp et al., 2016). This is due to the introduction of the Dutch guideline regarding medicinal pain relief that states that if a woman requests pain relief during labour, that is enough indication to proceed (Klomp et al., 2013). However, in 2016 it was noted that approximately two third of women in the Netherlands gave birth in a hospital under the care of an obstetrician (Perdok et al., 2016).

However, as mentioned earlier if a woman wants an epidural she is transferred to secondary care under the supervision of an obstetrician. If a woman during pregnancy indicates that she is interested in pain relief during labour, she may have a consultation with the obstetrician, however, most of them still begin their labour under the care of a midwife (Klomp et al., 2016). If during labour, a mother wishes to receive an epidural, she is transferred to the hospital (Klomp et al., 2016). There are no implications for the midwives as there is a diminished caseload for her but the extra expense is something the birthing woman and her family would need to take into consideration (Klomp et al., 2016). Even though some studies show positive outcomes in dealing with pain in the Netherlands where women give birth without an epidural or any pain relief, my study definitely includes women that advocated for themselves and requested medical interventions. This caused issues and tension between the mother and healthcare providers as the whole maternity care is designed for women to give birth as naturally as possible.

1.3.5 Agency

Agency is a very dense concept that varies easily amongst individuals and can be interpreted in many ways. In this section I will focus on looking at various definitions of agency written by different authors and then elucidate how it has been used in other medical and reproductive literature and finally how I'm going to use and understand agency through my ethnography. According to Nash (2005), human agency is the "ability of people to act intentionally to shape their worlds" (p. 67). Whereas, Kockelman (2007) explains that "agency might initially be understood as the relatively flexible wielding of means towards the end" which to say an individual has more agency than another, is to say they have more flexibility and accountability. The more agency one has over a process, the more in control one can feel no matter the outcome (Kockelman, 2007). Therefore, agency can also be understood as the "inherent human capacity" that can be used as a tool to represent hope or rebellion and sometimes as free will or choice (p. 375). Kockleman (2007) also understand agency as a kind of resistance or resilience and is also used interchangeably with the terms knowledge and power. Nahar (2014) on the other hand defines agency as "people's ability to make choices and act and thus (to some extent) steer their own lives" (p. 382). Agency denotes that each person has a sense of certain freedom to exercise when they are being oppressed (Nahar, 2014, p. 382). Therefore, while the term can be applied to every individual, it is most popular in studies of vulnerable groups or people. Since birthing women are in a vulnerable position in the birthing room, studying their agency or freedom to exercise their voice and power in the birthing room is an interesting and important topic.

With regard to agency, pregnancy and birth, Witten (2016) defines agency as "a complex concept that revolves around a person's confidence or sense that they are capable of exerting influence over their behaviours and the environment in order to affect change" (p. 8). Here, agency involves forming personal expectations and confidence and is part of the discourse concerning decisions that involve disproportionately the knowledge and power of the person making certain choices (Witten, 2016). Patients may be intimidated to construct agency due to the responsibility and accountability that comes with decision-making (Witten, 2016). However, Witten (2016) argues that reproductive agency is important in the decision-making process in pregnancy and childbirth as it "elicits and empowers patient voice and helps women towards a partnership when engaging in decision making" (p. 8). Childbirth has exponentially found its way into the social sciences where the perspective of women on their pregnancy, labour and birth, technology's growing impact, the dominance of biomedicine, the role of spirituality, and the need to gain freedom are all tied to the agency a woman holds during pregnancy and childbearing (Miller et al., 2012).

Moreover, Campo (2010) explains that while women are viewed as free and independent, agency can often be limited by the type of choices that are made available to them by their medical provider in a particular cultural context that is further mediated through hegemonic medical knowledge. This can be noted in the Dutch context too since there are clear guidelines noted on what women should and shouldn't be doing with their bodies, making it an interesting place to study the

reproductive agency of birthing women. It is particularly evident in pregnancy and childbirth literature that the woman's use of knowledge, power and control during all phases of her pregnancy frame her agency (Moore, 2011). In my research, I aim to understand how women gain or lose their sense of agency during their pregnancy and childbirth and how her and other actor's knowledge, power and control play a role in influencing their agency. In the next section of this theoretical framework, I will closely theorize the terms knowledge, power and control and how they closely relate to the framing agency of a woman.

1.3.6 Knowledge, Control and Power

In this section of my theoretical framework, I will use the notion of knowledge, power and control to operationalize the dense concept of agency. The power dynamics within the birthing room between actors involved but also the inner power/strength a woman may experience, her control within the birthing room and knowledge with regard to her body, practices, pregnancy and birth all play a significant role in shaping a woman's agency during childbirth as explored during my time in the field and in academic literature. Hallam et al, (2019) describe childbirth as an extraordinary and powerful life-changing experience that has long-term physical, mental and emotional outcomes for women. Positive birth experiences are linked to feeling strong and empowered while negative birth experiences can be linked to feeling failure, guilt, depression and violation (Hallam et al., 2019). A woman's expectations, assumptions and beliefs about childbirth are closely linked to her actual birthing experience, indicating that positive expectations for a woman's birth can lead to a woman feeling more controlled and satisfied with her birth, whereas, negative expectations about her birth can lead to unsatisfying experiences and loss of control which can negatively impact her overall well-being (Hallam et al., 2019). Hence, the birthing expectation and experiences of a woman remain important due to the large positive and negative consequences on their physical and emotional well-being (Hallam et al., 2019). In this section, I hope to elucidate the differences and similarities to set the stage for later parts of this ethnography where these terms pop up.

The role of knowledge during pregnancy and labour can influence a woman's agency deeply. Body and birth knowledge is closely related to a woman's self-confidence during childbirth (Moore, 2011). The medical knowledge of a health provider can strongly shape the perception of what is considered normal and safe during childbirth and can end up devaluing or dismissing the experience or knowledge of the woman herself. The birthing woman's autonomy in decision-making during her pregnancy and birth is an essential part of admirable maternity care and a crucial part of taking responsibility for the health and well-being of the mother and baby (Vogel-Broeke, et al., 2023). Women that are given the option or choose to make decisions during their pregnancy also accomplish more control and a more positive experience no matter what the outcome, whereas, disengagement in decision-making may contribute to a negative or traumatic experience (Vogel-Broeke et al., 2023).

With her own knowledge, a woman can challenge or question the medical authority if necessary, further reducing fear, making informed decisions and asserting her agency (Moore, 2011).

As can be highlighted, a woman's knowledge is closely related to exercising control within a situation. Nieuwenhuijze et al., (2013) confirm that a sense of control was the strongest predictor for a satisfactory childbirth. However, the sensation of control is a multifaceted concept that is considered important to the physical and psychological function of humans (Nieuwenhuijze et al., 2013). Control can be divided into two dimensions - internal and external (Nieuwenhuijze et al., 2013). The internal control for a birthing woman includes a sense of control over emotions, behaviour, thoughts, pain and general self, while, external control was related to involvement during labour and birth with regard to what the healthcare providers are doing and how they were involved in and informed about certain decisions and procedures (Nieuwenhuijze et al., 2013). The notion of control isn't much related to actually being or having control over a situation but is more about feeling involved and involved in decision-making with the possibility to hold authority, assert their agency and feel in power as well as empowered during their birth (Nieuwenhuijze et al., 2013).

In the birthing context, Moore (2011) defines power as the ability of a woman to greatly influence her pregnancy and birth experience with regard to the birthing environments, the attendants as well as the type and level of intervention employed during both pregnancy and childbirth and her involvement in those decisions. Asserting power and being empowered is recognised by many women and midwives and is eventually a major goal for childbirth (Moore, 2011). While it is important for women to feel empowered and in power/control through the entirety of their pregnancy and labour, I will also use power to describe the power in terms of unequal and asymmetrical relationships that can often set a hierarchy in the birthing room. Since obstetricians and midwives hold a more prominent authoritative power, the domination of the medical system ends up placing women in a more subordinate position where their agency might be diminished and their choices may be overlooked (West & Bartkowski, 2019).

To summarise, a woman's knowledge of her birth and body, the power to take hold of the decision-making related to birth and the ability and desire to feel in control of her birthing experience are three ways a woman may exercise agency and feel confident about the relevant decisions she might make during her labour and birth (Moore, 2011). It should be noted that all three terms, knowledge, control and power are closely related and in some cases can and were used interchangeably with each other or with agency.

1.4 Research Question and Operationalization

Building on the theoretical framework I laid out in the previous section, I have formulated a question to examine how pregnant women in the Netherlands experience their pregnancy, birth and agency within the unique system where life experiences, thoughts, ideas and beliefs may crash with one and another between actors involved.

The main research question of my thesis is:-
How do women experience and enact agency in what is ostensibly a women-centred birthing system?

My first subquestion is:- How is natural versus medical seen by other actors within the system?

Within this subquestion, I will closely examine the general debate and changing patterns on natural versus medical and the way medical practitioners view this dichotomy within the system. Later, will closely examine the beliefs of midwives, obstetricians and doulas within the system, how their practices are different from each other and how they conceptualise the agency of a birthing woman. However, this chapter will begin to question how women-centred the birthing system really is and how growing tensions have the possibility of affecting a woman's experience and agency.

My second subquestion is:- How are these notions negotiated and acted in the birth trajectory?

In this subquestion, I will closely examine three distinct case studies involving women who held contracting perspectives and expectations concerning birth, pregnancy, labour and eventually childbirth. By closely inspecting their individual circumstances within the context of the Dutch birthing system, I aim to examine and unfold each of their respective journeys. Through analysing each of their case studies I delve into their interactions with medical professionals, their personal beliefs and how events unfolded within the labour and delivery room. The debate regarding natural versus medical birth and differing opinions of actors will show how the notion is negotiated and acted in real-life situations.

My third subquestion is:- How does the natural versus medical debate impact women's agency within the system?

In my final subquestion, my object is to illuminate how the ongoing debate on natural versus medical manifests in real-world scenarios, ultimately investigating what truly constructs a women-centred birthing system. Further, I intend to understand how the ongoing debate has influenced women's agency and autonomy. Lastly, I aim to gather insight and recommendations from all the individuals I've interviewed regarding potential improvements that could be implemented within the system.

1.5 Methodology

This thesis adopts a qualitative research design to explore and gain in-depth insight into women's experiences as well as the working and collaboration of healthcare professionals within the medical field and how they end up framing a woman's agency. It is based on data that I collected during three months of fieldwork with women and healthcare professionals in the Dutch birthing system. I carried out this research during the months of May and August 2022. My research was mainly conducted in Amsterdam and Utrecht, however, I did go to The Hague for a participatory

observation. Semi-structured interviews and participatory observation were used as primary data collection methods to gather rich and contextual data. Further, this design allowed for flexibility in exploring the perspective of participants while also enabling me to actively engage in the context. During my fieldwork, I met uncountable pregnant women, women that have already given birth in the Netherlands, doulas, prenatal yoga teachers, a midwife, gynaecologists and obstetricians and medical students. I also visited yoga studios, midwifery clinics, a hospital, homes and cafes for interviews and participatory observation.

Since the very beginning of picking this topic, I always questioned what my field would be since I was diving into the rather abstract topic of "experience" or "agency". I found myself questioning how I can study and conduct participatory observation in a field I don't really have access to. It wasn't possible to attend midwife/doctor appointments with women because they are too private, short and overwhelming. I couldn't possibly be a burden as a researcher to women, just so I could study and analyse what was going on in a room. I tried my luck and asked to be present at a friend's childbirth since perhaps she was the one person that knew me for me rather than a researcher. She still didn't want me in the birthing room so she could focus and be less conscious of herself and because she was at a birthing clinic which is a medical setting - it just wouldn't be possible. It was quickly confirmed to me that pregnancy childbirth is a stressful, private, precious and profound moment in a parent's life and to have any kind of researcher present at important meetings or moments would be an interference to the normal processes. I was also left disheartened when I realised it wasn't possible to spend days in midwifery clinics or hospitals walking around and speaking with people, since, it all required special permission and access that would've ended up taking a long time to resolve and I questioned how much data I would even be able to collect wandering corridors to find people to talk with. I realised my main motive for this thesis was to speak with women and healthcare professionals and I just had to get creative in my ways to find and approach them.

Since I already personally knew some women that had given birth in the Netherlands and some medical students that had done rotations at the gynaecology and obstetrics department and an obstetrician that has been in the medical field for the last 35 years, I decided that would be a good starting point to begin my interviews. Soon around that time, I started a volunteering job at a yoga studio called The Cosmos in Amsterdam that coincidently held prenatal or postnatal classes, I thought the best way to meet women and get a chance to speak to them would be to partake in these classes or speak to them before and after their lesson with hope to get an interview. I got most of my interviews with pregnant and postpartum mothers from this studio and also attended some classes at the studio with the mothers. These women included a mix of Dutch but also internationals. Since I followed a couple of famous Dutch midwives on Instagram, I decided to look at their following list and to my joy, hundred of doulas and midwives were following their pages. I messaged an uncountable number of healthcare professionals to ask for an interview and a few responded agreeing to be a part of my research. Lastly, I also found a few participants when I was conducting participatory observation for a

few hours at a midwifery clinic. My simple way to look for participants worked and soon I had a number of interviews lined up.

Semi-structured interviews were a key method in collecting research and most of the data from my field was derived from these interviews. I figured, the abstract topic of diving into “experiences” and “agency” could only be learnt through the lens of these women and their personal experiences, emotions and perceptions of pregnancy, labour and interactions with healthcare providers. Hence, interestingly enough my dilemma on how I can find the answers to the research questions in a field that I can’t actively be in was resolved. I learnt that even if I did get a chance to attend appointments or experience childbirth in front of my own eyes, that would’ve never been enough to answer my questions since that would’ve been my own interpretation and observation of the situation. The only way I could answer these questions is by learning through the lived experiences of these women and what they thought, felt and observed. Their lived experiences and words were my medium to access the field which was mainly possible through these semi-structured interviews. This was the same with healthcare professionals, no amount of observation could give me insight into their ideologies, beliefs and practices. Before all interviews, a guide with open-ended questions was prepared in order to make sure I gain insight into the participants' stories that they choose to share. Notes were taken during interviews along with audio recordings of each interview after the consent of the participants. The data was then turned into field notes and parts were transcribed for easy quotation while writing this thesis. Some participants were anonymized to ensure the confidentiality of them and their data.

I also conducted participatory observation so I as an anthropologist could dive into the research context, engage with my participants and conduct interviews with them at a later time. However, participant observation was used as a method to gain participants for my interview as opposed to understanding the in-depth dynamics between the actors involved. As mentioned earlier, through the three months, I spent time in a couple of midwifery clinics for a few hours each, a day in the hospital, went to a short appointment between a pregnant mother and doula and lot of time at prenatal and postnatal yoga classes. However, it must be noted that no key conclusions or significant findings were drawn from this specific data collection method alone. Participatory observation served as a complementary approach to the primary data collection method of semi-structured interviews. A combination of both participatory observation and semi-structured interviews was essentially used to comprehensively capture the complexity of women's experiences and agency during their pregnancy and childbirth to derive a holistic and integrated conclusion for this study.

