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2. **Author(s)**

Van Daalen, Rineke

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In the Netherlands the conditions for home birth attended by a midwife have been institutionalized early - in the first national Health Law in 1863 - and ever since these conditions have been supported by different parties. Home birth continued to exist beside hospital birth, while the division of tasks between autonomous midwives and obstetricians was institutionalized along lines of normality and pathology. From the 1970s these Dutch birth arrangements were defended by obstetricians, government, and also midwives. They became especially active in campaigning for home birth and for autonomy of the profession of midwifery. They saw a 'natural birth' at home and without medical interventions as the best way to have your baby. The Dutch birth arrangements could function as a model in the international struggle of feminist women, who agitated against the medicalization of births, who pleaded autonomy for women having a baby, and who supported the position of midwives. They were in favor of the 'natural birth process', just like the World Health Organization was in those days.

In 1993 Successful Homebirth and Midwifery: The Dutch Model was published. The editor, Eva Abraham-Van der Mark, wrote in the introduction: 'The present Dutch system of home birth and midwifery is in flux and should not be taken for granted' (Abraham-Van der Mark (ed. 1993:13). Nearly a quarter of a century later, her statement has become more than true. Dutch birth arrangements underwent important changes, the home birth is in danger, and the question rises if the Dutch system still can function as a model.

1. Dutch birth arrangements become a deviant case

In most of the western world having a baby became medicalized in the first half of the 20th century. Home births disappeared rapidly, gynecologists acquired a monopoly as birth attendants and hospital birth became labelled as 'modern' and as suitable for 'modern women', while the role of midwives was marginalized during this process. Developments in different western countries tended to converge into the direction of medicalized models. 'Pre-modern' varieties of birth practices tended to disappear. But in the Netherlands medicalization was not equalized to modernization and was not seen as a way to liberate women. Birth was and still is categorized in terms of normality.
and pathology. Selecting women who are at risk of a complicated birth, is done by midwives in the course of prenatal care visits, and during labor in case complications turn up unexpectedly or the process of delivering the baby is delaying.

In case of normal birth pregnant women are attended by midwives or general practitioners and they are allowed to give birth at home. In case of pathological risks they are sent to gynecologists and to hospitals. Dutch obstetricians have played an important role in establishing these arrangements, and in drawing the line between normality and pathology. A large part of them acted as supporters of homebirth and ascribed an important role to midwives, among them the respected and internationally well-known obstetrician Gerrit-Jan Kloosterman. By formulating the list with criteria which distinguished normality from pathology, obstetricians designed and legitimated a division of labor between gynecologists/obstetricians and midwives. They were also in favor of socializing midwives into the newest insights of their profession, and in case of normal birth they were willing to give midwives entrance into the hospital. So in the 1960s the so called ‘policlinical birth’ was introduced, the birth with a short-stay in hospital, attended by midwives. This gave women expecting normal birth an extra possibility to choose.

The introduction of the policlinical birth contributed to an increase in hospital births, because of its combination of safety/security and ‘gezelligheid’/cosyness. Hospitals even tried to promote a domestic atmosphere by imitating the interior of people’s homes. Between 1965 and 1983 the percentage of hospital births rose from 31.5 % to 64.9%; between 1970 and 1983 the percentage of policlinical births increased from 2.5% to 36% (Van Daalen 1988:421). Two conditions encouraged the normal policlinical birth, attended by a midwife. The small scale of the Netherlands made it easy to reach a hospital quickly; the existence of maternity care guaranteed the young family professional support at home. This last arrangement facilitated both home birth and policlinical birth. So until today, in the Netherlands home birth and midwives still exist in one and the same system with hospital birth and obstetricians. And although the continuation of homebirth is uncertain, mothers can still have their baby’s at home without being seen as irresponsible.

