Home birth care in the eyes of Indonesian women in Amsterdam, the Netherlands

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Summary

This research paper is about home birthing in the eyes of Indonesian women who live in Amsterdam, the Netherlands. The fact is giving birth at home is a choice of delivery, many Indonesian women never really thought of before, because in Indonesia, most women prefer delivering in a hospital. It then struck me to ask the question of how Indonesian women feel – keeping in mind that they have grown up with the values and advantages that they had received and had expected when delivering in a hospital - when they move to the Netherlands and the expectation is that a woman should give birth at home. Thus, Indonesian women have a different perspective on safety when it comes to comparing a hospital birth to a home birth. Based on this fact, then how do Indonesian women in the Netherlands make their decision on where to give birth in a country where home births are preferred?

Therefore, the aim of this research is to share the insight and perception of Indonesian women who live in Amsterdam, the Netherlands, regarding home birthing care. Specifically, this research will describe the experiences of Indonesian women who received services from midwives and gynecologists, as well as their meaning of childbirth, the experiences they had with home birthing care, the considerations they took into account in choosing a safe place for delivery and the economic influences upon them. All discussions will be explored using the authoritative knowledge concept by Brigitte Jordan, the technocratic imperative by Davis-Floyd, as well as ownership and perception of comfort and familiarity.

This research was an ethnographic, explorative, and descriptive study which was conducted in Amsterdam, as it is the capital of the Netherlands as well as the largest city in the Netherlands, with approximately 1.5 million people and approximately 173 nationalities in the greater Amsterdam area (Maps of the World 2006). Since Indonesia is a former Dutch colony, 2.4% of the Dutch population is identified as Indonesian (CIA World Factbook 2010) and a substantial number of this population resides in Amsterdam. I used maximum variation sampling and snowball sampling in this research paper, I also used guidelines with standardized open-ended questions for all my data collection techniques. I conducted in-depth interviews with fourteen Indonesian women, three husbands out of the Indonesian women I interviewed, four midwives, and also a gynecologist and a midwife assistant. I also conducted an interview with a newly married couple, who had been married for only two years at the time. I had observed
immunization services given to newborns twice during the course of my research. I succeeded in having the experience of accompanying a woman during her pregnancy check up at a hospital. Then, I triangulated my research findings as a way to maintain the validity of the data. All findings were organized, coded, labeled, categorized (using QSR Nvivo version 2.0 as my tool) for qualitative analysis. Regarding ethical considerations, I used verbal consent; I had explained to all of my informants that their participation was voluntary, that all names would be anonymous (using fictitious names), and that all information would be confidential.

Being a pregnant Indonesian woman in the Netherlands is more about the impact of the professional quality experienced, such as being respected and being made to feel special, as well as being appreciated. Being a pregnant woman is something special in the context of being in Amsterdam. Pregnant women also have the right to be understood, as they have a different condition which has to be treated specially. Pregnant women have rights which are reflected from government regulations that are applied in their offices and in the public areas surrounding Amsterdam. The fact is, pregnancies are full of exiting experiences and remarkable and joyful feelings that only add to the quality of the midwifery service, the social environment, and the supportive government regulations, which make for a dream combination for the pregnant woman.

Indeed, the meaning of childbirth for Indonesian women is socially constructed within the community in which they live. Even though some live for years in the Netherlands, they still see childbirth similarly to how they always have. Childbirth is an incredible event that is full of pain and can be especially unpredictable, which can put women at risk. Indeed, childbirth is also thick with spiritual values from both Islam and Christianity, which the husband of one of my informants made a relation between spiritualism and materialism, which actually for him was a critique for the way Indonesian women now see childbirth. Whereas, the meaning of “natural” is a little bit different from how a midwife defines “natural”. I argue in the light of authoritative knowledge, by Brigitte Jordan (1997); all these meanings are social constructions dependent on which part of society has the authority to define what “natural” means, whether it is secure or not. Even when childbirth is natural, indeed, naturalness is still a social construction. At the end of the day, authoritative knowledge is not about which knowledge is correct, but more about which knowledge is accepted within society (Jordan 1997:58). However, Indonesian women
accept which knowledge of childbirth is best for them, which influences the way they decide what is best for their delivery and what is the best place for their delivery. Therefore, some of my informants delivered at home, while others delivered in hospitals.

Based on three Indonesian women (Kelana, Fatimah, and Maria), I explored their experiences in home birthing, most however did agree that safety and health were the most important aspects of delivery and that hospitals were thought to provide the safest environment for child birth. Fatimah, for example, would only want a home delivery if there were to be a hospital nearby; Maria, on the other hand wanted her next child to be born in a hospital even though her home delivery went well. Women seem to get the greatest fulfillment out of “owning” their delivery process, such as Fatimah’s successful story of thorough preparations and of remaining in full control of the process – even more in control than the midwife, because she had pain-relief methods that the midwife had never heard of. “Ownership” of the delivery process however can quickly change, Kelana who the one, lost ownership when she had complications and had to be transferred to a hospital, and Maria lost ownership when she had to deliver at home. Therefore, “authoritative knowledge” in these stories of child birth in the Netherlands, are fully in hands of the midwives; they decide when women should be transferred to a hospital and when women can stay at home, such as in Maria’s case, who actually really wanted a hospital delivery. This is why Maria plans to exaggerate her condition next time.

My Indonesian informants followed the general “medicalization” trajectory, which is that the construction of childbirth is a risky event that needs medical attention (Jordan’s authoritative knowledge 1997); which is supported by the “technocratic imperative” idea, which follows that a body has its limitations and needs technological intervention during delivery (Davis-Floyd 1994). This adherence to the medicalization trajectory only increases because of the stories that are circulated about actual risky situations that occurred during home delivery (such as in Kelana’s story). The overall perception thus is that hospital deliveries are perceived to be safer than home deliveries.