1.6 Ethical Considerations

As an anthropologist, I felt like my responsibility lay in my participant's feeling heard, making their opinions feel relevant and telling their story as it is. While I think the commitment of researchers may change or differ to their subject depending on who they are, where they are from and

what they are researching, I want to stay committed to my participants by making their problems heard and validating their experiences. Even if my subject considers their problem to be “minor”, I hope to voice their opinion and make their problems important enough to be able to act on them throughout the entirety of this thesis. Throughout the whole process of my thesis, I encountered a number of ethical choices and considerations. I aimed to fully act in accordance with the specific codes of ethics specified by the American Anthropological Association (AAA).

The AAA Code of Ethics clearly states the main ethical commitment amongst anthropologists is to do no harm and an anthropologist must be aware of the sensitive nature of their topics and how they may cause harm to the participants with which they are working (AAA Statement on Ethics, 2012). I consider my topic to be a sensitive one that involved working with people like pregnant and birthing women going through a very delicate and vulnerable stage of their life and healthcare professionals who have spent years solidifying their practice. Since my data included information on health professionals not following protocol at times which could lead to a compromised situation if revealed, I will anonymise and reword their quotes to avoid them being traced back to them in any manner. Further, considering the contentious and ambivalent nature of this field, I made sure to not challenge or burden healthcare providers with constant opposing beliefs as I didn’t want to discredit their years of hard work. Hence, I tried to remain sensitive, sympathetic and unbiased while conducting the research, so my emotions or sometimes opposing beliefs weren’t revealed in an offensive or uncaring manner.

1.7 Chapter Outline

In Chapter 2, we dive into understanding the diverse perspectives on childbirth. The chapter will begin with a short history of the Dutch maternity care. After we dive into the dichotomy of natural versus medical care. Later the role, beliefs and perspectives of midwives, doctors, medical students, doulas and a *kraamzorg*. We can also gain insight into a few women’s opinions and experiences in this section. Lastly, the healthcare professionals' view on women’s agency is discussed.

In Chapter 3, I discuss three different case studies of women with completely different experiences within the same birthing care. Their view provides detailed insight into how notions of natural versus medical are negotiated and acted out in the birthing system. It can also be elucidated how “women-centred” the Dutch maternity care really is. A few other factors that also affected women’s childbirth experiences are discussed here.

In Chapter 4, we dive into how the dichotomy and differing ideas between natural and medical birth. Agency is operationalized with the notions of knowledge, control and power. Later some suggestions for improvement are provided by different stakeholders in the system.

Chapter 2

Understanding Diverse Perspectives on Childbirth

In this chapter, I aim to examine the intricate web of Dutch maternity care and how different medical professionals within the system play an essential role in guiding and supporting women through this pivotal moment in their lives. First, I will briefly dive into the history of the Dutch maternity care and how the historical developments are shaping the unique childbirth approach in the country. I will then lay down a foundation of the general debate on natural versus medical, and how different professionals view this debate on natural versus medical. Later, I will delve into the diverse standpoints on pregnancy and childbirth held by mothers, doctors, medical students in training, midwives and doulas. Depending on their medical profession, each actor involved has their own ideas on the way they viewed natural versus medical and the way they approached their patients. Lastly, I will dive into how each medical professional conceptualises a women's agency. Through this ethnographic research, I had the unique opportunity to gain insight into the immersive experience of mothers and each medical professional to gain an understanding of their beliefs, ideologies and practices. I hope to bring to life the rich tapestry of viewpoints surrounding childbirth and maternity care. Through the course of this segment, I present vignettes that allow me to capture the essence of each medical professional gaining valuable insight into their role in the birthing process.

Midwives are vital to the Dutch birthing system and take a holistic approach to childbirth care (Klomp et al., 2016). The midwife I interviewed, offered a glimpse into her unfiltered work and her take on women's autonomy, empowerment during childbirth and general working within the system from her perspective. We together, navigated her practice and beliefs in the care and challenges she herself encounters in the field. Additionally, we addressed possible tensions, differing viewpoints of different medical practitioners and how philosophies of different actors might intersect and diverge with each other. The obstetrician is a prominent figure in Dutch medical care, similar to any other country. During my interview with the doctor, we explored the ideas of natural versus medical and the changing dynamics and perspective of women around birth, how the system reacts to those changing ideas as well as the technological advancement, its effect on birthing outcomes and how he viewed different actors within the medical system. The two medical students I interviewed, had done or were currently on rotations at the gynaecology/obstetrics department. Being at the onset of their career, they offered me a new perspective on childbirth but also the various philosophies and practices that shape evolving beliefs. Their information was similar to that of the doctor I interviewed and will be discussed in detail in this chapter complimenting the information the doctor gave me. Lastly, I interviewed doulas, who are women that assist the birthing women emotionally, physically and spiritually during childbirth (He, 2013). My interviews with doulas offered me insight from the

perspective of someone who doesn't actively take part in the medical processes but is there to observe it all and make sure a woman feels empowered through the entirety of her labour.

Throughout this chapter, a common thread emerges - the presence of tension and differing beliefs within the system and between actors. The interactions between the actors involved expressed issues of institutional practices, power dynamics and hierarchy, as well as diverse and differing philosophies and ideologies that lead to conflict in beliefs. I aim to critically analyse and recognise these tensions between medical providers, insurance companies and the general workings of the system to create a foundation for *Chapter 2* where I dive into the implications of the birthing experience and agency of women.

2.1 A Short History of The Dutch Maternity Care

In this section, I will briefly dive into the past and present of Dutch maternity care in order to set the way for the beliefs and collaborations of midwives, doctors and doulas. During the 18th and 19th centuries, childbirth transitioned from a women-only realm to become a focus of study for medical practitioners (Darra, 2009). The specifics of each women's birth weren't taken into consideration and were moved from home to hospital all around the developed world (Darra, 2009). However, in the Netherlands, the 19th century was a crucial period as the midwives' presence in assisting during birth and gaining their autonomy in the field (Van Lieburg & Marland, 1989). In the early parts of the 19th century, midwives were already taken into account with regard to their medical training and practice, so later in the century when the role of obstetricians and general practitioners roles were delineated, it gave midwives an opportunity to start their own independent practice (Van Lieburg & Marland, 1989). In 1910, more than 60% of birth were attended by midwives and even though through the years there was a slight change in the statistics, by the 1980s midwives were well-established professionals in the Netherlands that held a position of similar status to that of an obstetrician (Van Lieburg & Marland, 1989).

However, in the 21st century, there are rising concerns about the quality of healthcare in The Netherlands due to the increasing perinatal mortality rates (Offerhaus, 2015). Moreover, the birthing patterns seem to be changing due to negative media attention on homebirths and increased fear of the safety of birth and pain levels during birth (Offerhaus, 2015). Lastly, with the increasing referral rates from primary care to secondary care, the current Dutch maternity even for healthy pregnant women, there is a growing concern about the autonomy of the midwives and their position within the system (Offerhaus, 2015; Klomp et al., 2016). Even though there are discussions on certain downsides of maternity care, it still remains to be an integral part of the Dutch maternity care and continues to add value to the system and is appreciated as a whole. In the following part of this chapter, I will dive into the debate on the current natural versus medical childbirth in academia and then into the beliefs and practices of medical practitioners and how they end up shaping the agency of birthing women.

2.2 Dichotomy of Natural versus Medical Childbirth

There are two dimensions of birth - one where it is seen as a natural process and the other as a medical event (Vogel-Broeke et al., 2023). The debate on the dichotomy of natural versus medical childbirth is persistent, complex and multifaceted within the realm of maternity care and the contentious discourse generally stems from differing philosophical beliefs on childbirth. The advocates for natural birth believe pregnancy and childbirth to be a physiological process that doesn't require much medical intervention but requires women to trust in their bodies and surroundings (Vogel-Broeke et al., 2023). Meanwhile, supporters of medical childbirth may argue that birth is a high-risk situation for both the mother and baby and medical interventions might be required to ensure the safety of both (Vogel-Broeke et al., 2023). The conflicting assumptions about "natural" versus "medical" both shape women's internal and subjective experience of birth (Brubaker & Dillaway, 2009).

Brubaker & Dillaway (2009), explain that the dichotomy of natural versus medical hasn't been problematized enough through the years considering the debate between the two has caused most of the criticism for the medicalization of childbirth and hasn't proven meaningful to women. In the 18th and 19th centuries, there was a continuous "devaluation of nature" in biomedicine where in the discourse women were linked with nature and men were linked with culture as seen in the Netherlands as well (Brubaker & Dillaway, 2009, p. 33; Darra, 200). Historically, worldwide women's and midwives' practices were represented as illogical and groundless as their bodily knowledge was more based on tradition which indicated that the guidance of men was required since they were informed on the scientific knowledge (Brubaker & Dillaway, 2009). Hence, a lot of "biological," "physiological" and "natural" characteristics of women's bodies such as menstruation, pregnancy, childbirth or menopause were marked by men's scientific control to be "pathological," "abnormal" and "unnatural" (Brubaker & Dillaway, 2009, p. 33). The "natural" female processes were then seen as illnesses or an anomaly that started to develop into the momentum of medicalization (Brubaker & Dillaway, 2009).

However, there is a present "cultural valuation" that goes on with 'natural' with respect to any part of health and sickness (Brubaker & Dillaway, 2009, p. 34). For example, some women may use painkillers for menstrual pains but may want to avoid any form of medical intervention during birth, while some people give birth naturally but may avoid breastfeeding due to it being an uncomfortable or embarrassing practice (Brubaker & Dillaway, 2009). Hence, a lot of theories on female reproductive topics aren't fully understood yet due to differing cultural valuations on what is considered natural and what isn't (Brubaker & Dillaway, 2009). Historically, it can be noted that women's bodies and their functions were studied by men to be abnormal or unnatural hence they came under the medical gaze which has managed to carry on today. Traditional feminists believe 'natural' birth is the only way a woman can assert control over her bodily process and medical technology destroys the chance of any sort of control (Brubaker & Dillaway, 2009). Medicine and technology are used to trust birth over the abilities of women's bodies, so much so that some women themselves

today trust these technologies more. Birthing naturally includes women trusting their conscious ability to birth and midwives help with encouraging women to cope with their natural ability (Brubaker & Dillaway, 2009).

However, Brubaker & Dillaway (2009), further explain how the medical model of birth seems to dominate the discourse around women's reproductive health since many women perceive childbirth as a process that necessitates medical interventions. For some a medicalized birth is more comprehensible, accepted and linked with 'control' over a situation in case something were to go wrong, while, a natural birth lacks clear understanding amongst the majority of women (Brubaker & Dillaway, 2009). Further, due to the hierarchical nature of obstetricians and the power they hold, may make it harder for women to accept midwives' knowledge of natural birth (Dahan & Cohen Shabot, 2022). Overall, the increased medical gaze has led to being triggered by criticism of the natural approach to birth due to the oversimplification of birthing experiences that may deny women their choice and agency during birth (Brubaker & Dillaway, 2009). For example, natural childbirth includes the limitation of pain medication so if a mother is experiencing terrible pain she may feel the need to avoid any sort of pain medication limiting her sense of control in the need to appear passive, when in this case the use of pain medication may provide more relief (Brubaker & Dillaway, 2009). Further, natural birth is sometimes also synonymous with being a good mother and if they use pain medication they have maybe known to feel as if they were failures, cheaters or even unfeminine and therefore putting women to conform to these ideas of inherently natural can be damaging (Brubaker & Dillaway, 2009). It can clearly be noted that both natural and medical birth is associated with their own sense of control and agency experiences and can shape a woman's subjective experience during birth.

In the Netherlands, the birthing system emphasizes the "normality" of childbirth with the use of low medical interventions and high home-birth rates (Vogel-Broeke et al., 2023). Healthy women can choose to give birth either at home or a birthing clinic, while, women with any complications are referred to obstetrician care in a hospital only when needed (Vogel-Broeke et al., 2023). Moreover, insurance companies are also designed in a way where they support a more "natural" childbirth. The system is designed such that women are encouraged to lead a more "natural" route as it seems to be the norm in the country. However, with increased rates of low-risk women wanting to medicalize their birth - questioning the safety of home birth and authority of midwife-led care during birth, makes the Netherlands an interesting place to study the natural versus medical debate, as well as, study the "women-centeredness" of the birthing system.

2.3 Midwife - Her Role, Beliefs and Perspective

As noted earlier, in Dutch maternity, midwives play a pivotal role as the gatekeepers, offering complete care to all low-risk pregnancy women and guiding them through the birthing process. Their central position in the system is what gives Dutch maternity care a reputation as "women-centred"

care since they view pregnancy as a physiological change rather than a medical matter (Amelink-Verburg, 2010). This segment of my thesis delves into the perspective of a midwife, shedding light on their opinions and current issues. By incorporating the opinions of women's quotes alongside the midwife, I hope to showcase an argument on both the differing and similar viewpoints within the context of maternity care. Through this exploration, we gain valuable insight into the nuances of maternity care and the broader pregnancy and birthing experience.

It was extremely challenging to get interviews with a midwife, so when Margot agreed to be a part of my interview I jumped at the opportunity. We met at a charming cafe in Amsterdam filled with details of wood from the ceiling to the floor. I was there earlier than Margot, already sipping on my ginger and orange tea while I flipped through my book and looked through my interview guide. Margot walks in and I recognise her immediately, waving at her, she sees me and walks towards me. I go for a handshake and she goes for a hug, of course, we hug them. I step to the counter and order another ginger and orange tea for the table. We settle into a cosy corner of the cafe. "Thank you for coming in on your day off Margot, I appreciate this so much," I say. "This is important, so don't worry about it" Margot replies with a friendly smile on her face. Margot has been working as a midwife for over 7 years and through her time in the care, she witnessed an abundance of birthing experiences. She stood proud of the work she does and the care she provided but she remained attuned to the array of opinions prevalent in the field. In our candid conversation, she mentions how certain tensions manifest from her perspective all while acknowledging the varied, complex and contentious nature of maternity care.

2.3.1 Natural or Medical?

While inquiring about her stance on natural versus medical childbirth debate, Margot acknowledges her bias but still had a very neutral stance. She generally tends to advocate for natural childbirth because she thinks it's the safer option for both mother and baby, even though most mothers do have contrary beliefs on the safety of birthing without doctors. Margot explains "I really do encourage more people to give birth naturally, more at home or in the birthing centre of course if they have a normal pregnancy. The thing with this is that when women leave to go to the hospital to give birth, we really can't control anything as a midwife because we can't be there." Nonetheless, Margot is very conscious about the way she approaches clients because she doesn't want to come across as "anti-hospital" in any way since that would take away the autonomy in the way people make decisions about their body. However, she does notice that women tend to have more scarring experiences when they go to the hospital due to the lack of attention given due to the busy nature of hospitals, as well as cases of obstetric violence. She also notes obstetric violence can also happen when a midwife is assisting in the birth but the chances are much lesser.