**Why did the Netherlands become a deviant case?**

In most other western countries home births disappeared, or almost disappeared, while the position of midwives became peripheral. Both home birth and midwives were associated with pre-modernity and backwardness. Why didn’t that happen in the Netherlands, why did the Dutch organize an integrated system of birth arrangements in which midwives and obstetricians were interdependent, both with responsibilities and expertise of their own? Why did they organize a system in which home birth remained
a viable option for having a baby?
Part of an explanation may be sought in the medical field, in the early institutionalization of the profession of midwives, and in the associated specific relations between different professionals. But in understanding the ongoing existence of the homebirth and the autonomy of midwives I will also argue for a social historical approach, which searches for an explanation in the history of Dutch family life. Relevant characteristics are the private place of families in the larger community, and the division of labor and the power balance between men and women. What’s specific in these relationships compared to other European countries or to the United States? In those countries developments around the medicalization of birth have converged, as professionals and parents-to-be have emulated each other.

2. The sociogenesis of the domestic family in the Netherlands

The specific birth arrangements in the Netherlands can be seen as one of the elements which for a long time have been typical of families in the Netherlands. Other associated characteristics were the inner-directedness of the Dutch nuclear family and the clear-cut division of labor of fathers and mothers. These characteristics feature in the long historical tradition of the specific Dutch family constellation. They are still important, because these characteristics have been the cultural starting point of later child arrangements within the frame of the 21st century welfare state.

The 17th century Dutch Republic: the sociogenesis of nuclear families

Once I visited the Rijksmuseum in Amsterdam, where I faced a number of so called ‘kraamkamers’, paintings of childbed scenes, made by Cornelis Troost, a seventeenth century Amsterdam painter and actor (1697-1750). I wondered why this man was especially interested in this kind of scenes and I did some research into his life, hoping to find a clue. But while I became more and more knowledgeable about Troost and his life, I found something else. Looking in the Koninklijke Bibliotheek for ‘kraamkamers’ by Troost, I found a folder which was filled with more paintings of such childbed scenes, made during the 17th and 18th century and pictured by different painters. Indeed, picturing childbeds appeared not to be typical of Troost, who painted genre scenes like most of his colleague artists, but who became famous because of portraits and pictures of actors. Childbed scenes appeared to be a subject in Dutch genre-paintings, which were so characteristic of the 17th century urban, bourgeois society of the Dutch Republic. Genre paintings depicted people functioning in daily life scenes, family scenes in their own homes, in their kitchens, in café’s, at work. There existed in those days a lively market of this kind of paintings which were bought by the urban elite to decorate
the walls of their homes.
So, a range of childbirth scenes gave me the occasion to do research over a longer period. My research material consisted of 50 paintings, pictured between about 1650 and 1750, which I could compare in several respects. My most important findings pointed to a process of the privatizing of family life. In the course of these hundred years the depicted homes became more closed, they showed less and less open doors or open windows. The scenes became more intimate, more inner-directed. The number of people who were present on the scene decreased. On the early paintings people like neighbors and extended family were present, drinking a glass to honor the newborn and their mothers. But on the later paintings these outsiders disappeared. Instead, the mother and the baby became the focus of the room, and apart from them the father, the medical practitioner and the nurse were the only persons who were present in the room (Van Daalen 1993: 77-94). This development is the more interesting because it corresponds to other characteristics of early Dutch family life which point into the direction of further privatization. Take for example the building of the houses of merchants and other members of the bourgeois elite, along the canals in Amsterdam. Each family built a house of their own, with a door and an entrance of their own. There were no apartment buildings with common corridors and entrance (Olsen 1988/1990). Or take another indication of privatization of family life in the 17th century, the separation of the family home from the working place. People belonging to nuclear families became more interdependent, while their ties with members of the extended family loosened. Inner-directedness and domesticity became highly valued characteristics of their family life. Fathers were responsible for the connections with the world outside and they were accountable for the household income, mothers stayed at home and cared for the children.

Figure 1 A wealthy Dutch man comforting his wife after giving birth
(Engraving by P. Tanje, 1757, after C. Troost.)
Source: http://catalogue.wellcomelibrary.org/record=b1175119

Figure 2 Houses of the bourgeois elite along the canals in Amsterdam Herder (Fotograaf)
Source: Rijksdienst voor het Cultureel Erfgoed
Privatized bourgeois family relations become a model

Although these specific family traits in the seventeenth century developed only among merchants and other members of the urban elite, during the centuries that followed, such ‘bourgeois’, ‘burgerlijke’ relationships became the dominant model for the family life of other social strata. And, while I am making a large step in history, during the urbanization and industrialization in the last decades of the 19th century domestic relations between men and women, and between nuclear families and the world outside, gradually became the prevalent family ideals. In this period it became a sign of poverty when mothers had to earn money. Within Europe this family model was not exceptional, but in the Netherlands people succeeded relatively well in living up to this standard and in keeping women at home. The relatively low rate of labor participation of Dutch mothers around 1900 can illustrate that success (Plantenga 1993; Pott-Buter 1993).