Between the ownership of childbirth and the perception of feeling secure among Indonesian women, my informants believed that safety was more important than the idea of ownership. Child birth was perceived to be a risky event that needed the intervention of technology, so therefore providing more to be considered in the medicalization of childbirth.
Even though women feel less empowered during hospital deliveries, they prefer hospitals as a place to give birth.

Within the perception of comfort and familiarity, most of my informants agreed that home births were more familiar, relaxing, and flexible. Indeed, these qualities made them feel comfortable, and made them even consider the home as a place of delivery, one that can even be fulfilling. Kelana eventually chose to give birth at home because it felt more comfortable for her. However, for those who went through traumatic experiences in hospital birth, such as Sarah and Helena, they thought of delivering at home for their next pregnancy, if it were to be healthy and normal. Yet, some still more strongly considered delivering in a hospital, even though they knew it would be uncomfortable, but in their perception, being alive was more important than their level of comfort.

Economic reasons did not seem to be a problem for most of my Indonesian informants, or at least they did not see it as a problem or as something that they needed to strongly consider. One of my informants gave me an illustration of the advantages of insurance; they did not believe that it was necessary to pay for all the services from antenatal care until post partum care. For them, being alive was more important than money.

All of these findings lead me to the thought that if the disadvantages of home birthing was often promoted among Indonesian women, or particularly in my informants’ community, then it would be logical that they would believe strongly in supporting the medicalization of childbirth through the development of technology as a way to eliminate risk. So, the authoritative knowledge with regards to childbirth among Indonesian women was mainly from their peers and those within their Indonesian networks. The medicalization trend and technocratic imperative was already quite prevalent, but the circulation of certain scary stories about risky home deliveries in women’s networks strengthened my informants’ conviction that hospital births are preferred and home births are unpopular.

In conclusion, the perception of safety is more important than everything else, which falls in line with medicalization, and in line with the technocratic imperative. The “authority” in the perception of safety lies with the peer group. “Authority”, with regards to actual safety, usually lies with the midwife and/or the gynecologist – as they have the power to send women to the
hospital whether they want to or not, or they can send them home, etc. Yet, women retain some form of “ownership” by making sure they will deliver in a hospital (by exaggerating their complaints, etc).

In the end, authoritative knowledge, by Brigitte Jordan (1997), gave me the enlightened thought that one of the two choice is best for childbirth, and that it lies between medicalization and anti-medicalization - all of which is a matter of who has the true “authority” and power to bring knowledge which is accepted and legitimized as correct, and is both safe and good for birthing within a particular community, wherever it may be.
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Chapter One

Introduction

Background of the Study

Traditionally, childbirth occurred at home assisted by a midwife and family relatives (Chacko 2009:429). However, since the medicalization of childbirth in the 20th century, there have been many women, especially in developing countries, who prefer giving birth in a hospital as opposed to home (Chacko 2009:429). In the United Kingdom, since the end of the 20th century, all childbirth occurs in a hospital (Shaw and Kitzinger 2005: 2375). One reason women prefer delivering in hospitals is the perception of safety (Thomasson and Treber 2004:6). Hospital births, however, also fit within a more global tendency focusing on prevention of maternal mortality, which has been translated into (national) medical policies (Shiffman 2003:1198).

Indonesia is an example of a developing country in which this medicalization of childbirth can be seen; websites propagate the safety of hospitals and women perceive hospitals and midwife clinics to be safer than homebirths (Parentsguide 2007). Indonesia still has a high maternal mortality ratio (MMR) (228/100,000 live births) (IDHS 2007:20) and maternal mortality incidents often occur during childbirth at home (Thind et al. 2004: 285). Therefore, it is not surprising that many Indonesian women would prefer to deliver in a hospital, since a relatively large number of women die during or after childbirth in their home country. I am an Indonesian woman as well; I believe that the hospital is the only place I would like to give birth. When I came to the Netherlands, I perceived that every woman in a developed country would deliver in an advanced and sophisticated hospital. Then, indeed, I was shocked when I knew a research performed by de Jonge in 2009 state that 61% of 500,000 women in the Netherlands planned a home birth rather than hospital birth (de Jonge, et al. 2009:1). The option of home as place of birth is never existed in my mind. Most Indonesians however would prefer that their delivery take place in a hospital setting. Hence, no wonder, Selasih, mother of an Indonesian woman who accidentally experienced a home birth, in Amsterdam, told me the following with sorrow in her eyes.
… you know… all of my children were born in hospital and helped by gynecologist… and it was around 80’s at that time … all of her sisters were also delivering in sophisticated hospital and with gynecologist as well … when I know Maria delivered in home … me and my husband were so worries and feel pity for both of them … I never expect that in the Netherlands which developed country … it has this kind of services such home birth and I am surprised as well to the fact that many Dutch women whom I sure they are very well educated do delivery their child in home … even in my age when I delivered my child … there were no home birth anymore … it was so long time ago … for me it is a dangerous if deliver at home and I am so glad knowing my daughter and my grand daughter are safe… (Selasih, 8th June 2010)

In fact, the Netherlands, despite being located where the medicalization of childbirth began, many women prefer to give birth at home for normal delivery or low risk pregnancy (Davis-Floyd and Sargent 1997:9; Wieger et al. 1998:1505). In contrast to Selasih’s story, Brigitte Jordan, an anthropologist who wrote Birth in Four Cultures noted her amazement of the Dutch childbirth phenomenon as below:

To imagine that there is exists an industrialized country with all the resources of modern medicine, of pharmacology, technology, and surgery, whose professional subscribe to a scientific view of the world and whose citizens have a standard of living that easily puts at their disposal all the resources of technologies obstetrics, that there is such a country and that its women and care provider actively espouse a non-interventionist stance in childbirth. [Jordan 1996:ix]

Women in the Netherlands perceive childbirth as a natural event as they see their womb naturally works to deliver a baby (Van der Mark 1996:1). Childbirth also reinforces family values. The more natural the birthing process, with less medical intervention, the more pride Dutch woman receive from their society (Van der Mark 1996:4). These views of childbirth encourage many women in the Netherlands to prefer home birth, which is seen to be more
natural than a hospital birth. Therefore, the number of home births in the Netherlands is still high with a low rate of medical intervention (Wieger et al. 1998:1505).