Cohen-Shabot (2021) elucidates that women around the world are suffering from postpartum post-traumatic stress disorder from physical and psychological violence that can be initiated by

medical staff. Similarly, Margot explains that while many women come with concerns of unbearable pain during birth which is the reason they request medical interventions, these interventions could be more dangerous for the mother after birth because she holds all this trauma from birth. She explains "I never want to come across as anti-hospital because I'm not. Many women come in with deep fear of pain and sometimes their fear of pain and anxiety is so bad that the only option for them is a hospitalization and for them, I have to remain supportive and provide them with the best prenatal care I can." Nonetheless, the obstetric violence that women can face in the hospital is what makes her navigate to helping women make more informed choices as their overall health care will be between with a midwife at home or under the care of a clinical midwife since they tend to provide more holistic care.

Hence, if women say they want an epidural during birth, Margot does provide them with a warning that homebirth is safer but in many instances, women don't take this as a warning but get defensive and are unwilling to listen because they think the midwives are "anti-hospital." To shine a light upon this Katie, whose case study will be talked about in detail in the next chapter highlights her concern with midwives giving advice against a birth with medical interventions. Katie explains "She pushed everybody towards a homebirth without even giving or explaining other options to us" and later gets a list of everything that could go wrong with an epidural. Similar to what Margot explains, many women may feel attacked when advice against their own decision and think that the midwife simply doesn't care about their pain and pushes for a more natural job. "It is part of our job to inform our patients of certain risks that come with a procedure, I mean that's the case with all medical procedures, right? Not just birth…" Margot highlights.

While Margot explained that her stance on a natural birth was more based on safety and prevention of further issues, she did highlight "I don't know if you have heard but there is a chance they will get rid of the midwives as primary care and merge both secondary and primary care together since there are increased referrals to doctors but many midwives are worried they will lose their independent practises. This is concerning and I have heard they can tend to push for a more natural birth which I don't think is right." Margot does highlight that due to possible loss of autonomy, to protect their practice many midwives tend to push a homebirth or "natural" birth which can be damaging to both their reputation and the mother's attitude towards birth. Another pregnant mother, Roos mentions that her midwife encourages a hospital birth than a homebirth or birthing centre. The midwife was even fully supportive of her receiving an epidural. Here it can be noted that differing opinions and beliefs that are shaped by individual life and professional experiences demonstrate the potential impact on various perspectives.

2.3.2 Not Enough Time in the Overworked Care

A few mothers that I spoke with expressed their concern about there being not enough time with the midwives during their appointment while others claimed it was enough time for them. Xesca

points out “Yeah, there are only 15 minutes during each appointment where they also do other checks, I personally don’t think there was enough time to ask all my questions and get all the information.” Erika, a Canadian pregnant mother contradictorily explains “I think they (the midwives) are really there for me emotionally and physically during the appointments. I feel like I can talk to them about anything, may it be my recent gestational diabetes diagnosis, or that my hormones have been feeling out of control lately or my inability to deal with smaller stressors anymore.” While most mother’s in my study did claim they could use longer appointments with their midwife, only two felt heard and like they had enough time with their care.

Midwife Margot agrees with the first rather than the latter and says “I actually agree that 15 minutes for appointments with bigger checkups aren’t enough. Even though we as midwives really struggle to give all the information in that much time, it’s just not enough. Women can opt for longer appointments of course but then they need to pay by themselves since insurance won’t cover it. The sad reality is that the care is set up by insurance companies to make everything as cost-efficient as possible.” While insurance companies have a definite say on the length of appointments, it can also be noted that worldwide there has been a rising concern about the lack of time patients might have with primary healthcare professionals leaving many dissatisfied with the care they received (Wilson & Childs, 2006).

Similarly, Morgot noted that the lack of time during appointments was also what noted to maybe cause an issue with women making more “rushed” decisions about medicalizing their birth. “Most midwifery clinics do host a Q&A night or workshop for parents, where they discuss the options of birth and pros and cons of all procedures, however, that alone isn’t enough to convince people otherwise to not take the help of medication. I do think if we had more time at appointments I could help women build that trust in their body’s natural capability and to keep birth as natural as possible.” It can clearly be noted by Margot that she notices her bias and agrees to lean toward a more natural birth but only in order to protect the mother and her safety. She personally also thinks that the lack of time at appointments due to insurance policies contributes to increased fear. Margot believes she has the knowledge to make women aware of their body’s ability, however, the lack of time at appointments does contribute to more superficial contact without diving in deep.

2.4 Obstetricians & Medical Students - Their Beliefs and Perspectives

Obstetricians in the Netherlands play an important part in maternity care by managing medical interventions and providing their care to high-risk pregnant women. As it will be noted in the vignette, the perspective of doctors and medical students is based on pregnancy and birth being a physiological process that doesn’t need to be medicalised until waived to do so. Their training and practice are shaped by the equilibrium of protecting both mother and baby and only vouching for medical interventions when absolutely required. They value the midwifery care and encourage women to make informed decisions with regard to their bodies and stay in primary care as much as they can.

I made my way out of the metro rushing to the exits of the Amsterdam Sloterdijk Station, clenching onto my phone and staring at my screen that had almost entirely disappeared under the blazing sun. It was the wrong day to wear an all-black outfit, but I wanted to dress professionally for my meeting with Dr John Dawson. Even though Dr Dawson was the uncle of my partner, this was our first time meeting each other and he was a successful and busy gynaecologist/obstetrician and I was the researcher. I found my way to ACIBADEM International Medical Center and made my way into the private hospital through their long glass door into a bright reception. The hospital reception was surprisingly charming compared to other hospitals I have been to. The white walls had colourful paintings hanging all over the hall and a screen with proud pictures, names and departments of the doctors that worked at the hospital. “What name was the appointment under?” the polite receptionist asked me, “Sanchika Arora” I replied back. She stared with confusion at her screen. “I don’t see your name, madam,” said the receptionist, “Ah, I’m not a patient, I’m here to meet him for an interview” I replied embarrassed. She quickly rang Dr Dawson and he confirmed to let me in. As I got to the second floor, the smell of bitter antiseptic and sanitiser rushed over. I never liked hospitals like anybody else for that matter, they made me uncomfortable with their bright lights and quiet whispering voices. I waited uncomfortably in the room, watching the women head to their appointments as Dr John and the other gynaecologist stepped out of their offices in their white short-sleeved doctor’s coats. Finally, it was my turn and Dr Dawson, invited me in politely and there my nerves kicked in.

2.4.1 Everybody Wants Everything to Be Perfect

I made my way into the office with bright lights, and curtains drawn across the room and I sat across from him with my little red book and started our interview. “You know everybody wants everything to be perfect these days. If people don’t like their noses, they can get cosmetic surgery. People don’t feel good, they request bloodwork, it’s the same thing for birth” Dr John expressed. With increased access to information and the media, there is a growing need to have a “perfect” birth. “Back in the 80s, the technology available was much lesser and there were way fewer options for monitoring. We practised old school obstetrics where we only made a birth medical when it was needed, today everybody knows what options are available and choose to make decisions for themselves no matter what the midwife or doctors say” Dr Dawson signed.

With Dr Dawson practising for over 35 years in the field, he experienced the changing patterns in birth. “I really experienced, how with growing access to information, the fear around birth increased and more and more women started relying on hospital births. With all this knowledge and available options, it is hard for people to accept an unexpected or uncomfortable outcome which is why they try to take control into their own hands but this isn’t a good thing in the obstetrics department” expanded doctor. “You know, one unnecessary intervention leads to another unnecessary intervention and people just don’t understand that, they think an epidural or cesarian be the fix all

their worries and give them a perfect birth but that might just be the start of their problems" said Dr Dawson. Akash, the medical student in another interview explains "An epidural is actually a very very risky procedure and takes years of practice because if done wrong, it can paralyse someone forever. Only certified doctors are even allowed to administer it."

I very quickly understood that Dr Dawson, like other medical practitioners in the Netherlands, wasn't for medicalising birth until absolutely necessary and access to excess information and media is one of the causes for women to medicalise their birth in order to feel safe and protected. Hundley et al., (2014) explain that the media portrays pregnancy and childbirth to be a drama-filled event with a disaster waiting to take place, caesarean sections and bright lights flashing across the room, insinuating childbirth is a dangerous event. The study also indicated that women whose beliefs were shaped by media had a greater level of fear (Hundley et al., 2014). Further, multiple studies show that the need to request an epidural is closely related to higher levels of fear and anxiety with regard to childbirth which can lead to longer recovery time for the mother (Smorti et al., 2020). Hence, the pattern that Dr Dawson noticed on changing birth patterns can adhere to the argument of fear of birth.

2.4.2 Pregnancy is Not an Illness

"You know what makes obstetrics different from other fields is that pregnancy is not an illness" Dr Dawson highlighted during our interview. He explained that doctors are trained such to not interfere with the natural process, however with the increasing number of women requesting procedures, the role of medical practitioners is bound to change in the country. Further, Sophie, a medical student in another interview confirms that "People requesting procedures is not only an issue in the birthing care but in the whole medical care and the system here is designed such to keep the natural and normal processes of things going without getting too involved." As mentioned earlier in the debate of natural versus medical childbirth, Darra (2009) draws an argument that "natural" birth is often equated to normal childbirth as seen in this part of my study as well. Hern (1975) on the other hand explains that even though pregnancy, labour and childbirth are all seen as "normal" processes there are pathological characteristics of a pregnancy that can arise due to medical conditions and complications that can affect the women's and baby's health (p. 365). Many mothers I interviewed, wanted medical interventions because they were afraid of the pathological characteristics of their pregnancy. In spite of knowing the risk involved, medical practitioners often waive off pregnancy, labour and childbirth as a normal state of health and a natural and normal process that most women go through without much understanding of why mothers request these procedures (Hern, 1975). Xesca a Spanish pregnant mother mentions "I am all for natural medicine when I have the flu or headache but this is birth we are talking about. I mean I just feel more comfortable with having doctors around me. I have heard horror stories of my friends here when they tried to give birth naturally but something went wrong and they had to go to the doctor. I mean it's just crazy to go through that stress during labour."

In Xesca and many other women's cases, they don't look at pregnancy as an illness but they do view it as a risky procedure and feel more comfortable with having doctors around in case anything were to go wrong. Akash the medical student explained that they as doctors take an oath "to do no harm" but they also take an oath that patients have the right to make their own choice. Due to the conflicting nature of their oath, they do the procedures for the patient but it might not be to their liking. This made me question, if the attitude of doctors performing procedures that they don't want to, has an effect on the experiences of women that do want these procedures. Sophie very well answered this question for me explaining 'I'd like to think that a doctor's personal thoughts don't get in the way of the way they treat their patient but I would be lying if it said so. During my rotations, there were plenty of times when I heard doctors come into the break room, gossip about their patients and then weren't particularly friendly with them at meetings.' She recalls a time when a Polish woman came into the hospital on the verge of giving birth and demanded to get a C-section while doctors tried to convince her otherwise, she was so stern, that they performed a C-section but they really weren't happy about it. However, the aforementioned question will be discussed in detail in the next chapter while drawing closely to what mothers noted in their experience of the Dutch birthing system.

2.4.3 Pain During Childbirth

Akash stated during his interview "Pain is subjective." Similarly, Lundgren & Dahlberg (1998) explain that pain of any kind is a subjective experience and no one person can experience or understand another's pain but can only gain an understanding of another person's pain through their behaviour and physiological response. Most of the women I interview who were pregnant or had already given birth through secondary care were either fearful of pain because of stories they heard or because of the level of pain. Laura, an American pregnant mother explains "I want an epidural. I have decided. I was at my sister's birth of her baby boy in the US, it looked so so so painful and the screams scared me enough. Everybody I spoke with, all my friends said to get an epidural because you don't want to have to go through the pain." Even though Laura was happy with her prenatal care under her midwife, she explains that it would never be enough to convince her to give birth naturally without an epidural and so her birth plan includes an epidural, even though her midwife tried to warn her off otherwise. Sophie expanded on when I asked her about the cultural difference between people "It is difficult for people from America to understand the protocols here because their system is hyper medicalised."

Dr Dawson, on the other hand, commented "I understand that childbirth is a painful process, that is a reason many women want the help of medical professionals to assist with pain medication or c-section but there are painkillers like nitrous oxide and remifentanil that are considered natural too and can easily be administered by a clinical midwife during birth, but to request an epidural or c-section just because they are afraid of the pain, isn't something doctors like to do." Akash also commented "Birth is an anxious procedure, I see that but instead, women should get into a

conversation with their midwife or doctor because it's a terrible reason that my friend had an epidural because of the pain, so I should get one too. This is really difficult for doctors and midwives to grasp." Dr Dawson similarly explains "Sometimes women faint from how much pain they are experiencing and that's bad because they are pushing, then an epidural could possibly be an option." It can clearly be noted that pain is subjective and while mothers have their own reason to request procedures due to their pain levels, doctors only want to administer procedures for pain when it is medically required. The mother's fears and worries aren't deeply understood, however, the doctors do medically encourage women to give birth naturally due to the downsides and risks of an epidural.

2.5 *Kraamzorg* - Her Beliefs and Perspective

I had the pleasure of meeting Kyla during my time volunteering at the yoga studio, where she taught a postnatal yoga class on a rainy Sunday morning. As we introduced ourselves to each other, making polite conversation, she showed genuine interest in my research and what I was studying. When I mentioned my topic of study, her face lit up and she revealed that she herself was a *kraamzorg*. It was perfect, almost fate since I wanted insight from all four healthcare professionals that were mentioned in my study. Excitedly, I asked her if she was willing to participate in my study, and to my delight, she agreed. We decided to meet mid-week at a nearby cafe right by the yoga studio. It was noon, so the cafe was quiet, with only the occasional takeaway coffee orders and people typing away on their laptops. Kyla enters the cafe in her comfortable yoga attire and her beautiful blonde hair let loose.

Kyla hasn't been a *kraamzorg* for too long but she was already in the business; she was a post-partum doula before. However, after her own birth, her experience with her *kraamzorg* drove her into pursuing a career. Kyla appreciated all the care she received from her *kraamzorg*, but she wished it had been more holistic rather than more medical. Hence, she thought it would be interesting to merge her Ayurvedic background with being a holistic *kraamzorg* and providing mothers with tailored care around the ideologies of Ayurveda. As noted in the theoretical framework, the role of the *kraamzorg* is to provide postpartum care to mothers and babies after birth, while looking after the physical health of the mother and baby and helping around the house with household chores (Wieger, 2006). Through Kyla and my conversation, I identified two main themes - how the *kraamzorg* care in some cities in the Netherlands is in a dire situation because of the lack of *kraamzorg* care available and how this isn't particularly a good thing because the role of the *kraamzorg*, in the Dutch care is of hold a lot of importance to post-partum women due to their supportive and motivating nature.