The privatized family ideal was also very influential during the formation of the Dutch welfare state. Different elements of this specific family model became embedded in the structure of welfare arrangements, in the ways professions were organized, and in the design of the tax system. A clear example is the way child allowances were structured between 1900 and 1914. Autonomy of the family, and a strict division between homely tasks for mothers and wage earning tasks for fathers were the principles which underlied the establishment of this part of social security for families. The salaries of husbands and fathers were negotiated between employers and employees according to a male breadwinner logic. According to the ideal of a privatized family, the salaries of fathers should cover the cost of their own maintenance and that of their wife and two children (Van Daalen 2002).

One of the ambitions of such paternalist, breadwinning welfare states (Skocpol 1992; Pedersen 1993) was to set mothers free from the obligation to earn money. Mothers should be given the occasion to spend their energy full time on their household and on the care of their children and their husband. In this way both the autonomy of families towards the state was guaranteed and the breadwinners role of fathers. In her thesis How Welfare States Care: Culture, Gender and Citizenship in Europe (2005), Monique Kremer compares the UK, the Netherlands, Denmark and Belgium and she concludes - just like me - that family ideals and ideals of care are embedded in these different welfare states: in the facilities, in the regulations. She states therefore that one should not see an opposition between ‘state’ and ‘culture’ (Kremer 2007).

3. Present day frictions between the private and the public domain

The welfare arrangements which were established in the 20th century had unforeseen
and unintended consequences. One of these was a process of individualization within families. By making use of social security for example, women acquired more financial autonomy and they became more independent from their husbands (Van Stolk & Wouters 1983). Besides they came to be better educated, which also contributed to their independence. In the 1960s and 1970s in the Netherlands the emancipation of women reached a second stage. In the first stage at the beginning of the 20th century feminist women focused on the right to vote, in the second stage one of their important aims was promoting the labor participation of women, in particular of mothers.

As women started to leave their homes, the boundaries between the domestic family as a private bulwark and the world outside became blurred. This process went together with shifts and frictions in the functioning of the existing welfare arrangements. Success in implementing the ideals of privatized family relations in the long term had the effect that - apart from schools - public, collective arrangements for children were almost absent. There were some child facilities, but these were only organized for mothers who were in some respect deviant - they could be widows, they could have physical or mental complaints.

By the new division of labor between fathers and mothers the institutions for child care were no longer suitable. Care facilities for young children had to be established from scratch, something which didn’t succeed very well. This failing can best be understood by considering the moment when this collective child care was institutionalized: not in the stage of building the welfare state, like it occurred in the Scandinavian countries, but in the stage of trimming the welfare state because of high costs and overconsumption. In the neoliberal mood of the 1990s, collective child care in the Netherlands did not become a public service, but instead became commercialized. That gave a drawback which up till today could not be repaired and which goes together with tensions, both in the families and in the public domain, with children experiencing its negative effects (Van Daalen 2007). Dutch mothers, and fathers, became champions in the combination of part-time care and part-time work, while informal care remained up to now important. These individualized ways to supervise children diminished the urgency of organizing good collective care (Portegijs et al. 2006, 2008). The continuous importance of informal care may be illustrated by the contemporary trend that an increasing number of grandparents become caretakers today. Such contrived arrangements point to contemporary tensions and ambiguities in family ideals, especially concerning the role of mothers and the relationship between families and the world outside.
4. Family and birth in the 21st century

My interest in births in the Netherlands dates from the 1980s, and in 2017 I expected to find many new developments. But most trends which were important in the 1980s are still there and tend to develop into the same direction.