Hence, I conducted this ethnographical research in order to fulfill my own curiosity, also as Indonesian woman. I wanted to answer the question of how Indonesian women who have grown up with the values and advantages that they expect in regard to delivering their babies in a hospital, move to the Netherlands where the expectation is that a woman will give birth at home. Thus, Indonesian women in Amsterdam, the Netherlands, face a different safe childbirth perspective considering a hospital or home as place of birth. Based on this fact, then, how do Indonesian women in the Netherlands make their decision on where to give birth in a country where home births are preferred?

Research question

- How do Indonesian women who have delivered in the Netherlands perceive and experience home birth care in Amsterdam, the Netherlands?

Sub research questions:

- How do Indonesian women experience pregnancy services in Amsterdam? How are their experiences influenced by their perceptions of home as place for birth?
- What is the meaning of a childbirth event for Indonesian women in Amsterdam? Is this meaning the same for a home birth?
- Does a home birth fulfill Indonesian women expectation of safe childbirth?
- How do the women experience the Dutch home delivery system, which is different from their Indonesian perception of an appropriate place of delivery?
- What are their perceptions and attitudes toward a home delivery system?
- What influences the decision for Indonesian women to choose a hospital or home birth?
Chapter Two

Literature Review

The Dutch system of Midwifery

The Dutch system of Midwifery is known to be unique in the Western world because of the predominance of midwife-attended births, the high number of home births and less medical intervention during childbirth (Chowdhury 2003:7). Home birth is a reflection of natural nature of childbirth, which is congruent with the perception that pregnancy and delivery are a natural process. Moreover, the basic Dutch assumption is that it is natural for a woman’s body to do the work of pregnancy and childbirth (Van der Mark 1997:1). One of midwives I interviewed said that it is important to make a woman feel powerful and relaxed during childbirth so that she feels as if she is the owner of her own childbirth and feeling relaxed can stimulate the body to produce the hormone endorphin which helps reduce pain during childbirth. Moreover, childbirth is a valuable experience and gives a sense of pride and satisfaction to the woman if she can manage her own childbirth it creates an optimal relationship between she and her baby (Van der Mark 1997:4).

The high number of home births in the Netherlands is due to the decision in 1941 by Ziekenfondsen, the system of Dutch national health insurance that cover 65% of the population, to give midwives a monopoly for normal obstetrics. This monopoly implies that for a normal home birth, the insurance pays for the services of a midwife, which includes all prenatal and postnatal care. Initially hospitalization costs were covered only where there was some suspicion or evidence problem. However, since the 1980s, Ziekenfondsen (National Health Insurance) started to cover woman who prefer to access a 24-hour or short-stay hospital delivery as opposed to a home birth (Van der Mark 1997:5). Moreover, women who have private insurance can choose whether want to deliver at home or in a hospital, and can receive service from a midwife or a general practitioner.

However, in order to the decrease number of hospitalizations in 1973, the National Health Insurance system introduced a list of medical indications known as Klooterman list and the aim was to distinguish between a normal (physiological) and a complicated (pathological) delivery. Since then, this list has become a guideline for midwives and doctors to decide whether
a woman can deliver at home or in a hospital. Furthermore, the list was revised in 1987 and split into three categories: low risk (eligible for home birth), high risk (hospital birth) and medium risk. For medium risk, the midwife sends the woman to a gynecologist for consultation during pregnancy, at that point the midwife will decide to either keep the woman under her care or send her to gynecologist for the rest of her pregnancy (Van der Mark 1997:8-9).

The home birth care system in the Netherlands is based on an ideology that places a high value on motherhood and the home (Van der Mark 1997:13). However, the implementation of home birth has to be seen in the context of the Netherlands to understand why home birth is a safe place for birth in this developed country. As Treffers and Laan state in Van der Mark’s article (1997:12):

> It must be considered in the context of Dutch situation, including highly qualified midwives, good prenatal and post natal care, maternity home-care assistants, a careful system for screening high-and low-risk pregnancies, the high density of hospitals, and the absence of isolated rural areas (if complication suddenly occur during a delivery at home, rapid transport to a nearby hospital is easy). [Van der Mark 1997:12]

**Medicalization and anti-medicalization of childbirth**

“The birth process is a universal part of human female physiology and biology, but, in recent decades anthropologists have come to understand that birth is almost never simply a biological act” (Davis-Floyd, et al. 1997:1). Across cultures, childbirth has different meanings for women in every society. Some women in the Netherlands view childbirth as a natural event and believe that the womb has a natural function for giving birth (Van der Mark 1996:4). Whereas, some women in other societies view childbirth as an event that could expose a woman and her baby to risk; therefore, as a risk prevention and protection some societies believe that childbirth needs to be controlled through medical intervention. Indeed, according to “authoritative knowledge”, a concept created by Brigitte Jordan, the meaning of childbirth was socially constructed and maintained by medical authority to give the perception that childbirth was an event that needed medical intervention (Rapp 1997: xi). Medical intervention was considered to belong in a hospital rather than a home. Thus, if looking at these disparate meanings of childbirth using the
concept of “authoritative knowledge”, then, natural or not natural, both meanings are socially constructed whether by the health provider or others within a society.