2.5.1 Overworked *Kraamzorg* Care

The job of a *kraamzorg* is extremely crucial in the first few days of giving birth. The first and foremost is medical control with regard to the health of the mothers and babies (Wieger, 2006). Her responsibilities include meticulously checking the baby's weight, temperature and monitoring the

colour of stool and urine as well as the mother's scarring or bruising. Furthermore, one of her most vital roles medically is to provide support and guidance to new mothers during breastfeeding. In case of any alarming indication in the medical control, the *kraamzorg's* role is to let the midwife know immediately. However, Kyla noted that there is a huge shortage of *kraamzorg* in Amsterdam and cities around like Utrecht, Hilversum and Haarlem. The result of the shortage is unfortunately fewer hours that each *kraamzorg* gets to spend with the mother. As noted in the theoretical framework bit of this thesis, the *kraamzorg* spends around 8-10 days with a mother to ensure both mother and baby are doing well. While, Kyla explained that earlier, most mothers would get 8 days with 6 hours of help each other, because of the rising shortage most only get 3 hours of care a day which is only enough for medical control without any help in cooking or cleaning.

Through my ethnography, it was noted that the most unique part of the Dutch maternity care wasn't just the interplay of midwives and doctors but the unique postpartum care, that is individual to the Netherlands. Further, research has proven to show the correlation between the number of hours in postpartum care and the trust and faith of the woman in their capability to take of themselves and their baby (Wieger, 2006). The lack of hours in the care could result in negative experiences with birthing women since most women found the care of the kraamzorg to be key. To expand, while most women weren't fully satisfied with the care they received during their birth, almost everybody noted that the care from the *kraamzorg* made up for the lost agency and made their birthing journey end on a good note. In the next section, it will clearly be indicated why the *kraamzorg* care is vital to a mother's good experience.

2.5.2 The Supporter and Motivator

While it is extremely important to ensure both mother and baby are doing well, Kyla notes that to her, one of the most important jobs of the *kraamzorg* was to make the mother feel "self-sufficient." She expands "Sometimes during a traumatic birth, there isn't an instant connection between the mother and baby, which can cause the mother to feel stressed and feel like she's not enough. My job is to make them feel self-sufficient." Kyla expands that a lot of women have traumatic birth despite it being a natural or unmedicated birth. She observes it in both cases where some women end up having an extremely powerful hospital birth and traumatic home birth. She elucidates that neither natural nor medical birth is more responsible than the other in forming a traumatic experience, but depends on how the woman was treated and how her wishes were respected. Nonetheless, Kyla notes that a lot of mothers end up feeling as if their power has been taken away from them after a traumatic birth. She adds "My job is to support them and motivate them by making them feel like they can do it, they can be a good mother. I help them tap into their power again." Hence, the objective of postpartum care is to identify any potential complications and inform the midwife while also guiding the mother through the first few difficult days and ensuring she is confident enough in caring for their newborn (Wieger, 2006).

Similarly, all the mothers who had a traumatic birth experience highlighted that the *kraamzorg* played a significant role in making up for the negative aspects of their labour and birth care. Furthermore, due to limited space, the hospital prefers to discharge women that didn't need a medical birth but got one anyway, this ends up scarring women's expectations more and they end up feeling even more mistreated. For example, Olivia noted, "I mean it was just ridiculous, I was barely out of giving birth and they were already packing everything up and making me go home because they needed the room for the next patient." Olivia chose to have a medicated birth despite being low-risk so once she had given birth, they made her leave the room. Kyla explained that it is unfair for women and does add to the shock factor, especially if they had a traumatic birth, however, hospitals or birthing centres discharge women earlier because they know the *kraamzorg* will be present to provide them with the right postnatal care. Overall, women had no complaints about the *kraamzorg* care, nonetheless, the lack of time due to the shortage of the *kraamzorg* can perhaps cause a flux in negative experiences due to the lack of support and motivations that the system aims to provide. The aforementioned could especially be damaging for women who had traumatic or negative experiences and would require that extra support in the following days of their birth.

2.6 Doulas - Their Beliefs and Perspective

During my time in the field, I had the wonderful opportunity to engage with three eager and dedicated doulas, each contributing their own unique outlook to my study. The inclusion of interviews with doulas added a valuable dimension to my data. This was because the doulas are actively involved in observing the midwives or doctors in the birthing room and their presence in the care as an "outsider" brings an interesting perspective to the healthcare system. Their fresh insight into the observation and reflection on the system provided a valuable and distinct take on the dynamics at play. Further, there is an increasing demand for hiring doulas to provide support during childbirth in the Netherlands (Dahlen et al., 2011). The limited literature suggests that women are increasingly hiring the services of a doula to have a holistic and comprehensive birthing experience and to act as a safeguard against the tendency to overly medicalize their childbirth (He, 2011). While this may stand true that many women want to avoid a medicated birth due to the risks that come with it, the doula's role is to provide support environment during birth, help the mothers make informed choices on their birth, validate their fears associated with childbirth and advocate for any decisions that the mother chooses to make during the birth (Steel et al., 2015).

"I'm there for the woman no matter what way she decides to have her baby," said Doula Dorene in an online interview with her. Dorene stresses the fact that a doula's job is to support and empower women no matter what type of birth they choose to have. Their job is primarily focused on supporting the mother ensuring her voice is acknowledged and valued. As noted in the previous section, Kyla emphasizes how women undergo traumatic childbirth experiences usually as a result of comments or actions within the birthing environment, given the sensitive and vulnerable state they are

in during labour. The doulas collectively expressed that their role is to proactively prevent any issues from arising in the first place and their role is to serve as advocates for women and their choices within the birthing space.

2.6.1 Differing Perspectives - Tension and Time

Doula Iris identifies significant tensions within the system regarding natural versus medical debate, aligning with the opinions stated by the medical practitioners in the previous section. She explains that opinions are often polarized concerning women's choices in birthing approaches. As discussed in the dichotomy of natural versus medical birth, many doctors and midwives in the Netherlands believe that natural birth fosters a sense of control, while others argue women can feel more in control as medical resources can provide a safety net in case of complications (Brubaker & Dillaway, 2009). Similarly, Doula Dorene mentions, "I have heard hundreds and hundreds of birthing stories and it is possible to have a powerful medicated birth if everybody in the room is supportive of the mother and what she might need." Hence, even though the opinions of doctors and midwives come from a place of concern due to the risks associated with medical childbirth, Doula Iris emphasises that medical professionals need to "Respect women's choices" and provide them with the best support they can regardless of how they choose to birth.

The one thing that all doulas agreed to have in common was that medical practitioners simply just don't have enough time for the women, just as the midwife noted as well. Doula Dorene claims that even though midwives are better known to provide more holistic care, they just don't have enough time to support women emotionally. The care of the midwife still ends up being more medical. "Women sometimes have sexual trauma or other kinds of trauma and birthing for them especially is a very very delicate process. They end up being more anxious but the care that both midwives and doctors provide is still more medical. They aren't trained to support others emotionally, it is still more medical" noted Doula Dorene. Doula Michelle similarly noted an existing "gap" in the system that could be a result of overworked care, lack of emotional support or differing opinions within the system that could result in scarring a woman. Doula Michelle said that her job was to act like the "glue" in a system between the medical healthcare provider and the birthing mother to ensure the best and most positive results for everybody in the room. Further, Doula Michelle also notes that she provides tailored care for women that want to birth naturally and gives them suggestions on how they should breathe, move and create a supportive environment which all requires time that many midwives can't provide in limited time.

2.6.2 It's Hard for Women to Stand Up for Themselves

The preceding sections highlight that both the midwife and *kraamzorg* have observed instances of non-consensual acts or obstetric violence within the birthing room, leading to traumatic birthing experiences for women. The phenomenon is illustrated in a case study in the next chapter, where Rosa's decision to hire a doula stemmed from her desire to prevent any kind of harm caused by medical professionals during childbirth that could contribute to post-partum depression. Doula Iris emphasizes that there are instances when healthcare professionals fail to treat individuals appropriately. She recalls an incident where a nurse displayed rudeness towards a labouring mother. Doula Iris left the mother and went to speak to the nurse and said "You cannot speak to her like that! You understand that this woman will always remember the way you spoke to her at this moment and it will have an effect on her for a long long time." The nurse then went back to apologize and take accountability for his actions. Doula Iris advocated for the woman and protected her client's agency by standing up for her and also noted "It's hard for women to stand up for themselves. If I hadn't been there in the room, my client wouldn't have said anything and she wouldn't have been able to stand up for herself and he would go repeating his mistake with so many more women to come." Studies find that doulas are extremely informative and supportive when it comes to their client's rights and advocacy in hospital settings just like Iris demonstrated in the case of her client (Arteaga et al., 2023).

2.7 Healthcare Professionals' View on Women's Agency

In this section, I aim to gain a clear understanding of how the healthcare professionals I interviewed try to understand and conceptualize a woman's agency with regard to birth. As evident from this chapter, each healthcare professionals and mothers hold a diverse point of view regarding the contrast between natural and medical approaches showing the contentious nature of the maternity care. However, there is a prevailing tendency from all medical professionals I interviewed to lean towards a more natural birthing process, which remains integral to the principle of Dutch maternity care. In the array of interviews conducted, it was evident that both midwives and doctors tend to encourage a natural birth to women while both the doula and *kraamzorg* maintained a neutral stance, offering unwavering support for the woman's choices regardless of the direction they opted for. However, tensions arise within the system when low-risk women express their preference for a medical birth, due to the fear of pain or what has been portrayed in media.

2.7.1 Midwife's View

The midwives try to provide a "women-centred" approach to women by empowering their ability to birth naturally and helping women to make informed choices for their birth (Bringedal & Aune, 2019). The midwife Margot considers a woman's agency to be most empowered when women possess a comprehensive understanding of their bodies and their inherent capability to birth. Hence, midwives attempt to communicate the associated risks due to it being a mere part of their duty, but the information sometimes doesn't rest well with women. Margot also worries about obstetric violence

present at hospitals and hence suggests women pick a more natural unmedicated birth. However, women often feel trapped in the dynamics of the system and find themselves compelled to assert their preferences and advocate for their choices. Nonetheless, Margot suggested that helping women make informed choices and feel more confident in their ability to give birth is possible with longer appointments. However, with the lack of time at the appointments and differing ideologies and beliefs, it is harder for midwives to provide detailed care. Nonetheless, Margot maintains a neutral stance, prioritizing the women's needs in order to safeguard their agency and ensures they receive the most comprehensive and informed prenatal care to best make decisions for their own bodies.

2.7.2 Doctors' View

Similar to the midwives, the obstetrician Dr Dawson and the medical students Akash and Sophie express their views on natural birth being the safer option for women. In the Netherlands, doctors are trained to manage only high-risk pregnancies so when low-risk women request medical interventions, the physical risk associated with an epidural or any medical interventions tends to concern medical practitioners (Perrotte et al., 2020). Despite acknowledging the anxieties and fear with regard to pain related to childbirth, Dr Dawson and medical students emphasize that a woman's agency is best upheld through natural birth. They highlight that childbirth is a physiological process, not an illness and therefore doesn't necessarily require medical intervention. However, with an increasing need to have a "perfect birth", more and more women opt for a medical birth. In this light, doctors strive to preserve the agency of low-risk birthing women by advocating for a natural birth by ensuring safety and minimizing any potential physical risk.

2.7.3 *Kraamzorg's* View

The *kraamzorg* I interviewed expressed a pro-choice attitude and valued the women's autonomy in deciding between a natural or medical birth. Although the *kraamzorg* wasn't physically present during the birth, she points out that there was no discernible difference in the negative impact of one type of birth compared to the other with regard to emotional well-being. She emphasized that negative experiences didn't stem from the type of birth itself but rather from how women were treated and communicated with during the process. Poor treatment could lead to loss of empowerment among women, hence, the *kraamzorg* perceives one of their roles to facilitate empowerment once again. The *kraamzorg* hence views their role in helping women regain a sense of agency when it seems to have diminished. Since women lose their sense of agency, mothers often experience self-doubt and the confidence provided by the *kraamzorg* can assist them in rekindling their confidence and alleviating doubt (Wieger, 2006). Nonetheless, the scarcity of *kraamzorg* caregivers could potentially exacerbate the negative experiences, since many attributed their overall positive feelings to the care provided by the *kraamzorg*.

2.7.4 Doulas' View

During the interviews with the doulas, a clear focus emerged on their commitment to ensuring a positive birthing experience for mothers, regardless of their chosen delivery method. The doulas operating within the system also held a deep regard for women's choices, no matter which birth approach they opted for. They acknowledge that while the system and the medical actors within tend to emphasize a natural birth, the advice and risks associated with a medicated birth aren't enough guidance to alleviate the fears associated with natural birth. Further, Dorene highlights the possibility of a powerful hospital birth provided all actors in the room create a supportive environment. Although doctors and midwives express concerns due to risks associated with a medicated birth, doulas suggest it is best to respect a woman's autonomy and her choices. Hence, doulas stand up for their clients when in need and provide tailored care that respects their autonomy. Thus, the role of a doula involves preserving a woman's agency and advocating on their behalf, all while cultivating a nurturing and supportive environment (Arteaga et al., 2023). The doula hence perceives their role as bridging the gap in the system when it comes to time, support and advocacy.

2.8 Summary of Chapter

In this chapter, my objective was to address the subquestion: "How is natural versus medical seen by other actors within the system?" Throughout this chapter, we delved into the perspectives on childbirth from all the healthcare providers in the system, the midwives, doctors, doulas and *kraamzorg*. Exploring a brief historical context revealed how midwives gained autonomy in the realm of childbirth after childbirth was medicalized by obstetricians worldwide. However, in the present day, their position is similar to that of a doctor. The distinct features of low medical interventions, home births and the midwifery care are known to make the Dutch birthing system a "women-centred" care. Nevertheless, there is a noticeable change in birthing patterns since an increasing number of low-risk women opt for a medicalized birth going against the principles of the system. The demedicalization of birth emphasizes the natural versus medical debate in the country. Further, within the complex context, each practitioner has differing beliefs on what a woman should choose to do to her body. The midwives and doctors I interviewed encourage natural birth as the best option as women may experience more control and fewer risks than compared to the medicalized birth. They also thought women's agency was best upheld with natural birth. On the other hand, insight from doulas and the *kraamzorg* suggests that a woman's agency best thrives when her birthing choices are respected regardless of whatever they might be and the way she is treated and esteemed during birth is more important.

Chapter 3

What Do Women Experience?

In this chapter, I explore the unique birthing experiences of three women within the same birthing system, each with their own distinct expectations, attitudes, beliefs and trust in their bodies and system. The first case study is about Katie, a woman that wanted a medical birth but ended up giving birth naturally. The second case study is about Nina, a woman that wanted to give birth naturally but ended up having a medical birth. Last, we look into Rosa's case study, a woman that wanted and gave birth naturally. By closely examining their individual journeys through childbirth, including their insight into the processes, their encompassing perception of natural or medical birth, their perception of fears and pain and their general interactions with the systems we can gain profound insight into how these women's experiences were shaped and how their agency evolved through the process. Each case study presented in this chapter offers a deep dive into the intricate details of these women's interactions with medical providers during their pregnancy and labour, including how their wishes were acknowledged and considered.