Continuing trends

In the last decades of the twentieth century several developments had a negative impact on the frequency of home birth. First, the continuing emancipation of women and in particular mothers, especially in terms of education and labor participation. These processes resulted in more individualization and in the opening of families. Both processes had their impact on the perception and practices of safe birth. Dutch family life lost some of its traditional domesticity and became less inner-directed - conditions which had stimulated the home birth. In this way the successes of the women's movement weakened the status of home birth. Individual 'autonomy' became an important value for mothers-to-be, while having a baby at home, attended by a midwife lost the attraction it had in the 1980s. The ideal of female midwives versus the model of the male obstetrician became less appealing, the more so as many obstetricians nowadays are female. Home birth became one of several feasible alternatives, but many parents-to-be saw that option as riskier than a hospital birth. The increased assertiveness of emancipated women also had the effect that part of the pregnant women no longer wants to accept the pain of birth. They ask for anesthesia, and their request is taken seriously. In 2015 21.8% of the laboring mothers had epidural anesthesia (Stichting Perinatale Registratie Nederland 2016). Some decades ago, this was unthinkable. Midwives and also gynecologists fiercely argued the advantages of having a baby without anesthesia. But today one can find instruction films on Youtube, in which associations of midwives present different types of pain relief as normal procedures, giving instructions about the pros and cons.

While in former times the instructions and advices of professional attendants, mostly midwives, were the most important source of information for pregnant women, today their better education and the worldwide web enable them to inform themselves thoroughly about the state of the art of the knowledge of pregnancy and birth, about risks, diagnostics, medical possibilities and medical interventions. Preventive medicine has become more important and this emphasis has made the always contested demarcation line between normality and pathology more diffuse. In their explorations on the internet mothers-to-be become more sophisticated about the risks concerning birth. Their consciousness of risk has grown, the more so as they are also confronted with professional disputes. They perceive that part of the professional knowledge is
under debate. The associated dilemmas and controversies are characteristic for risk societies, in which individuals have to deal with insecurity (Giddens 2001:68,69). Just like professionals pregnant mothers have to negotiate this new forms of doubt and uncertainty.

Secondly, the emancipation of women is also reflected in a transformation of the professional life of midwives. The traditional midwife disappeared. The unmarried, childless woman on her motorbike, working in wind and weather, has been replaced by a part-time employee, often with children at home, working in a midwife association, a birth centre or a hospital, preferably between 9 and 5 o’clock. This new-style-midwife is no longer able to act as the one-and-only professional, who is always stand-by.

Thirdly, further globalization had another unintended side-effect. From the sixties on there was a considerable increase in the number of immigrants in the Netherlands, first in particular from countries like Maroc, Turkey and Surinam, later from all over the world. These immigrants are not familiar with the tradition of the Dutch birth model. They see hospital births as modern and desirable, home birth as obsolete and as something for the poor. This encouraged further medicalization and the decline of home birth.

In 2015 29% of the births were attended by a midwife, of which 13.1% took place at home (compare: 78% in 1953, 35% in 1997–2000, 29% in 2005–2008), 2.4% in a birth centre while 13,1% was a policlínical hospital birth. These data indicate that a growing number of pregnant women without a medical indication prefers to have their baby in hospital, attended by their midwife, and with the possibility to return to their homes some hours after birth – be it in the middle of the night. The steady decline of the home birth tends to reach a critical point. In order to acquire sufficient exercise midwives need a certain minimum of homebirths during their apprenticeship.

In 2015 71% of the births was attended by an obstetrician in a hospital (compare: in 1953 22% of the deliveries took place in hospital; CBS 16/2/2009; CBS Statline, De Staat van Volksgezondheid en Zorg https://www.statavenz.nl/kerncijfers/geboorten 27/1/2017).