Various perceptions of childbirth are congruent with how childbirth itself is treated and relate to the perception of the best place for giving birth. I will show that some studies on childbirth issues include exploring how the meaning of childbirth perception of safety are embedded in women in society and influence them in their decision about who will be their delivery assistant and where they will give birth. Later, these findings from several studies will lead to the issue of medicalization and anti medicalization in childbirth. Medicalization is defined as below:

Medicalization consists of defining a problem in medical terms, using medical language to describe a problem, adopting a medical framework to understand a problem, or using a medical intervention to “treat” it. [Conrad 1992:211]

Childbirth as a natural process within human life become medicalized since childbirth perceived as risky event by medical authority so that all that attach with childbirth will view in medical lens and of course will be treated using medical intervention (Conrad 1992:213). The perception of women in societies where childbirth is seen as a dangerous event that needs specific medical intervention to ensure a safe childbirth, leads to the medicalization of childbirth. I think that many societies—also those in which the medical system is not very developed—childbirth is viewed as something risky. I explore findings from several research studies which give insight on why some women or societies, whether in developed or developing countries, prefer a hospital birth rather than a home birth, or in the other words, reflect an attitude of pro-medicalization of childbirth. Whereas, not all studies agree with the medicalization of childbirth for several issues, some studies consider the theme from an anti-medicalization viewpoint, as evidenced by women’s empowerment or women giving birth being perceived as a human being not as a machine who produce a baby. More studies show that women’s preferences for natural birth are reflected by a home birth and these studies also criticize the medicalization of childbirth. Moreover, the Netherlands with home birth care may be seen as an example of an anti-medicalization view on childbirth. However, Conrad (1992:225) states that childbirth is still
defined as a medical event because medical personnel still attend it. Hence, home birth in the Netherlands is still viewed as medicalized because there are medical personnel assisting the delivery process and medical intervention although it is rare.

**Authoritative knowledge and technocratic imperative**

Davis-Floyd (1994:7) introduced the concept of technocratic imperative; the idea that a human body has limitations so it needs technology in order to control and achieve the ability of body. Because a women’s body has a limitation to counter complications that could arise during childbirth then this causes the woman and baby to be at risk. Therefore, there is a need for medical intervention through technology to make childbirth more predictable, controllable and safer than before (Davis-Floyd 1994:6). Due to this childbirth technology, such as the discovery of anesthesia to reduce, or even eliminate pain during the childbirth process, many women in the United States, India and Germany no longer give birth at home and move to a hospital for normal delivery (Thommason and Treber 2004:14; Donner 2003:335; Davis-Floyd 1997:9). Women in Calcutta, India, prefer to have a caesarean section for normal delivery in a hospital because it causes less pain (Donner 2003:335). Moreover, a hospital as place where medicalization originates, becomes a symbol of advanced and modern delivery which can increase women’s prestige within society because it reflects a wealthy status such as in Calcutta, India (Jordan 1996:x; Donner 2003:334). Hence, the technocratic imperative that results in less pain for women and an elevation in prestige enhances the ‘medicalization of childbirth’.

A research study in United State from the 1980s to the 1990s of 100 women showed that 75% women desired or relatively content with highly technological birth experience (Davis-Floyd 2008:37). Moreover, the government in the United States gives women the right to receive epidurals and use fetal monitors in order to ensure that every woman uses their choice and agency to reinforce biomedical hegemony and thus the increasing technologization of birth (Davis-Floyd 2008 :37). Hence, the technocratic imperative in childbirth, which promotes the idea that childbirth can be less painful and safer than before, seems to be a miracle that fulfills the need for women who live in dread of the pain of the natural process of birth and who want to gain prestige in their society. In the end, the technocratic imperative strengthens the
medicalization of childbirth and the hospital becomes the most desirable place of delivery for many women in developed and developing countries, including Indonesia.

However, Davis Floyd’s concept of technocratic imperative is actually a critique of the medicalization of childbirth. She tries to explain how women can be so afraid of feeling pain and feel so situated in a dangerous position when delivering that they begin to think that technology is a solution for a safer delivery. In this case, the medicalization of childbirth seems logical and reasonable, both for the health provider and for women.

There is another critique that arises about humanizing birth. The idea that a birthing woman is a human being who we should respect, her body is not a machine that can produce a baby. Respecting a women as a valuable human being and women experiencing giving birth as fulfilling and empowering can make women strong and create a strong society as well (Wagner 2001: 25). Unfortunately, this technology makes many women become dependent and not feel confident or safe unless there is medical intervention in their childbirth process. I argue that there is an unconscious situation within a birthing woman that slowly causes them to entrust their lives to technology and consequently, they do not trust their own ability to have a successful delivery. Successful delivery is based on how sophisticated and modern the technology is that women use in their childbirth process. Thus, women in the delivery process become an object of technology rather than the subject of their own childbirth.

However, the medicalization of childbirth does not always make women choose a hospital birth as women in the Netherlands exemplify. Many Dutch women have their babies spontaneously, without anesthesia and this is related to the perspective of Calvinistic views of giving birth to children in sorrow. Physical pain during childbirth is all caused by emotions, and these emotions cannot be eliminated by anesthesia (van Daalen and van Goor 1996:194-195). Therefore, many Dutch women prefer home birth for a delivery process that is more natural and has less medical intervention.

The authoritative knowledge concept, introduced by Brigitte Jordan in her book Birth in Four Cultures (Rapp 1997:xi), suggests that all medical intervention in childbirth reflects how the meaning of childbirth was constructed by medical authorities as a risk event so that medical intervention would be required as the best way to safeguard women and their babies during childbirth. Medical authorities, such as doctors, are considered as the a dominant profession that
in the Dutch home birth context the midwife has autonomy from the medical profession that has increased throughout the years and most recently in 1987 where midwife has power to define normal and abnormal birth (Jordan 1996:ix). Based on the way a midwife sees a pregnancy as a normal or abnormal birth, leads to a decision about where a mother will deliver whether in the home or a hospital (Chowdhury 2003:7). Hence, natural birth by home birth in the Netherlands, actually, is a reflection of the authoritative power of midwife. The predominance of the midwife is one of unique characteristics of the Netherlands obstetric care.