Through the analysis of each individual case study, it can be noted how different all the cases were from each other within the same system. Further, we unravel the factors that shape a woman's autonomy and agency during childbirth. Additionally, we dive into how the midwives, doctors and doulas played a role in alleviating or exacerbating their emotions. Lastly, the exploration of the dynamics between healthcare professionals, their collaborative efforts and the role of insurance also influences the woman's overall satisfaction with the care they receive. By using the contrasting nature of these case studies, we can identify common themes that many women in my study highlighted. It sheds light on the multifaceted and complex nature of pregnancy and the birthing process. It underscores and makes it clear how the field is marked by contention and ambiguity due to the various actors involved, further contributing to the ongoing discourse on the 'women-centeredness' of maternity care in the Netherlands. By delving into these individual experiences, this chapter aims to provide a comprehensive and inclusive understanding of the diverse realities of childbirth, further offering insight into the improvement and development of the maternity care.

3.1 "I wanted an epidural, but I ended up giving birth naturally": A Case Study of Katie's Pregnancy and Birthing Experience

This case study explores the childbirth experiences of Katie, a 33-year-old American woman that planned to give birth in a hospital with an epidural but ended up giving birth naturally with her first child and then decided to take matters into her own hands with her second birth.

As I sat in the middle of my friend Katie's warm living room and her 8-week-old sound asleep in his little blue crib, Katie hands me a glass of cold iced water. Much needed on a warm day. Katie and I have known each other for a while already. I used to babysit her older son, Thomas and no later than that, we developed a sister-like relationship. She was always very vocal and passionate about

sharing her childbirth experiences. She and I spent hours talking about them so when I asked her if I could interview her for this ethnography, she jumped in at the opportunity! She truly believes in being transparent and vocal in sharing her journey through the birthing system and wanted her story to be heard as she believes that her voice wasn't of much importance during her birth. Katie's first instance with the Dutch maternity care was when she faced a miscarriage. She went to her general practitioner still mourning her loss and remembers there being no care, tenderness or compassion from her doctor. "They lack bedside manners here" Katie expressed. Simply being prescribed some paracetamol and rest, she was asked to go home as if she was going to the doctor with a complaint of a little headache. Being American and living there almost her whole life, Katie wondered if her encounter with her doctor would've been any better. Warding it off as a cultural difference, Katie didn't give much importance to it.

Katie's Pregnancy Experience with First Child

Soon after Katie found out she was pregnant again! This time it was her first son Thomas. Katie had a wonderful time with the midwifery care, "there were four midwives and all of them were angels" she expressed. She thought they were compassionate, vocal and clear whenever she had questions or concerns. In the beginning, there were fewer monthly checks that lasted 30 minutes long and as the pregnancy progressed the appointments turned weekly and were around 15 minutes long. Katie recalls feeling uncomfortable while she was pregnant due to the lack of testing and screening for gestational diabetes. Whenever she went to the midwifery clinic, only her blood pressure and baby's heartbeat were checked and only a few ultrasounds were administered. Katie even requested an extra ultrasound because she found the gap too long between the last one and her baby's birth. Her anxiety and stress led her to think of the worst ever since she experienced her miscarriage. She wanted to assure the baby wasn't in breach, so she made an out of pocket expenditure, to calm her doubts. Katie recollected "I remember being really anxious with Thomas. I was always afraid something worse would happen and then nobody would be there to support me but my husband."

During her time with care under a midwife, the midwifery care organised a birthing class that was hosted by a retired Dutch midwife. "She pushed everybody towards a homebirth without even giving or explaining other options to us. The funny part was most people there didn't even want a homebirth" Katie commented. On discussing her birth plan with her midwife, she made it very clear that homebirth wasn't even an option for her. "I immediately told her I am looking for an epidural and instead of explaining other options to me, she started going down the avenue of what can go wrong during an epidural and with all the drugs they give you" she expanded. Katie felt uninformed of any other possible options and when she confirmed her birth plan, the midwife warned her that if the birth becomes medical, the midwives will not join her and they will just be her prenatal care.

Katie's Birthing Experience with First Child

Soon the time came in and Katie started labouring. She called her midwife who would come in to help her find a hospital where she can get admitted into. “The one midwife who I had never met from the practice came to my labour. It was the worst experience because she was unempathetic, impatient and so uncompassionate. Her job was to find me a hospital and go home” Katie complained. They finally found a hospital in the East of Amsterdam and rushed to the hospital so she could get an epidural. “So there are very few anesthesiologists in the whole of Amsterdam and they move from one hospital to another. When we got to the hospital in *Oost* my contractions weren’t even far along but since I had a small window to get the anaesthesia from the doctor, I took the epidural. The epidural didn’t work and nobody even came to check if it worked or not” Katie signed as she recalled. She wanted to speak to a midwife or doctor since she was throwing up from the pain for over eight hours but only a male nurse came in once in a while to be sure if she was coping. She asked the nurse if anyone could come in to check her dilation but the only available clinical midwife was assisting a c-section. Finally, night turned to day, hazed from the lack of sleep she remembers someone coming in, asking for how long she had been screaming and crying and moved on to administering some morphine for the pain. With teary eyes, she said “The morphine was a terrible idea. The morphine made me so high and so much more in tune with my pain. I was so drugged and then I threw up because of the pain. It really just didn’t take the edge off like they said it would.” The morning shift of the hospital showed up to Katie and her husband’s relief. “I wanted an epidural but I ended up giving birth naturally. No forceps and no interventions, just the good old fashion of screaming and shouting, till my baby came out” Katie stared down at the floor.

While even though her birthing experience was not what she imagined it to be, “the resources for the postnatal care were amazing” she explained. There was a consultation bureau that took really good care of monitoring the health of the baby. However, she felt they monitor the mother’s physical health but don’t give much importance to postpartum anxiety, rage or depression that mothers might experience due to hormonal loss and lack of sleep. Overall she felt the compassion for mothers right after birth was missing but the care and compassion for babies was commendable.

<u>Katie’s Pregnancy Experience with Second Child</u>

As Katie started to tell me about her pregnancy and birthing experience the second time around, Felix, her newborn started moving around in his crib, letting out a cry. Katie immediately grabbed him and started kissing and singing him to sleep. He refused so she decided to hold him and rock him in her arms instead. I refilled my glass of cold water from the fridge and sit back down to hear the rest of her story. “I had to switch midwifery clinics when I was pregnant the second time round with Felix because I didn’t want to be anywhere near the uncompassionate midwife” Katie explained. At the clinic, Amstermoms, the midwives were very responsive to all of her needs but with regard to options for her birth, she decided to take things into her own hands to avoid repetition of the trauma she experienced from her first birth. Within her meetings, she went through a list of all the

procedures she would be open to and backup plans as well. “During my previous birth, I put all my trust in doctors, which I think was the wrong idea but this time round I want to make a more rigid birth plan and make sure I prepared to the best I could” Katie expressed. This time around, she wanted to give birth in the birthing centre where she knows her care will be provided by a clinical midwife, unlike the hospital that relies on doctors. Through her prenatal appointments, the midwife continued to suggest a home birth as a second option in case there were no available beds at the birthing clinic. Nonetheless, her second option was the hospital. Under no circumstances, did she want to give birth at home. “It’s just not for me, and in case something would go wrong, they would have to airlift me with a helicopter to the hospital because I live on the third floor and that’s not something I want” Katie said sternly.

Katie’s Birthing Experience with Second Child

During her second birth, Katie had more trust in her body and its capacity to handle the pain “If I could do it naturally once, I can do it again” she recalls assuring herself. The only thing that Katie wanted from her second birth was to feel more supported compared to her first birth which left her feeling isolated. This time around, a midwife that Katie knew well came to assist at her birth, as she was giving birth in a birthing clinic as opposed to a hospital. Although, Katie hoped for a shorter labour this one turned out to be long too. “The pain of course was unimaginable, I tried the birthing pool for the pain but that didn’t work so I tried the nitrous oxide and it was just nice to know the hospital was right there if something happened” explained Katie. “They did break my water with a hook because it didn’t break naturally and that really sped up the process thankfully” she sighed in relief. However, with all the voices around her telling her to breathe and move a certain way, she grew frustrated when the pushing wasn’t working. To Katie’s relief, a new shift of clinical midwife came in “She gave me tips on how to push, what position to get in and told me to hold my breath and push. I trusted this midwife immediately and he came out.” Katie expressed her second time round was much better but it was because she was more prepared for the system and knew what she should and shouldn’t expect from them. “The system is definitely more catered to give birth naturally when you have a normal birth, it was crazy that I had to go through all of that to learn. Nobody should have to go through that” Katie said, nodding her head from side to side.

Katie with her son, Thomas and newborn, Felix.
A couple days after Katie gave birth, I went to visit her and took this photo them.

With regard to postpartum care, Katie couldn't be more thankful for the *kraamzorg*. "The *kraamzorg* came for a little over a week and helped me with cooking, breastfeeding, putting the baby to sleep and letting me have a shower or nap in peace without worrying" Katie stressed. She called them "miracle workers of the healthcare system" and the "best part of giving birth in this country." For the rest, Katie found the system to be a bit "dicey" and not really catering to all the needs that a woman would have if she were to want a medical birth.

3.2 "I just don't trust doctors or the medical system as a whole": A Case Study of Nina's Pregnancy and Birthing Experience

This case study explores the childbirth experience of Nina, a 32-year-old Dutch woman that followed her pregnancy in Bali, Australia and the last four months in the Netherlands. Even with some medical indications, Nina advocated for herself and pushed for a natural birth because of her distrust of the medical system.

I stepped outside my house during a sudden downpour, my neat outfit held safe under my raincoat and umbrella held over my head. As I walked in the rain my shoes got drenched, the umbrella corners started dripping water and my raincoat was covered in little raindrops. I was thrilled to walk into Uncommon Amsterdam, a beautiful speciality cafe tucked away neatly in the West of Amsterdam. Nina was my boss when I worked at Uncommon. I knew Nina was always very conscious about the food she ate and served at the cafe. It was always organic and of high quality. She towards living a life attuned to nature from the food she ate, the clothes she wore and the principles she followed. All of these made me curious about what Nina's pregnancy with Bo would've been like. As I got to the cafe, I left my umbrella in the little bucket and raincoat at the entrance and walked to the end of the cafe where Nina was sitting on the high chairs already there before me. I went to hug her hello, "Go grab yourself a drink" she smiled. I went to the counter and politely asked for a cup of lemongrass tea. I quickly sat down with Nina and set up my phone to record the interview and a little notebook in my hand.

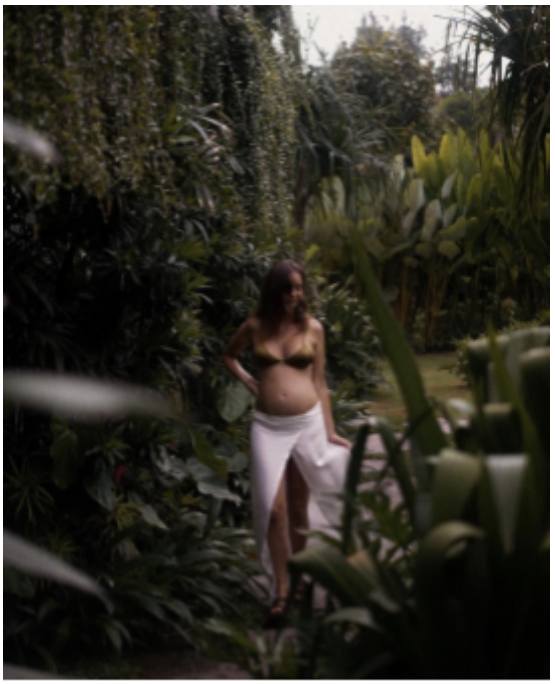
<u>Nina's View on Medical Systems</u>

Nina smiles "What do you want to know?" she says. "Everything, anything, whatever you like, let's start with your pregnancy!" I reply. Nina was in three different countries during the duration of her pregnancy, Bali, Australia and then the Netherlands for the last four months. "When I found out I was pregnant, I actually wasn't doing so well health-wise. I had been dealing with a chronic condition for years and it was giving me a particular amount of trouble at that moment. I remember thinking it was a really bad time to find out such beautiful news" Nina said. Being particularly stressed out at the moment, she knew she had to leave the Netherlands momentarily. "My father is a doctor so I grew up in the medical environment my whole life. After I started suffering from my chronic illness, I was told that I would be stuck in bed my entire life and would never live a normal

life” Nina explained. She thought to herself, that can’t be her whole life. So Nina set out on her journey to find an entire community of people that healed themselves using food and plants. “I moved to a more natural way of life then, no medicine, no hospitals, no doctors. I just don’t trust doctors or the medical system as a whole! Doctors never reach the root cause of anything, they just try to find a temporary fix.” Nina said calmly while fiddling with her ring.

Nina’s Pregnancy Experience

Nina and her husband Claye, left for Australia since her husband was from there and they had a comfortable home to stay in. Nina spent her first two months in Australia and where she continued to struggle with her health and soon after she decided to leave for Bali. Alone, she heads off to an eco stay in Bali even though everybody thought she was crazy for doing so. She was drinking fresh juices, eating more fruits and vegetables, avoiding all processed food, taking in all the blazing sun, and walking everywhere. Every day she started feeling better and better. “I finally felt that I was physically able to carry on the pregnancy and I felt more confident in my body” Nina noted smiling. She later moved back to the Netherlands because she wanted to give birth naturally, and “What other place better than Holland” she thought. Nina really enjoyed her care under the midwives in Utrecht. She had a really good relationship with all of them and she felt really understood by all of them. “I wanted to give birth at home, but that wasn’t an option because I live on the fourth floor and so that isn’t the safest if something goes wrong” Nina explained. She decided to settle for the option in between which was a birthing centre. From the very beginning of her pregnancy, Nina wanted a very holistic approach to her birth. She was worried, it would become medical too quickly if she went to the hospital. However, at 40 weeks, Nina went to the midwife for a check-up and they recorded high blood pressure which meant her pregnancy was now high-risk. Despite that she under no circumstance wanted to give birth in a hospital since her midwife wouldn’t be allowed, “I want to avoid unnecessary stress and impersonal behaviour from the doctors” she expanded. The day arrived and Nina went into labour. “I felt completely fine and I didn’t think anything was wrong. I really didn’t want to go to the hospital so I asked Claye to call the midwife and he insisted she come in and check my vitals” Nina explained. The midwife came in and her vitals were normal so gave her the green light to birth in the birthing centre.



Nina During her Pregnancy in Bali
She showed me her beautiful photo during our interview.

Nina's Birthing Experience

At the birthing centre, Nina was in the water bath and everything was going smoothly. "I was coping really well with the pain in the water bath, but I think the clinical midwife was in a hurry because she had to leave. To speed things up, to induce labour she used a hook to break the water" Nina said nodding her head in disapproval. Suddenly her pain levels went from a building up pain to excruciatingly painful and all the plans she made to bear the pain seemed to go downhill. "I really didn't want to take nitrous oxide but I had to because the pain was unbearable and I could barely breathe with the mask on my face. It went in a completely unnatural direction and of course, the one intervention of the midwife led to more" she explained. Nina was soon transferred to the hospital due to being in distress from losing blood and fainting. "Exactly what I wanted to avoid, happened and eventually they had to use the vacuum to get Bo out. Then they had to stitch me up from all the tearing. I couldn't even walk and then they forced me to go home because they needed to evacuate the room in case there was another emergency" Nina voiced.