Giving birth in hospital gives women a higher chance of interventions and of the use of medical technology. As the number of births happening in hospital increased, the frequency of medical interventions grew as well. Take for example the rise of the frequency of cesarean sections, from 15% in 2004 to 16.6% in 2016 (Stichting Perinatale Registratie Nederland 2007; Perined 2016). The technological imperative, which obliges to give the best care that is technically possible, was earlier only the norm for obstetricians (Compare Guillemin & Holmstrom 1986: 130, 268), but today midwives are also urged to act according to this imperative. Prenatal screenings and diagnostics - blood research and ultra sound examination - have become normal routines, pain relief is no longer taboo.
Panic about perinatal mortality rates: the Dutch model under debate

As long as the Dutch system of birth care yielded excellent results and perinatal mortality rates in the Netherlands were among the lowest in the world, voices of obstetricians who argued as early as the 1970s in favor of further medicalization didn’t get much response. While the Netherlands could internationally boast about their neonatal/perinatal/foetal mortality rate, home birth and the supervision by independent midwives, could not be discarded as obsolete and dangerous and people had every confidence in the Dutch model. There was no reason to question the basic assumptions of that model: ‘pregnancy and having a baby are natural phenomena, no illnesses’, 'nature knows best', and a conservative, non-interventionist medical approach can prevent the negative side-effects of medicalization and medical interventions.

This attitude changed however in the past twenty years. Perinatal mortality rates in all European countries have decreased steadily, and although in the Netherlands they did so as well, this decrease happened less rapidly than elsewhere. In 2004 the perinatal mortality in the Netherlands was 10.5/1000, ranking the country as 16th in a range of 23 European countries and regions; in 2010 the perinatal mortality rate in the Netherlands had been decreased to 9/1000, which resulted in a middle position in the international ranking (Euro-Perinatstat 2013). But this improvement in the international ranking could not impede that these data undermined the general equanimity about natural birth and the trust in nature, both important pillars of the non-medicalized birth model. The basic assumptions of the Dutch birth model were challenged. The awaiting, conservative medical attitude concerning pregnancy and birth became defined as outmoded. In one of the Dutch newspapers a new anxiety was formulated by a gynecologist: ‘We should abandon the idea that everything will probably be all right’ (Volkskrant 03/07/10). Critical commentators pointed to the incomparability of the ratings, but that didn’t stop the public anxiety.

For obstetricians who plead more medicalization mortality rates are the benchmarks in an international competition, and the new perinatal mortality rates confirm their views. They encourage a discourse in which risk in general becomes the dominant sound, and they point to the risks of home birth. As more and more risks of pregnancy and birth are identified and are recognized as suitable for treatment, it has become more difficult to take for granted that the conventional home birth is safe.

In the media more preventive medicine is seen as one of the solutions. Both professionals and parents are considered to be inadequately instructed. Campaigns to heigthen their risk awareness and their level of vigilance are seen as ways to decrease the mortality rates. Professionals should be more alert during preconception, pregnancy and birth. Prenatal care should be more intense and more interventionist, with more medical tests, more ultrasounds and more measurements of the growth of the foetus;
the supervision of birth should be more alert and more 'medical'. Many of the proposed measures are routine procedures in neighboring countries. Parents-to-be should be better informed – about smoking and drinking alcohol, about growth delay of the foetus, about different illnesses, like e.g. Cytomegalovirus. They should know about the risk of having your baby in poor circumstances, in flats without escalators or without good sanitary equipment. They should know that 40% of the primiparae who start to give birth at home, will finally have their baby in a hospital. Such warnings do not dismiss home birth as such, and in case of normal pregnancy parents-to-be are still free to choose home birth, attended by a midwife. But the dominant undertones of the debate imply doubt, the 'Dutch model' is doubted, the prevailing knowledge about its risks is doubted, the responsibility of parents and professionals for the health of fetuses and infants is in question.

For midwives the degradation of the Dutch score in the international perinatal mortality ranking is the most problematic and threatening. In the 1950’s and 60’s midwifery in the Netherlands was characterized by growing professionalization: midwives’ qualifications were increased, standards for recruitment and training were made more rigorous, and their organization became more powerful. In other western countries they lost ground, but in the 1980’s their position in the Netherlands was supported by part of the obstetricians and by the state. One of the arguments was that their lower costs were attractive in a period of severe cuts in spending on health care.