However, the medicalization of childbirth does not always make women choose a hospital birth as women in the Netherlands exemplify. Many Dutch women have their babies spontaneously, without anesthesia and this is related to the perspective of Calvinistic views of giving birth to children in sorrow. Physical pain during childbirth is all caused by emotions, and these emotions cannot eliminate by anesthesia (van Daalen and van Goor 1996:194-195). Therefore, many Dutch women prefer home birth for a delivery process that is more natural and has less medical intervention.

Indeed, medical intervention can cause many women, in developed and developing countries, including Indonesia, to move to a hospital birth because of the way they perceive a safe childbirth and for reasons of having a painless childbirth through anesthesia and caesarean section. However, this does not apply to Dutch women who prefer to keep the birthing process natural and physical pain is part of it. In the end, the choice of a place of to give birth is based on authoritative knowledge in how the meaning of childbirth is constructed within a society, whether by medical authority or society itself. This meaning will lead to a decision, which will be the delivery attendant, whether it includes the use of technology or not and where the delivery is performed.

“Ownership” in the delivery process: medical authorities or women themselves

One important issue is, who will be the center of attention for a successful delivery—the midwife, gynecologist or the woman herself. Childbirth as a natural event depends on how a mother manages herself during the delivery process and makes her own effort to push the baby out from her womb, using the midwife only as a facilitator. Meanwhile, if the delivery process is
helped by a doctor and medical equipment (e.g., caesarian operation) then the childbirth process depends on the skill of the doctor and sophisticated technology. Therefore, a successful delivery will belong to the doctor rather than the mother because the doctor appears to have made more effort to make the birth successful than the mother did.

Jordan (in Donner 2003:315) raises a fundamental question about the place of birth given the effect of the distribution of decision making power and the power of women to control the entire reproductive process during childbirth. In home birth, in England, for instance, women have greater control over all the processes of delivery. The woman has the power to control and manage every single thing that she wants in order to support her delivery process (Shaw and Kitzinger 2005:2376). In a hospital birth, the couple has little power to control environment of the labor room and they became a powerless (Chacko 2009:232; Walton 2009:6). In regard to a humanized birth, women who give birth are supposed to have power to control everything in childbirth situation, not a doctor or midwife (Wagner 2001:25).

Here, there is an ownership issue in terms of who will be a center of attention in a successful delivery and a woman’s empowerment to control their own childbirth is experienced differently in a home birth compared to a hospital birth. For women who really desire the autonomy of their own body during childbirth then a home birth seems to be the right place for delivery. This is one of reasons that Dutch women choose home births, to have full control of their body during childbirth (Rothman 1996:203). Moreover, a woman will view her successful delivery as an optimal relationship between her and her baby (Van der Mark 1996:4).

Women are empowered in the sense that they use their power in their own childbirth process in order to control everything and this reflects on the way they perceive a successful delivery. Let a woman decide what is best for her as long as she and her baby are not placed in a dangerous situation. Successful deliveries belong to women because they are the ones who are in charge and a doctor or midwife are just facilitators. In this situation a woman feels confident and as if she is the leader of herself thus the childbirth event will be meaningful for both the mother and the baby. These empowerment factors can influence a woman to deliver at home or in a hospital. In fact, perhaps for women who decide to deliver in a hospital, where it is known that they will feel powerless; this factor should not be considered as the most important in deciding the best place for giving birth.
Perception of comfort and familiarity

In the United States and the United Kingdom, hospitals focus on customer-service that offers women a more comfortable situation and gives assistance to women that they might not receive if they deliver at home. In England and India, within a hospital birth service, women are assisted by trained nurses and can stay for several days during the recovery period after childbirth meaning that the women are released from all household duties (Shaw and Kitzinger 2005: 2375; Donner 2003:335). Beside, there are also some women who choose a home birth in England and thus, with reason, feel more comfortable at home because they are familiar with their own environment and feel more peaceful during the childbirth process (Shaw and Kitzinger 2005:2376; Walton 2009:5).

Meanwhile, in Indonesia, the possibility to be released from household duties during post partum care is also a reason that Indonesian women give birth in a hospital; otherwise, commonly, if a woman delivers at home, she will still have to do household duties although she may not have completely recovered from childbirth (Martha et al, 2006:5). Moreover, based on my experiences when I visited a woman relative who delivered in one of hospital in Jakarta, the capital city of Indonesia, she stayed in a single room. She looked really happy staying in the hospital, because if she needed anything she just called the nurse by pressing the bottom beside her bed, she could watching TV while receiving a visitor, and her family could stay inside the room until night. When I saw her, she looked like she was staying in a hotel room with hotel services rather than in a hospital. Indeed, it was comfortable and relaxing. It is also could performs family event in hospital.

In the Netherlands, some women feel more comfortable at home because they are familiar with their own environment and feel more peaceful during the childbirth process. The others reason Dutch women deliver at home is to be surrounded by all their families’ members during childbirth in order to give psychological support and other help to ensure they are comfortable and confident when delivering their baby (van Daalen 1996:81).

Home birth care in the Netherlands includes a service from a maternity home care assistant, called kraamverzorgende, who helps the midwife during childbirth and post partum care, but is supervised by the midwife (Van der Mark 1996:5). The home care assistant takes care of the mother and the baby for several days after the delivery period and the assistant also
helps with all necessary household tasks (Van der Mark 1996:5). The home care assistant teaches the mother how to care for her baby including: breastfeeding, how to bath a baby, etc. Through this service a mother feels emotionally close with her baby and will quickly increase her confidence of being a mother because of the intense relationship (Van der Mark 1996:5). The service by kraamverzorgende is one of unique aspects of the obstetric care of home birth in the Netherlands (van Teijlingen 1996:161-162). This factor might influence women to give birth at home because they feel familiar in their own house and they receive help from an assistant home care professional during the recovery period that make them comfortable.