When they got home Claye was holding a newborn baby and one hand and had his wife in a wheelchair unable to walk up the stairs to their home. Luckily their neighbours were there to assist. "The whole system snatched the power right away from me during my birth. I really didn't expect this from the system because I felt so powerful during my pregnancy despite my health issues" she explained. Nonetheless, she was very grateful for the *kraamzorg* because it was a week until she could get on her feet. The emotional and physical help that the *kraamzorg* provided to Nina, Claye and Bo was beyond what she could imagine. While everything ended well, Nina did share her concern with the midwifery care. "I still think midwives in Holland are trained more medically than holistically because if they were more holistic, they would themselves never use interventions in the first place or rush anybody, next time I will make sure to get a more holistic midwife to avoid what happened with Bo" Nina concluded.

3.3 "I'm going to do it my way and give birth at home": A Case Study on Rosa's Pregnancy and Birthing Experience

This case study explores the childbirth experience of Rosa, a 31-year-old Dutch woman that chose to give birth, at home the traditional way against all odds that were thrown at her. She chose to trust her instincts and give birth in her bedroom with care under a midwife and doula.

I walk into Rosa's quaint little home in the middle of Utrecht. Nostalgia rushed over me and took me back to the time I used to live in the city and I was happy to be back with a purpose this time. I met Rosa through word of mouth when I was speaking with a pregnant woman at a yoga studio in Amsterdam. In conversation, she told me that her older sister gave birth naturally and it worked wonderfully for her and how she wants to do the same. Soon I got in touch with Rosa through her sister and she was delighted to be a part of my interview. I got to her home, it was a beautiful little white home resting in the little charming streets of Utrecht. I walked in and Rosa greeted me with a

warm hug. She offered me some tea and chocolate, and I accepted politely. I made myself comfortable on her dining table and brought out my little note and phone to record the interview. Rosa, dressed in her black top and blue jeans with her brownish-blonde hair wrapped in a bun, sat down opposite me. "What do you do for work?" I asked politely. "Oh, I'm a photographer, a wedding photographer. That's my main source of income." she smiled. I thanked her for taking the time to meet me and letting an absolute stranger trust me with her story. She was happy to share.

Rosa's Pregnancy Experience

As I sipped on my green tea, Rosa started to tell me her story. "I have a sister in law that followed everything by the system. She didn't really prepare for her birth with yoga classes or anything, she just wanted to give birth in the hospital and ignored her pregnancy a little bit. She said when I have a kid everything will be fine but it was a total disaster for her. I also had other friends who had total disaster experiences" explained Rosa. All the women she had heard stories from weren't prepared for their birth at all, everything was shocking and most of them ended up with postnatal depression. She soon heard from a friend that gave birth with care under a doula and had an amazing experience. "I really wanted to avoid that because I earn the main income in my family or most of the money here and I was worried that even I would end up being depressed or something. So I decided that when I give birth, I really want a doula because then the process is way better and I saw it as an investment for my job to avoid financial problems later" stated Rosa. Her midwifery care was really good and "very down to earth" but she felt like she didn't get enough time with them as it was the usual routine check-up and then they sent her home. Somehow she felt that the care was superficial because even though they meant to be there for her, 15 minutes wasn't long enough. "They are sweet and they ask you questions but I wouldn't call it real real care" Rosa explained. For that reason, she wanted to prepare more for her birth and called a yoga studio where her yoga teacher ended up being her doula.

"I read a book on natural ways of giving birth and it talked about how currently there is a culture of fear and most people want to give birth in a hospital in case something goes wrong and so really a focus on fear" she reiterated. The book really inspired her to look at giving birth in the Netherlands very differently and Rosa took a stand to give birth at home. "My mother-in-law who is a doctor was really not okay with me giving birth at home. She was really worried something would go wrong and had a very serious conversation with me about how I should give birth in a hospital in case something goes wrong. She was really afraid I was going to die. I said hell no, I'm going to listen to my feelings also because of the book and I'm going to do it my way and give birth at home" Rosa said confidently. But Rosa's previous home where she lived had two floors, with her living room on the first floor and bedroom on the second. Since she was stern on giving birth at home and her bedroom was on the second floor, Rosa had to sign a waiver (given to her by her midwives) stating that if something were to go wrong she would be transported downstairs with firemen and fire stairs.

Rosa's Birthing Experience

The time had come as the clock hit midnight, she called her doula first and the doula was ready to come over to help Rosa, but Rosa explained that she would wait a little bit longer and then let her know. When Rosa called her night shift of midwives, they weren't really happy about the timing and they encouraged her to take some Aspirin and go to sleep. Even with her water broken, she waited for eight hours until calling the midwives again. As night turned the day, the midwives continued to postpone their visit to Rosa. Her doula pushed her to say, that she needs midwives to come right away but if it weren't for her doula, she would've been afraid to call the midwives as it wouldn't align with their timeline. The midwife finally came over and checked her dilation and agreed to come over again when she was more dilated. "It feels like the midwives don't really take you seriously because it's your first baby or you aren't dilated enough and they assume it will take much longer which isn't right because one of my other friends gave birth within two hours" she complained. As the day processed, the pain got worse and called her doula over to help. Her doula drew her a bath, gave her a massage and really took care of her but she was unhappy with the fact that the midwives don't really support women through the labour, they just check the dilation and leave. However, as time passed, the midwife came through to assist in the birth. The doula provided Rosa with more emotional and physical support during the birth and that gave the midwife the opportunity to focus on the medical. So in her bath, with no pain medication, Rosa gave birth to her healthy baby boy.

She stood proud of her stance to give birth at home naturally with the care of a midwife and doula and repeated "I wouldn't have it any other way." While Rosa had a wonderful and relaxed experience through most of her pregnancy and birth, she did reiterate that midwives don't have enough personalised time for women coming in and aren't very responsive or supportive through the entire journey of labour. They support and encourage women while they are birthing but there is a lack of personalised care with regard to everything before the actual birth. While Rosa hired a doula for emotional and physical support she does recall that it is an expensive service for women, that not all women have the luxury to afford at the end of the day

3.4 Experiences of Pregnant and Birthing Women - An Analysis of the Case Studies

Borquez & Wiegers (2006), unfolds that a woman's childbirth experiences are an important step in examining her labour and delivery process as a whole. Since maternity care in the Netherlands focuses on a "women-centred" approach, women's satisfaction and experiences with the care become an interesting topic of study. Wieger (2009) also suggests that a woman's interpretation of her experience is usually like in the route through their care system. Further, the quality of that maternity care isn't only studied through the morbidity and mortality of mothers and babies but also through factors such as calmness and control of the environment (Borquez & Wiegers, 2006). This can be noted in the instances of the case study too, that what women faced when they were pregnant and in

labour had a huge outcome on how they overall experienced birth as well. Overall it can be noted that all women, Katie, Nina and Rosa didn't have the "perfect" experience no matter what path they took, be it natural or medical. It always felt like something was lacking for all of them. Saying that Rosa did have a much better experience giving birth at home than compared to Katie and Nina, who gave birth at the hospital or birthing centre. While all women were pleased with their prenatal care and postnatal care, when the time came to give birth, most of them experienced trouble navigating through the system despite the care the Dutch system promises.

3.4.1 Katie's Experience:

For Katie's first birth, she was left unsatisfied and disappointed because she chose to have a medical birth that the system wasn't catered to do for women with low-risk birthing experiences. She was left isolated, misunderstood and completely out of control over her body. Even though Katie received an epidural, it was administered to her at a completely wrong time when she wasn't even in pain. It was simply given to her because she wanted it. Whereas, when Katie was suffering through her terrible painful labour where she was screaming and nauseous from the pain, an overworked nurse just simply walked in and out of the room to check on her. In this instance of birthing, Katie's needs were completely overlooked. Cohen-Shabot (2021) not that women's voices during labour are often ignored and not taken too seriously. The main reason behind dismissal usually lies in how society usually views the idea of giving birth where her knowledge of her body is considered to be flawed since she is in the midst of birthing (Cohen-Shabot, 2021). Moreover, since Katie is from America, her cultural ideas of birth are different from Dutch ideologies. She wanted an epidural so she could feel in control of her pain level. This takes me back to the debate on natural versus medical in the previous chapter which talks about the complicated nature of both natural versus medical birth and its dependence on cultural valuation where women from different places may have different ideas of what they may want or need.

Finally, she ended up giving birth naturally, which restored her faith in her body to give birth without any medical interventions the second time around. Taking from her previous birthing experience, her experience was much better the second time around because she instilled trust in her body to give birth naturally like she did before. Katie also knew if she requested a hospital birth, it would go wrong again. So she decided to give birth in a way that fits the system's ideologies, in order to have a better experience. This can draw me to the question: is the Dutch birthing system "women-centred" if a woman wants a medical birth? Indeed, they claim to be "women-centred" because the actors within the system make birth to be a natural and physiological process, but how can a system be women-centred, if the woman's needs and wishes aren't taken into consideration? How can it be "women-centred" if she feels a complete loss of control in the birthing room, everything she acknowledges about her body isn't validated, and she feels a complete loss of power in the birthing

room? Nonetheless, Katie was extremely pleased with the post-partum care in the Netherlands with a *kraamzorg* and indicated it was the best part of giving birth in the Netherlands.

3.4.2 Nina's Experience:

While Katie's bad experience with her first childbirth could've been blamed on her choosing a medical birth in a system that favours natural, Nina's case is an interesting one because she chose to have a natural birth but due to errors within the system, she ended up having a medical one. Nina had bad experiences with doctors and lacked trust in the medical system as a whole when she was told she would remain sick and on bed rest for the rest of her life. When she found out she was pregnant, she decided to follow her pregnancy in a more natural route in Bali, when the time was coming she decided to give birth in the Netherlands due to her ideologies matching those with the midwives here. In Nina's case, she decided it would be best to birth in a birthing centre since her home was not an option due to her living too high up in her building. Logsdon & Smith-Morris (2017) draw a connection between birth centres and home births being closely comparable to one another since there are similar natural pain management relieves such as the possibility of freedom of movement or a shower or tub for a water birth. The aforementioned is also what drove Nina to have an as natural birth as possible away from her home and put trust in the medical system to give her a similar experience.

Nina especially demanded no physical or medical interventions and prepared certain breathing techniques, tried to move freely through her birth in order to handle the pain and eventually have a water birth. Despite that, the clinical midwife broke her water in order to try and speed up the process. Darra (2009) notes that a woman should never be hurried during her birth and should be treated humanely for the entirety of her pregnancy. Similarly, another mother Emily also complained about a situation that happened to her, however, this will be discussed in a later section. For Nina, the one intervention brought up her pain levels so high, she had to use more interventions because of the one little non-invasive procedure. It led her to first rely on the pain medication, nitrous oxide that is administered by the clinical midwife. Nonetheless, the little intervention to speed up the process, ended up in Nina giving birth at a hospital with all the interventions she didn't want to avoid from the very beginning.

In another study, it was duly noted that any sort of pressure or rush from the medical professionals ends up disrespecting and damaging women's experiences of her childbirth (Collins et al., 2021). Similarly, it was also noted that many experiences that women have birthed in a birthing centre were similar experiences to those in hospitals due to the increased availability of medical help (Logsdon & Smith-Morris, 2017). Further, the rushing of birthing processes is also closely related to insurance policies in the country, which will be discussed in the late part of this chapter in greater detail. While Nina had plans of having an empowering natural birth journey in the birthing centre, she

ended up feeling completely out of control over her body, extremely powerless since she couldn't use any of her prepared wisdom and trust in her body and ended up with a scarred sense of agency.

3.4.3 Rosa's Experience:

Rosa's birthing experience among all the case studies stood out as the most favourable compared to the other two women in the birthing systems. This can be attributed to a couple of distinct characteristics in her birthing journey that wasn't present for Nina or Katie. Firstly, Rosa chose to give birth at home, even though a family member who was also a doctor advised against it. Despite the opposition, Rosa remained adamant in her choice and proceeded to give birth at home regardless of the risks and protocols associated with it, as indicated in the required waiver she had to sign off with regard to a home birth on the second floor. The second factor that contributed to Rosa's positive experience was hiring a doula who took an active role in protecting Rosa's agency throughout the entire birthing journey. The doula provided her with valuable knowledge, advocated for her when in need and ensured that she felt in control and empowered throughout the entire birthing process. A study even reported that women that were in labour were best supported by a doula (Collins et al., 2021). This support from the doula played a critical role in shaping Rosa's birthing experience and fostering a sense of empowerment.

It has been reported that women that choose to give birth at home under the care of their own midwife and in their own familiar surroundings reported a higher level of satisfaction with the care and had stronger feelings of security and support through the birthing process (Wieger, 2009; Borquez & Wiegers, 2006). Rosa's experiences align with this finding, as she felt in control and empowered throughout the birthing process. However, there were moments when her voice wasn't fully respected by the midwives. During her labour at midnight, the midwife delayed coming and instead advised Rosa to wait until the morning, which was also observed in Katie's case. This can indicate a common trend where birthing women's voices may not be taken as seriously, especially when they are in the midst of labour and birth (Cohen-Shabot, 2021). Rosa's doula played a crucial role in validating her feelings, protecting her agency and encouraging her to assert her needs, demonstrating the importance of having strong support during childbirth. While Rosa ultimately had a positive and empowering birth, the midwife's delayed response reveals potential flaws in the "women-centred" aspect of the system.

3.5 Other Factors That Affected Women's Childbirth Experiences

As demonstrated in the aforementioned cases, a seemingly small detail can significantly impact a woman's birthing experience and her sense of agency. Despite preparation and expectations, the often unintended actions of medical professionals can swiftly alter a woman's journey. As noted in the previous chapter, the actions of these professionals are usually a result of their own education and experience within the system. Hence, the complex and contentious nature of Dutch maternity care and

the varying actors present within is what makes the system so fragile. Any subtle variation in action, thought or beliefs can lead to tensions among the various stakeholders within the system. This can duly be noted just in the three case studies I present, if I were to go into further detail of each woman I interviewed, I would exceed the scope of this thesis. Nonetheless, there were a common few themes identified that shaped the women's experiences within maternity care.

The themes that significantly influenced a woman's birthing experience were her level of trust in the overall healthcare system, the collaboration between healthcare professionals, the quality of bedside manners exhibited by healthcare providers, and the role of insurance. These factors played a crucial role in determining how women navigated through their birthing journey and overall satisfaction with the maternity care that they received.

3.5.1 Trust in Medical System

Trust is considered especially important between healthcare professionals and patients due to uncertainty and the element of potential risk involved in healthcare sometimes (Calnan & Rowe, 2007). Trust in the healthcare system should be created through conversations, empathy and understanding of the patient and highly correlated to the satisfaction of the care provided (Calnan & Rowe, 2007). During my fieldwork, the notion of trust emerged in various facets, intricately intertwined with how women navigated and experienced the birthing system. For instance, Olivia, a birthing mother, highlighted her lack of trust in primary care as a whole since the system as a whole works off demedicalizing and "gaslighting" medical concerns. Medical gaslight is a common phenomenon where medical professionals dismiss women's health concerns enforcing the conventional idea of women's concerns being irrational (Fraser, 2021). Hence, Olivia always felt compelled to do her own research during her pregnancy since her distrust in the medical system caused her to feel anxious and stressed, which is also why she wanted a hospital birth with doctors rather than a homebirth or birth centre experience with midwives. Trust shows to also be an important phenomenon when dealing with continuity of care and satisfaction with the particular type of care Calnan & Rowe, 2007).