But in the beginning of the 21st century midwives and obstetricians blame each other for the perinatal mortality rates and the sensationalist messages in the media forced especially midwives in a defensive position. Risk awareness among parents-to-be has stimulated medicalization and midwives refer more women to the obstetrician. The result is more hospitalization and more medical interventions. In the sixties professionalization was for midwives a way to act as a full fledged colleague of obstetricians. But as they try to further professionalize themselves their new tasks and new qualifications tend to overburden them, while they lose their specific competence as attendants in a normal birth situation. Today it is government policy to force midwives and obstetricians to work together. In this new system birth care will become the collective responsibility of the cooperating network, individual professional autonomy will become subordinate. In order to bring this about they are united in one network, the College Perinatale Zorg (CPZ), and they have to come to multidisciplinary agreements. This is threatening for midwives. They want to be competent colleagues of the obstetricians, but in working together in this new organization they are afraid to lose their autonomy. Up to now midwives and obstetricians didn't succeed to reach agreements about their future team work.
5. What about the future?

Changes in risk perception and trust relations

The Dutch model still exists, but the setting and the relationships between parents, midwives and obstetricians have changed. The family has become more open. Mothers have become more equal to fathers as regards the division of labor: mothers participate on the labor market, fathers also have caring tasks. The level of education of the Dutch population has risen, which made parents more knowledgeable and better equipped to inform themselves. These changes went together with processes of globalization and further internationalization. In the field of birth, that implied further medicalization, a strengthening of the position of obstetricians, and a weakening of that of midwives.

These developments influenced the perceptions of risk and changed the traditional relations of trust between mothers and the different professionals. Risk perception and belief in the reliability of the existing birth arrangements are shaped and reshaped in relations and interactions. Both phenomena are relational and are historically rooted. Risks are defined in contact with other people, trust is a building stone in the network of relations. People’s awareness and appreciation of dangers, their expectations of a situation and their confidence in a good outcome are not so much the products of rational calculation, but the result of exchanges with people around them. Hazards and safety are always about social relations and about the thinking and feeling of people.

During the last two decades in the Netherlands awareness of the risks of birth has grown. International medical competition has contributed to this new framing, just like negative media attention, and the rise of new screening techniques. These sources of anxiety undermine the trust in a ‘natural birth’. In earlier times parents, midwives and obstetricians gave an interpretation of the situation during pregnancy and birth, starting intuitively from what they knew and did not know. Of course there were insecurities, but it was easier to reach confidence and to overcome the doubts which are implicit in this dynamic mixture between knowledge and ignorance. It was easier to suspend their anxieties temporarily and to make the mental leap from their often intuitive interpretations into expectations for-the-time-being (Möllering on Georg Simmel 2001). Interactional routines and associated expectations around normal pregnancy and birth pointed in the Netherlands self-evidently into the direction of confidence in home birth and attendance by midwives.

More medical possibilities and a growing risk consciousness made that leap however more difficult. Georg Simmel sees this mental leap between interpretations (‘good reasons’) and expectations as a kind of mysterious element, a kind of faith that requires separate attention in research (Möllering 2001: 414). In the case of birth changes interactions between parents, midwives and professionals during pregnancy and birth
in reaching confidence should be researched, confidence in themselves and each other, in place of delivery, in lifestyle. When are they willing to suspend the unknown and to make a mental leap into the direction of temporary trust? How do they decide for one of the options – e.g. for midwives and homebirth, for midwives and policlínica births, for obstetricians and hospital births, for medical interventions? Which role does serendipity play in their final decisions? How do they make the mental leap from not-being sure to acting? Narratives about pregnancy and birth, about the course of the delivery, told by mothers-to-be and by professionals could tell us more about the roles parents, midwives and obstetricians played, about their considerations and their feelings. That could give starting points to unravel the difficult relations between them, to research the problems and to search for solutions in order to keep the Dutch model up to date but intact. How to guarantee its continuity, with its unique combination of normal birth by midwives, at home or policlínica, and hospital birth by obstetricians? How to realize that midwives and obstetricians cooperate, integrated in one system, while keeping their autonomy and their specific expertise? How to keep the Dutch model successful? That’s the question.


Plantenga, Janneke 1993, Een afwijkend patroon: honderd jaar vrouwenarbeid in Nederland en (West-) Duitsland. Amsterdam: SUA.


(本稿は、2012年3月26日に奈良女子大学で行われた講演をもとに加筆・修正したものである。講演は、科研基盤(B)「アジアにおけるリプロダクションの歴史的変遷—医療化の要因と女性への影響」(代表 松岡悦子)による。)