**Conclusion**

In the light of authoritative knowledge concept, childbirth defined as a natural or a risky event depends on how this perspective is socially constructed either by a medical authority or others within society. Indonesian women, who come from a country that prefers hospital birth, perceive childbirth as a risky event so that need for medical intervention is a safeguard. This perspective is in agreement with the technocratic imperative concept that technology is invented to make childbirth more controllable, predictable and safer than before. This technology in childbirth makes medicalization looks like a miracle in fulfilling the need of women who dread the pain of a natural childbirth and are immersed in the perception of danger surrounding childbirth. This technology will make women feel more dependent toward and slowly entrusting their life to technology.

Women and medical authorities in the Netherlands seem to perceive childbirth as a natural event; they perceived that womb works naturally for giving birth. A childbirth event gives autonomy of women body itself. In the concept of natural childbirth, there is no need for technology to eliminate all painful feelings because pain is part of the nature of birth. Pain makes a childbirth event more valuable and the baby will be more priceless to the family. However, home birth in the Netherlands is not fully free from medicalized values, as long as a delivery assisted by midwife or gynecologist or general practitioner, then it is still a medicalized childbirth.

Being empowered through childbirth is also an issue that arises in deciding place of birth. Home birth looks to be a better fit for those women who want to have autonomy of their body
and have power in managing their own childbirth situation and condition. Whereas, a hospital birth appears to make women become more powerless. This empowerment issues leads to the center of a successful delivery that should belong to the women. Yet, maybe this factor is not so important in influencing Indonesian women when choose place of birth.

In the end, I show my exploration surrounding home birth care in the Netherlands based from findings from Indonesian women in Amsterdam using four concepts: authoritative knowledge, technocratic imperative, ownership and perception of comfort and familiarity. This ethnography research brings me to the window of the anthropology of childbirth from Indonesian women eyes. As Davis-Floyd said in her article

“Birth ethnographers only really know what the women they study show and tell them. It is our job to specify, contextualize, and render meaningful the choices these women make in all their diversity, so that we can tell the world what women know” [Davis-Floyd 2008:38]
Chapter Three

Research Methodology

Study type

This research was an ethnographic, explorative and descriptive study. I focused on exploring the perception and insight of Indonesian women in Amsterdam on the subject of home birth care system and how they perceived home birth care as influenced by their original perception, beliefs, social relation, education and other factors. This exploration guided me to display a descriptive picture of Indonesian women’s notion of childbirth and home birth care in the Amsterdam context.

Study location

This research was conducted in Amsterdam, as it is the capital of the Netherlands and the largest city in the Netherlands, with approximately 1.5 million people and approximately 173 nationalities in the greater Amsterdam area (Maps of the World 2006). Since Indonesia is a former Dutch colony, 2.4% of the Dutch population is identified as Indonesian (CIA World Factbook 2010) and a substantial number of this population resides in Amsterdam. Secondly, I had an access to Indonesians in a mosque, located in west Amsterdam. That access helped me in building rapport with Indonesian women of the mosque since they already knew me.

Sampling method

I used maximum variation sampling and snowball sampling in this research. Maximum variation sampling was my way of obtaining informants with a variety of characteristics such as religion, age, number of children, duration of time living in Amsterdam and occupation. This maximum variation sampling gave general pictures rather than specific ones of Indonesian informants such as women, husbands, and key informants in Amsterdam. Since I knew only a few Indonesian people in Amsterdam, I used snowball sampling as my strategy to get an adequate number of informants and to reach my research goal. I built a network with several gatekeepers in the
Indonesian community so that I could included informants with various characteristics and have multiple entrance points for access to Amsterdam’s Indonesian society.

**Gaining access**

Through Indonesian Muslim women society at the mosque, I got access and applied snowballing technique to get my informants such woman, husband, new married couple and *kraamzorg* (midwife assistant). Besides this access, I did manage to link to a friend of my friend who introduced me to the Indonesian society of Amsterdam of the mosque. Some of the members of the mosque are non-Muslim so I used these relationships as my second option to gain access to Indonesian women who are not Muslim and live in Amsterdam. The number of informants I needed was still insufficient. Therefore, my weekly activities at the mosque were useful in identifying additional informants; again, I used snowballing technique. Moreover, a non-Muslim friend linked me to new informant, from whom I got information about home birth from the perspective of a non-Muslim Indonesian. To have midwives as informants, my lecturer and supervisors connected me to midwives in Amsterdam. AMMA alumni facilitated my finding a gynecologist. An additional, I got two midwives by going directly to meet them at their hospital.

**Data collection technique**

“I want to understand the world from your point of view ... I want to understand the meaning of your experience, to walk in your shoes, to feel the things as you feel them, to explain things as you explain them, will you become my teacher to help me understand?”

(Spradley in Ulin, et al. 2002:80)

I considered my informants as teachers to explain their world to me. Though, I am Indonesian, I would not have the same perceptions of childbirth care as Indonesian women who have lived for years in Amsterdam. Therefore, I conducted in-depth interview, couple interview and participant observation with local Indonesian women (and in some cases, interviewed a husband too). I applied the techniques in order to capture a comprehensive answer for my research question.
I used guidelines with standardized open-ended questions for all data collection techniques. The guideline helped keep each interview on topic and congruent with the research purpose. All guidelines for in-depth interviews, interviews with couples and observations are displayed in Annex 1. Furthermore, I used a tape recorder to record conversations in order to prevent missing information because of faulty memory. I addressed ethical considerations before I used the tape recorder by asking permission and assuring anonymity of the informants.

In-depth interviews
Information from in in-depth interviews reflects thoughtful meaning from an interviewee about something they exchange with a researcher (Ulin, et al 2002:46-48). In-depth interview was my main technique for collecting information. I interviewed several Indonesian women as my main informants and key informants such midwives, gynecologist and assistant midwife.