Contrasting, Roos, a Dutch pregnant woman, who also planned a hospital birth with an epidural had a completely different perspective and belief of the Dutch system. She chose not to give birth at home with midwives because in case there was a traumatic incident, she didn't want it to take place in her home and her midwife also encouraged her to give birth in a hospital. "I really really trust the system in the Netherlands and I choose to put trust in the doctors or whoever is around me" Roos explains with a big smile across her face. Hence, it can be noted that trust or distrust in a system contributed to the way women felt or approached their birth and their attitude towards their medical provider. As seen with Katie as well, she initially chose to put her trust in the doctors around her but since she was let down, she chose to take her birth of the second child into her own hands instead of relying on the system for support, she chose to trust her body and her ability to birth. Even in Nina's

case too, her distrust of the medical system, chose her to lead toward a natural birthing experience, which also managed to turn into a negative encounter, despite her trust in the primary care. Hence, it can be noted that trust can also lead to distrust in cases of exploitation or domination (Calnan & Rowe, 2007).

3.5.2 Bedside Manners

"I think they lack bedside manners here" explained Katie, who experienced a miscarriage and went to her general practitioner. Wittekower & White (1954) define bedside manners as "an unsystematized understanding of a patient's emotional needs" (p. 1432). "I experienced a miscarriage here and I remember there being no care, no compassion and no tenderness. It was a really scarring experience but I guess these are the Dutch bedside manners. Perhaps it was cultural differences or just the way they were taught to deal with it. I still wonder if I was in America if my experiences would've been different…" Katie signed. When I asked Sophie, the medical student about the lack of these bedside manners she explained "I do think the bedside manners are degrading for some reason. Perhaps with the addition of technologies such as electronic health records, doctors are now meant to type everything into unnecessarily complicated software during appointments because if they leave it for later it's two and a half hours of unpaid work and there is a risk of forgetting details." Similarly, Kyla, the *kraamzorg* said, "I really do hope they improve their bedside manners because it really has an impact on women especially just a few days after giving birth."

Akash also expanded "I personally think there are overwhelming expectations from patients that doctors have to deal with. People have a lot of questions these days and they want to talk, which is a good thing but the system is not refined for that. The system is made for people to come in, show their problems and give you a solution. Doctors also simply just don't have the time to attend to everybody's special needs, especially with regard to birth. We have all become like robots moving from one patient to the next trying to finish our day on time." Sophie also pointed out that Dutch culture might be a reason for poor bedside manners hence cultural differences may cause miscommunication between one and another. Person & Finch (2009) pointed out that patients found positive bedside manners associated with doctors that were caring, confident, empathetic, communicative and good listeners. In the Netherlands, doctors have limited time with patients and additionally need to fill in all their data electronically during the meetings, so even if they wanted to spend more time with the patient, the system just isn't designed to provide that level of care. To add on, culture differences and the level of care might be interpreted in different manners by the doctors and patients which could result in a lack of bedside manners, even though thats not what's doctors mean to happen.

3.5.3 Collaboration Between Health Care Providers

Interprofessional collaboration is of fundamental importance for effective maternity care (Warmelink et al., 2017). Many mothers I spoke with weren't pleased with the collaboration between primary and secondary care. Olivia complained "I really don't think there is any collaboration between the clinical midwife, doctor and midwife. It was so stressful for us because it felt very separate. Once I was moved to medical care, my time with my prenatal care was done. All this time I spent trusting people that supported me emotionally and physically was gone. I felt so abandoned and weirdly felt that this is what I deserved for choosing to get an epidural." Various Dutch studies have shown the lack of collaboration and communication between primary and secondary care professionals in the Netherlands which seems to have an effect on birthing women (Warmelink et al., 2017). Nonetheless, Akash explains "I think there is enough collaboration between the medical professionals, I mean in theory, everything should be relayed from primary to secondary care." Sophie on the other hand said, "I think it depends on the midwives and doctors how the information is transferred but there were a couple of birth I attended when a normal midwife was assisting and then something went wrong and a clinical midwife took over immediately and just sat back and watched everything happen." She explained that transfers happen particularly quickly because of the protocols they all follow, however, she can imagine information getting lost. On the contrary, Dr Dawson explained "There is good collaboration between the primary and secondary but it could definitely be improved. You see there are issues transferring all the information correctly from primary to secondary care all the time. The rapid switch to secondary care can certainly cause communication issues or details to go missing."

Meanwhile, even though the medical professionals saw overall good collaboration with each other in my research, the women in my research didn't seem to agree with them and did the lack of interpersonal collaboration as one of the reasons that contributed to their negative experiences. Further, in a study carried on by Cronie et al., (2018) it was noted that over 40% of respondents consisting of midwives, obstetricians, nurses and maternity care assistants were not satisfied with the collaboration in the Dutch maternity care. It was noted that there was a lack of communication, a presence of competition and a lack of trust between colleagues (Cronie et al., 2018). While on the other hand, Warmelink et al., (2017) explain that levels of satisfaction with collaboration amongst healthcare professionals did vary between the levels of care. Specifically, interactions with non-physicians such as midwives and clinical midwives were awarded a more positive ranking compared to interactions with physicians or obstetricians (Warmelink et al., 2017). The lack of collaboration also seemed to have an effect on birthing women's experiences since they cultivated a relationship with their midwife and felt abandoned when they were transferred from primary to secondary care, especially when fear drove them to have an epidural.

3.6 Summary of Chapter

In this chapter, my aim was to answer the question "How are these notions negotiated and acted in the birthing trajectory?" Through three different case studies, I present how the notions of natural and medical birth are enacted in the real world. In the first case study Katie planned for a hospital birth with an epidural, but she ended up giving birth naturally. During her time in the care, she felt treated poorly by her midwife and hospital staff and faced issues with receiving an epidural. Katie's first birthing experience was terrible but during her second birth, she took more control and ended up having a better birthing experience. In Nina's case, she wanted a natural birth in a birthing centre with no interventions but ended up giving birth in a hospital due to a small intervention initiated by the clinical midwife. Nina ended up having a terrible experience. Her case showed flaws in the system with regard to rushing women to make space for more patients. Rosa, on the other hand, was the only one to abide by the Dutch birthing beliefs and had an unmediated birth at home under the care of a midwife and doula. She was the only one to have a positive experience, but even she showed concern about the midwife not being very responsive when she was initially in labour. Rosa had to advocate for herself for the midwife to show up. Hence, it could be noted that notions of natural and medical manifest in different ways depending on people's subjective attitudes and beliefs. Further, other factors such as trust or distrust in the system, lack of bedside manner and insufficient interprofessional collaboration also impacted how women experience the birthing system. Hence, this chapter highlights the contentious and ambivalent nature of the field and how different stakeholders in the system with differing attitudes and beliefs are negotiated and acted out.

Chapter 4

Natural versus Medical - Its Impact on the Sense of Agency

Within this concise chapter, my objective is to delve into the practical implications of the ongoing discourse between natural and medicated childbirth. The preceding chapters delved into how the debate plays on in real-world scenarios and seems to question the "women-centredness" of the birthing system. The focus of this chapter is to uncover the key elements that truly define a women-centred birthing system, and we will soon arrive at a conclusion regarding the claims of the Dutch birthing system being women-centred. Furthermore, we will delve into the ways in which women's agency is either upheld or compromised within the birthing system. To operationalize the concept of agency, we dive into the concepts of knowledge, control and power. This approach is necessary due to the complex, subjective and multifaceted nature of agency. Concluding this chapter, I will explore recommendations offered by medical practitioners and women to improve the workings of the Dutch birthing system. This insight is crucial in understanding how different stakeholders within the system perceive the strengths and areas that require improvement.

4.1 Natural versus Medical - How "Women-Centred" Is the Dutch Maternity Care?

Shabot (2022) poses an interesting take on natural versus medical childbirth in a "woman-centred" birth and elucidates on birthing as a complex topic in feminist theory. She describes birth as part of a feminist sacrifice where women endure severe pain and "embodied crisis" to experience a "transcendence and positive transformation" (Shabot, 2022, p. 417). Natural birth is equated to the "rawness of true femininity" and a medicalised birth is a device to free women from the "curse" of a painful and deadly birth but can end up leaving women feeling upset, out of control, injured and traumatised from non-consensual intervention (Shabot, 2022, p. 417). The text argues against the idea that women must either numb their pain to childbirth and give into medicalization or experience it without any medicalization as these ideas are often seen as patriarchal sacrifices of women (Shabot, 2022). Women in turn shouldn't be viewed as objects to be sacrificed for the well-being of the baby or societal ideas of feminity (Shabot, 2022). Instead, Shabot (2022), proposes a more feminist lived-experience understanding of birth, which is the ambiguities and complexities of its experiences. This approach sees birth as an interpersonal event where a woman is connected to her newborn baby being born and others present at the birth and not much importance is given to how and where the baby is birthed. The article stressed the possibility of a feminist sacrifice in childbirth during which a birthing woman's wishes and needs are honoured and celebrated, however, this can only take place in a woman-centred birth (Shabot, 2022)

Similarly, Darra (2009) challenges the assumption of a "normal" birth being synonymous with a "natural" birth by highlighting how terms are constructed by society and influenced by culture

and medical practices. She questions the idealization of a specific birth and argues for a more inclusive understanding of what a positive birth can contain (Darra, 2009). The author points out the make-believe ideas revolving around natural birth as it seems to be a romanticized notion seen in some cultures and women's instincts (Darra, 2009). The approach of all-natural birth can have portrayed ideas on women's bodies and them being equated to failures if they divert from the natural which in turn doesn't fit well with modern feminist ideas (Darra, 2009). Instead, the author, suggests ideas of different normal variabilities that can emphasize an individual's birthing experience and to instead empower women to make the right choices that align with their preferences (Darra, 2009).

As seen in the literature above, the debate on natural versus medical surrounding childbirth needs to evolve beyond the fixation on how, where and with who birth is given. Instead, the emphasis should be given to providing individualised care that is tailored to each woman's needs and preferences. In the Netherlands, the birthing system emphasizes normal childbirth with the use of low medical interventions and a natural birth (Vogel-Broeke et al., 2023). Moreover, insurance companies are also designed in a way where they support a more "natural" childbirth. One of the medical students, Akash, I interviewed even said, "It is mainly the insurance companies running the show, we are just the actors that need to stick to our job and oblige whether we like it or not." The system is designed such that women are encouraged to lead a more "natural" route as it seems to be the norm in the country.

However, the increased rates of low-risk women seeking medical interventions during childbirth have raised concerns about the safety of home births and midwife-led care and the fear of pain that comes with childbirth (Hollander et al., 2017). Unfortunately, women encounter a loss of autonomy when transitioning from primary to secondary care if they choose to have medical interventions. Most births under the secondary care among the women I interviewed, resulted in negative experiences involving the way women were treated, ignored and disregarded. Hence, the aforementioned can question the "women-centredness" of the system. Despite the focus on demedicalizing birth, my research revealed that even women opting for a natural birthing experience sometimes did not receive optimal care. In the case of Nina and Emily, interventions were used to break their waters in order to speed up their birthing process and both needed additional interventions in order to manage their pain. While Emily managed to give birth in a birthing centre, Nina had to be transferred to a hospital against her wishes. The only one who abided by the system and had a natural birth at home under the care of a midwife was Rosa. Even she expressed disregard for her initial calls with the midwife and was only able to advocate for herself because her doula gave her a voice.

Overall, even midwife Margot, Dr Dawson and both medical students were vocal in them favouring a natural birth over medical birth. Margot showed her preference for natural birth as she suggests it upholds women's agency best, while Dr Dawson and the medical students support a more natural birth due to its medical safety. However, the doula and *kraamzorg* endorse women's autonomy is best upheld when women's choices on what they want to do with their bodies are respected. Kyla,

the *kraamzorg* summed it up by saying "The system is not women-centred but the one way to make it be is to respect women's choice." Hence, the Dutch maternity care can only be women-centred when women's choices and lived experiences are honoured and women are empowered and supported no matter how, where and with whom they choose to give birth (Shabot, 2022; Darra, 2009). This brings me back to the initial conversation with Salima that I presented in the introduction, where she highlights no matter how a baby might come out, it is all-natural, hence, the debate on how with whom and where shouldn't even be up for debate. In the following section, it will highlight how this dichotomy had an effect on birthing women's agency. Nonetheless, moving away from the rigid dichotomy and embracing a more inclusive perspective can foster a more holistic understanding of childbirth and celebrate the choices of women's wishes and needs by valuing both natural and medical births to ensure the most positive birth outcome for mothers and babies.

4.2 Women's Experiences and Their Effect on Agency

In the context of pregnancy and childbirth in the Netherlands, the concept of agency does manage to grab the limelight as women navigate through the intricate web of medical systems, the beliefs of actors within and their own personal choices. Agency in general refers to an individual's ability to make decisions that influence their own lives (Hitlin & Elder Jr., 2006). Hence, the agency holds significant importance during childbirth as it involves a deeply transformative experience for women. As observed throughout the preceding chapters, Dutch maternity care is a contentious and ambivalent landscape where every actor carries their own distinct set of personal beliefs, ideologies and narratives that are responsible for forming levels of trust or distrust in the medical system and their bodies. When a combination of contrasting perspectives comes to face each other it results in conflicting viewpoints that can be noted through the entirety of this ethnography.

While conflicting ideas may be an inherent part of human interactions, women may find themselves in a vulnerable position due to the authority that midwives and doctors hold and the power imbalances at play (Dahan & Cohen Shabot, 2022). This usually results in women having to advocate for themselves and if they don't, their sense of agency seems to be a bit lost. As noted in the previous section, even though the Dutch birthing system is claimed to be women-centred, in reality, the system isn't as women-centred as it seems due to the fixation on women giving birth naturally. Hence, the fixation and opposing ideas of doctors and midwives seem to have an effect on some women's agency. In this section, we will analyse how women's agency was lost or gained in the ostensibly women-centred system. Agency is a complex notion and can be enacted or lost in several ways. As discussed in the theoretical framework, I will be using the notions of knowledge, power and control to operationalize agency. Defining and understanding agency practically will enable us to encompass the subjective experiences of each woman (Dahan & Cohen Shabot, 2022).