I did in-depth interview with fourteen Indonesian women. Their ages ranged from 24 to 51 years old, and all were highly educated. By religion, 11 were Muslim, 2 Protestant, and 1 Catholic. Some of these women were married to non-Indonesian men, like a Dutch or Moroccan man. The duration of living in the Netherlands also ranged from 1 to 30 years. The number of offspring varied from 1 to 4, with delivery experiences in both home and hospital settings. Three women had had a home birth experience, three women planned for home birth and ended up at a hospital, and eight women opted for a hospital birth experience. Detail characteristics of the women informants is in Annex 2.

Furthermore, during in-depth interviews, I asked the women if they were willing to show me the documentation of their childbirth process, whether video or photograph. These videos or photos helped me to understand and gain insight about the information that they provided during interview. In addition, I employed these videos or photos to see and probe for information about how the women perceived home birth care through their own experiences. This technique was a way to remind the women again about their own experiences in childbirth process, especially for those who’s experience was a long time ago.

Furthermore, I included husbands as informants for the in-depth interviews; three Indonesian husband participated. Two of them were nurses who worked at a geriatric unit in a hospital; the other was a PhD student. The length of their stay in the Netherlands ranged from 4
to 9 years. From husbands informants, I searched for information on the decision making process within an Indonesian family and the most significant factors that influenced their decision on the place of birth, and their opinions about home birth care from a male perspective.

Furthermore, as a way to capture a complete picture in this research, I performed in-depth interviews with several key informants: 4 midwives, 1 gynecologist and 1 midwife assistant. All these key informants brought a unique view of home birth care in the Netherlands especially in Amsterdam context. Characteristics of these three sources were diverged. From the midwife group, I had four midwives as my source of information: three midwives were independent midwives in Amsterdam; the other one was a hospital midwife. I met a gynecologist, from AMMA contact, who was also the head of gynecology unit at hospital in Amsterdam. The midwife assistant I met was Indonesian. She had lived in the Netherlands for 33 years. She had been a midwife assistant by profession for 11 years.

**Interview couple**

I conducted one interview couple as a way to receive data of rich detail on the experiences and reasons behind of the spouse practices, perceptions and attitudes toward home delivery care and childbirth (Carey 1994: 226). This couple is new married couple. They had only been married for two years. I searched for information on the decision making process for an Indonesian family and the most significant factors that influenced their decision on the place of birth and I explored information and perception about home birth and any support they received from people surrounding them (family, friend, neighbor, colleagues, etc). The information from this activity enriches data from in-depth interviews and I used it as part of triangulation analysis in order to maintain validity of data. Detail characteristic of this couple in annexes.

**Participant observation**

I did participant observation in several activities. I observed immunization services given to newborns two times. By having this observation, I broaden my knowledge of the midwifery system in the Netherlands and was able to witness maternal care given by a midwife. I also observed how the service mechanism ran and how the women would feel in receiving such services and attention from the midwife.
I succeeded in having experience of seeing a woman having a pregnancy checkup at a hospital. By having so, I could see the way gynecologist and midwife at a hospital treated the woman and how she reacted to his. This direct observation helped me to understand the mechanism and phases of services given to women having pregnancy check-ups at a hospital.

**Data analysis**
I did triangulate my research findings as a way to maintain validity of data. Instead of making full transcripts from the interviews, due to time limitations, I categorized general findings for most of the interviews. These were organized, coded, labeled, categorized using QSR Nvivo version 2.0 as my tool for qualitative analysis. This software helps in minimizing researcher subjectivity and allows attention to detail, both holistic and integral, from all data (Martha et al. 2009:7). Yet, my subjectivity was still a factor as I interpreted the data from my fieldwork. The analysis process was based on three basic elements: systematic, credibility and creativity (Gerrits 2010:2).

**Ethical consideration**
“All human research should begin with the informed consent of participants” (Ulin, et al 2002:61). I used informed consent as a reflection of respect for all informants who voluntarily participated in this research. Through verbal informed consent, I explained to all of my informants that their participation was voluntary, all names of informants were anonymous (anonymity), all information was confidential (confidentiality), and I asked permission to use tape recorder and turned it off when they objected and I acted honestly about the intended use of the research. All the aforementioned were ethical responsibility of this research.
Chapter Four

Being a pregnant Indonesian woman in the Netherlands: How does it feel?

Generally, my women informants say that pregnancy is a dream for every married woman, especially for Indonesian women. A married woman is required to get pregnant as soon as possible after her wedding, either by her own family or the husband’s family. This is because pregnancy is a symbol of fertility for both the husband and wife. Then they can continue their family line through biological child. The tension of attention is more on the woman’s side rather than the man’s side. Commonly, big families of couples will always ask the wife whether she is already showing signs of pregnancy or not. If the answer is still nothing then there will be social pressure which increases with time; the big families puts the woman into an inconvenient situation, up until stressful feelings escalate and the big families start to give the woman a negative label as an infertile woman. Therefore, pregnancy is most wished among married women because they will be release from all social pressures from their extended-families and it also gives them prestige as a fertile woman and as a good wife. As one of my informants said below:

Who isn’t happy to get pregnant? I have been married for two years, and my family and my husband’s family almost always ask me if there are signs of pregnancy or not in my body when I call them. So it feels like it is mandatory for me to get pregnant. Sometimes it feels stressfull, but I know it is good for my family so that there will be children who will take care of us when we are old. (Aisyah, 30th May 2010)

Furthermore, pregnancy is a symbol of God’s trust, whether in Islam or Christianity. If God believes that a couple has the ability to raise a child in a good way, then He will make the woman pregnant. Some of my women informants have said that God will not have trust or give a blessing in the form of a pregnancy to the couple who are careless in His eyes. Hence, pregnancy in a sense is a little human being inside the womb, and is a reflection of something God has entrusted to man, so the couple has a duty to maintain what God has entrusted as well as possible. Their effort in maintaining a healthy pregnancy is also a reflection of them being good servants for their God. Hence, it is no wonder why pregnant women are happy to be released
from their social requirements, such as being a wife, as I mentioned above, but they also clearly have a positive position in God’s eyes by Him giving them a pregnancy.