4.2.1 Knowledge

Knowledge constructed around the body and birth by medical practitioners tends to dominate discourse around childbirth due to the hierarchical nature of midwives and doctors (Moore, 2011). This further has a direct effect on the way women choose to approach their pregnancy and birthing choices (Moore, 2011). Due to the long history of obstetricians having more authority in the medical field worldwide, women tend to trust doctors' knowledge for handling the pain of childbirth in case something were wrong (Dahan & Cohen Shabot, 2022). However, as noted through this ethnography, the contrasting nature of women's beliefs and the medical system's preferences for natural birth is what causes a clash between knowledge and impacts a woman's agency. However, despite the Dutch system framing birth to be a physiological process, conflict arises when low-risk women seek pain relief due to their own knowledge shaped by media, stories or fear creating a tension between the two opposing knowledges. Yet, many women assert their control by asserting their voice on what's best for them. Going against authoritative knowledge is also a way women assert agency (Moore, 2011). This suggests that medical knowledge from practitioners and their authority isn't enough for women to submit to their ways. Women challenging doctors and advocating for themselves, rather than doctors deciding against their beliefs can maintain agency.

Moreover, "embodied knowledge" or knowledge derived from understanding the emotions running through the body also remain important while in labour and while birthing (Moore, 2011, p. 880). Often the embodied knowledge of a woman is dismissed just because she is in the midst of labour and birthing and is brought into question by medical staff who privilege from their epistemic knowledge (Cohen Shabot, 2021). This ends up in medical gaslighting and further taking away from women's positive experiences (Fraser, 2021). It can be noted in Rosa and Katie's case where their voice and embodied knowledge were disregarded and gaslit which in turn ended up affecting their agency. While Katie was subject to the testimonial injustice, Rosa had the support of the doula who held her autonomy and encouraged her to stand up for herself. Nina's embodied knowledge of her body told her to steer away from any form of doctor or medication due to her previous experiences. However, when the medical staff didn't respect her choices and made their own decisions for her body, all the time and energy Nina spent cultivating her bodily knowledge was dismissed due to the bodily knowledge of medical practitioners. Hence, the dismissal of one's embodied knowledge also highlights how their sense of agency could be taken away from them.

4.2.2 Control

A woman's perceived personal sense of control over her childbirth is an important factor in feeling greater satisfaction with her birth (Karlström et al., 2015). Moore (2011) suggests that control can be understood best when the notions of knowledge and power are merged together. Hence, when women feel confident in their knowledge as well as empowered during their birth, they tend to have more of a sense of control over their surroundings. In numerous instances, in my research, expressed

losing a sense of control over their bodies and birth when their decisions weren't acknowledged or respected. In numerous pieces of literature, the sense of loss of control has been associated when women opt for a medical birth under the guidance of an obstetrician and feeling more in control when they choose to give birth at home.

However, I would like to argue quite the opposite. Based on my time in the field, I would like to argue that women felt a loss of control when either of their chosen options to birth was not respected. This can clearly be noted in the case of Katie and Nina. In Katie's first experience of birthing, although the birthing process took place in a hospital, her feeling of being out of control didn't solely stem from being in the hospital. Instead, her loss of control emerged when her midwife left her unsupported, the pain relief she requested wasn't administered to her correctly and when nobody came to check on her while she was screaming in pain. Olivia noted a similar experience as well and explained she would feel more in control of her environment if she had doctors monitoring her and medication for pain relief as well. This suggests that some women may opt for a hospital birth despite the risk because the hospital setting might provide them with a sense of control. Contrarily, Nina, felt a loss of control when interventions she didn't ask for were administered to her, building on her loss of control. Hence, birthing bodies need to decide what makes them feel in control.

Nieuwenhuijze et al., (2013) suggest that control has two dimensions: internal and external control. Internal control is the frame of mind of a woman while external control is related to the surrounding environment and her involvement in the birthing process (Nieuwenhuijze et al., 2013). I suggest a woman's internal thought patterns are influenced by external control factors and the attitude and support of her external surroundings. The way she is treated externally has an impact on her inner sense of control. Therefore, a supportive environment that respects the woman's choices is conducive to the internal control of her mind and overall experience of the system. On this note, in a supportive environment, when women trust their birthing professionals, their willingness to listen to them, accept their knowledge and follow their instructions by giving them control is also a way agency can manifest itself (Walsh, 2007).

4.2.3 Power

Abd El Aliem et al. (2020) define empowerment as the process of improving a woman's ability to make decisions and turn the choices available into her desired outcome and action. Further, when the birth plans of the women are followed through, it can result in increased self-esteem and assurance for the birthing woman (Abd El Aliem et al., 2020). Studies even show that when a birth plan is followed through there are lower rates of C-sections and overall better birthing outcomes and more positive outcomes for a woman (Abd El Aliem et al., 2020). In the Netherlands, women are encouraged to make birth plans with their midwives during their prenatal care to inform the medical team of a woman's wishes for her birth (Joles et al., 2019). All women that I interviewed, had a

birthing plan and as the author suggests, when these birthing plans weren't followed through it resulted in women feeling disempowered during their birth.

Throughout the preceding chapters and sections, a clear pattern seems to emerge which are negative birthing experiences often stemming from unfulfilled wishes. The stories of Katie, Nina and Olivia reveal instances where their sense of empowerment was seized when wishes were overlooked. On the contrary, Rosa once again only stands out as a positive example of feeling empowered not solely due to her natural birth but because her birth plan and wishes were respected. Additionally, Kyla, the *kraamzorg* noted that women felt most disempowered when their choices weren't seen and respected, and it was her job to make the women feel powerful and restore faith in their abilities. Therefore, true empowerment arises for birthing women when they are given the space and confidence to trust their bodily knowledge and retain control over their external and internal settings. The absence of the aforementioned as noted through this ethnography results in the weakening of power, diminished bodily knowledge and finally a loss of agency.

4.3 Suggestion for Improvement - Women, Midwife, Doctor, Doulas and Kraamzorg

When I inquired about what could transform the Dutch birthing system into a more "woman-centred" system, I got an array of insight from all the stakeholders in the system. The women suggested longer appointments with midwives, additional testing and screening for their babies and their birthing choices be respected by medical practitioners regardless of the route they select. The midwife also weighed in and suggested a couple of longer appointments with an in-depth discussion on the birth plans where she could help women realise their ability to birth naturally. Dr Dawson suggested an integrated obstetric care model, where primary and secondary care comes together to provide care for birthing women. In the integrated model, the collaboration between primary and secondary care can also improve and provide smoother and better experiences for birthing women. Dr Dawson even suggested there is space for doulas in the integrated model of care since their emotional support is beneficial in creating a holistic model. Doulas, on their part, recommend their inclusion within the existing framework by making their services part of insurance policies so their service can be made accessible to more women. The *kraamzorg* suggests the improvement of bedside manners by nurses and doctors, a call for treating women with more empathy and medical practitioners respecting women's choices could make the current birthing system more women-centred than it is.

4.4 Summary of Chapter

In this chapter, it becomes evident that the Dutch maternity care system may not entirely align with its claims of being completely women-centred. Insight from various authors reveals what truly needs to be prioritized in order to make childbirth women-centred. One author identifies that women's lived experiences need to be taken into consideration and her choices need to be honoured and celebrate regardless of the type of birth (Shabot, 2022). While another author claims the focus should

shift from the dichotomy between natural and medical childbirth and instead the emphasis should lay on empowering women and creating a supportive environment, regardless of the type of birth (Darra, 2009). Hence, it can be noted that the Dutch maternity care is not as women-centred as it claims to be. Further, the contentious viewpoints and ostensibly women-centred system have an effect on women's agency. Agency was operationalized through the notions of knowledge, power and control. When the preconceived knowledge of women and their embodied knowledge wasn't validated, it seemed to have an impact on women's agency. Internal and external factors of control seemed to diminish or enhance a woman's sense of control as well. The execution of birth plans held considerable power in shaping women's feelings of empowerment or disempowerment. Lastly, stakeholders across the spectrum offered suggestions to enhance the women-centred nature of the Dutch birthing system.

Chapter 5
Conclusion

In this ethnography, I explored the question - How do women experience and enact agency in what is an ostensibly a women-centred birthing system? In order to answer these questions, I had three sub-questions that I aim to answer below.

1. How is natural versus medical seen by other actors within the system?

Chapter 1 looked into the diverse perspectives of healthcare practitioners in the birthing field and gave insight into some of their attitudes, beliefs and perspectives on the dichotomy of natural versus medical birth. In the first part of this chapter, we briefly dive into the past and present of the Dutch maternity care. In the 18th and 19th centuries, women's physiological processes like birth were marked as pathological by obstetricians indicating that women's natural processes were an illness or an anomaly (Brubaker & Dillaway, 2009). However, in the 19th century, Dutch midwives gained autonomy over the maternity care and assisted women in giving birth naturally at home (Van Lieburg & Marland, 1989) However, at present with an increasing number of women wanting to medicalize their birth and moving away from giving birth at home, the debate on natural versus medical remains to be a hot topic in the Netherlands. Many women question the safety of birth, fear the pain and view it to be a dangerous procedure. The field is contentious and contracting attitudes, beliefs and practices seem to cause tension within the field.

The midwife I interviewed encouraged women to keep their birth as natural as possible since it's the safest option for women and their autonomy is best held with a natural birth. However, women have their own reasons to want to birth in a hospital and consider hospital births to be safer. Although Margot the midwife, tries to remain as neutral as possible with her patients, she wishes she had more time with women to restore faith in them and their bodies to give birth as naturally and unmedicated as possible. Similarly, the doctor and medical students I interviewed noted the medical risks that come with childbirth. Dr Dawson noted that the increasing need of women wanting to have a 'perfect birth' is also a reason more and more women are choosing to have medicated hospital births. They note the tricky nature of pregnancy since it is not an illness, however, with the way media represents birth and the pain associated with childbirth, more and more women tend to medicalize their birth. All three of them noted that a woman's agency is best upheld when they give birth naturally without the additional medical risk involved.

On the other hand, the *kraamzorg* noted, that women's choices in birthing must be respected regardless of where, how and with who she gives birth. She notes that the way a woman is treated and respected during her birth seems to have more of an emotional effect on her in the post-partum days rather than the choice of a natural versus medical birth. She notices many women losing their power

and sees it as her role to make them feel empowered and capable of their abilities again. Most women I interview, despite their negative experiences with the primary or secondary care, commended the work of the *kraamzorg*. Doulas similarly note that women's bodily choices must be respected. They also see themselves as advocates for birthing women and aim to protect their agency and autonomy in the birthing room by creating a supportive environment and standing up for their choices and needs since the birthing women might be in a vulnerable position to do so herself. In this chapter, we can clearly identify the contentious and ambivalent nature of the field.

2. How are notions negotiated and acted in the birthing trajectory?

In this chapter, I aimed to dive into how the debate on the dichotomy plays out in real-world situations. I presented three case studies of three women with three completely different birthing experiences and outcomes. All of them had completely different ideas and knowledge of their bodies and birth. In Katie's case, she wanted a medicated birth but ended up giving birth naturally in a hospital. During her first birth, Katie chose to put her trust in the doctors but was betrayed by the actors within the system. She felt treated poorly by her midwife, nurses and doctors. Her initial plan included an epidural, but she ended up birthing naturally. Her case highlights how differing opinions in the system can clash with one another and can have a negative impact on a birthing woman.

On the other hand, Nina wanted a natural birth but ended up with a medicated one, due to a small intervention initiated by a midwife that Nina specifically wanted to avoid. Her case showed systematical errors within the system in regard to rushing patients in order to space for more. Rosa was the only woman to have a positive birth experience since she abided by the ideas of the system, and she chose to give birth at home under the care of a doula and a midwife. Even Rosa faced an instance with her midwife, where she had to advocate for herself in order to get her to come home. In the case studies, the delicate nature of the pregnancy and birthing can be noted as tiny instances that seem to have a huge impact on the way women approach and experience their care.

Further, other factors that seemed to affect women's experiences were their trust and distrust in the medical system, bedside manners and interprofessional collaborations between medical professionals. Trust is especially important in healthcare due to the elements of potential risk involved (Calnan & Rowe, 2007). Women's experience previous attitudes and experiences with the Dutch birthing system seemed to have an effect on the way they approached and experienced their birth as well. Women that didn't trust the system, didn't have the best experience, while women that trusted the system had a better attitude towards their medical practitioners and their beliefs. The lack of bedside manners also seemed to have an impact on women's experiences, the way they were spoken to or treated had a huge effect on their birthing journey, however, doctors had their own opinions on the lack of bedside manners. Finally, women complained about the lack of collaboration between healthcare professionals. It was noted that when women were transferred from primary to secondary care, they felt betrayed and abandoned when the primary care left them just because the women

wanted an epidural. On the other hand, some noted that transfer from primary care wasn't always smooth due to the rushed nature of transfers themselves.

Therefore, the general life experiences of the women, experience with a previous birth, trust or distrust in biomedicine, confidence in the Dutch birthing system, trust in their bodies, and different ideas of tolerance of pain or the healthcare providers attending to them shape their experiences of their pregnancy and birth. Hence, it can be observed that the notions of natural and medical birth seem to present themselves in varied manners depending on the individuals' subjective attitudes and beliefs. The contentious and ambivalent nature of the field continues to be highlighted in this chapter.

3. How does the natural versus medical debate impact women's agency?

In Chapter 3, it becomes apparent that the Dutch maternity care is not as women-centred as it claims to be. Shabot (2022) explains that a truly feminist system doesn't differentiate between natural versus birthing but instead seeks to understand the lived experiences of women and the ambiguity and complexities it comes with birth. Alternatively, the literature suggests that importance should be placed on providing the best care to the mother and baby where the choices of the mother are celebrated and honoured rather than on how and where the woman is birthing (Shabot, 2022). Similarly, importance should be placed on fostering a supportive and empowering for the birthing woman (Darra, 2009). Thus, it suggests that Dutch maternity care may not fully embody the women-centred care, it claims to be.

Furthermore, the conflicting viewpoints and the ostensible women-centred structure of the system seem to have an impact on women's agency. Hence, women experience and enact their agency differently, so they reclaim their autonomy. However, they still end up losing their autonomy sometimes due to the actions of their practitioners. The concept of agency is explored through the lens of knowledge, control and power. Since doctors or midwives tend to dominate the discourse on body and birth yet women step up and assert their agency to get the best results for themselves. Further, often the embodied knowledge of women in labour is disregarded since it is considered flawed. In these instances, women can seem to lose their agency.

Further, women felt most satisfied with their birth when they felt in control of their surroundings and themselves. Hence, internal and external control are important factors that affect a woman's agency (Nieuwenhuijze et al., 2013). A woman's internal thoughts are based on external factors such as a supportive and respectful environment. Therefore, women should pick an environment where they feel fully in control, that could mean a home birth for some and a hospital birth for another. Moreover, control can also be exercised when the birthing woman chooses to trust the medical practitioner and follow their lead which can also manifest as a form of agency. Lastly, the power a woman experiences can closely relate to the way her birth plan was followed (Abd El Aliem et al., 2020). When these birthing plans weren't followed through women felt most disempowered in the birth as noted in the many cases of the women I interviewed.

In the last section, all the stakeholders from diverse backgrounds and perspectives presented some suggestions for improvement that would help transform the Dutch birthing system into a more women-centred one. These recommendations included extended appointments with the primary care, additional testing and screening for pregnant women, integrating the primary and secondary, and respecting women's birthing choices.

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