*Pregnancy means ALLAH (the name of God in Islam) has trust in parents who are raising a child; it also means that these parents have a better position alongside God than other parents. Children are entrusted from ALLAH to their parents, so we have to maintain this trust as best as possible.* (Bambang, 30th May 2010)

Therefore, becoming pregnant is a special happiness for a woman no matter where she is; especially for those who had to wait a long time to conceive a child. In fact, in Indonesia there is a celebration for women who are seven months pregnant. This celebration is a way to express their gratefulness to God and is an occasion to ask God to protect their pregnancy until the day of delivery. The celebration is joyful because there will be a child who will continue their family line. Thus, pregnancy brings a lot of happiness for Indonesian women.

As I mentioned before, pregnancy itself gives a feeling of happiness for Indonesian women wherever they are. Therefore, becoming pregnant in the Netherlands not only gives feelings of happiness but also of confusion at the same time. Women who have stayed in the Netherlands for short periods of time, such as one or two years, felt more confusion than Indonesian women who stayed for more than five years. For those who have stayed in the Netherlands while they were pregnant, and who did not yet understand the Dutch language, felt confused in understanding all the pregnancy guidelines, which were in the Dutch language and in terms of the midwifery system in the Netherlands. Whereas, informants who stays more than 5 years, they do not have a problem in this matter because they have ability Dutch language and getting used with Dutch terms. Hence, language could be a significant barrier or not, it depends on how long these women stayed in the Netherlands and how fluent they became in Dutch. Some of my informants, although they could not speak Dutch, had a sufficient enough English proficiency to consult with a midwife in English. Hence, for them, language was not a significant barrier. Yet, if they could have known Dutch, then communication between the midwife and the woman during the consultation would have more openness and clarity, or in other words, could prevent misunderstandings between one another, whether the pregnant woman, the midwife, or the gynecologist. But still, all the guideline books and brochures from
the midwife are in Dutch, so a pregnant woman would have to be an active person in searching for information regarding pregnancy through other sources, such as the internet, magazines, etc. Hence, most of the confusion experienced by Indonesian women that are pregnant in the Netherlands stems from a language barrier. This barrier is less inhibiting when the woman can speak English—even though a lot of information provided by the Dutch health care system is in Dutch—but it is a lot more difficult for women who do not speak Dutch and barely speak English.

For one of my informants, language became a significant barrier during her pregnancy. Her name is Aminah (a pseudonym), she stayed in the Netherlands for less than two years and was pregnant for her first year there. She came to accompany her husband who works as a nurse in Amsterdam. She had very limited English skills and did not understand the Dutch language at all. This language barrier made her feel neither free nor flexible when she wanted to ask questions surrounding her pregnancy or when wanting to express all of her feelings. She had to be accompanied by her husband, who could speak Dutch every time they checked in with a midwife. Her husband would translate what the midwife said and vice versa. Hence, most of the time, when she checked up on the progress of her pregnancy, she became more of a passive patient, or in the other words just a listener and a recipient. She became dependant upon her husband. Fortunately, her husband had an educational background in nursing from when he was in Indonesia, and so then he had some knowledge regarding pregnancy, from which he could draw from when asking the midwife questions which he transferred the information correctly to his wife. However, Aminah felt stressed because she had a heart disorder and she worried whether her condition could influence her baby or herself during the day of delivery. She could not talk about this condition freely to the midwife, even though the midwife already knew of her condition, but she could not share these worries which made her so stressed. Indeed, Aminah really felt uncomfortable with her condition and of feeling dependant and powerless. By the end, she decided to just follow what her husband said based upon what he understood from the midwife and so she resigned herself to God.

*I just followed the rules in the Netherlands based upon what my husband said to me. I couldn’t reply to what the midwife said even though I really wanted to ask certain questions or clarify some information. I felt sad but I didn’t have any choice because I*
lived there so I had to follow the rules and let Allah (God) do the rest. (Aminah, 3rd May 2010)

Beside language issues, the other problem is confusing in adaptation period with midwifery system in Amsterdam. However, this is just happen when first month of pregnancy not the whole pregnancy. This feeling is especially for them who never has experienced at all in pregnancy. Women experienced problems such as where to check up on their pregnancy for the first time, where they could find a midwife, insurance to cover their payments for all services received for their pregnancy until day of delivery, and of course finding out what efforts they needed to do to maintain a healthy pregnancy. However, this confusing feeling did not occur for a long time or for just a short time, especially in the first months of pregnancy. Usually, most of my informants searched for information through their Indonesian friends or their peers. Most of my informants were from Islamic mosque communities, so that is where some of the Indonesian women started to make acquaintances. These women informants often shared experiences with each other among a group of their peers and made it more like a consultation where they could consult on all things pregnancy related. Hence, even though some of my informants did not understand Dutch, they had their Indonesian friends that worked as their source of information for all things surrounding pregnancies and the midwifery system, including choosing a place of delivery. This group of peers also worked as a support group, so that they could support each other, including if there would be a woman who needed someone to accompany her midwife, then one member of their group would accompany her. The Indonesian women whom I interviewed made quickly built strong relationships with other Indonesian women in Amsterdam, even though there are few Indonesians in Amsterdam. These relationships resembled a ‘big Indonesian family’ in Amsterdam.

From this group of peers, newly pregnant women will know what they should do and how the midwifery system works in Amsterdam. Based on my informants’ information, the first thing to do is to register and find a midwife who practices near one’s home, and from there the midwife will decided whether the woman should check up on her pregnancy routinely with a midwife or a gynecologist. Hence, finding a midwife is the first step in the midwifery system for every pregnant woman in the Netherlands. Most of my informants checked the progress of their
pregnancy in their first months with an independent midwife. An independent midwife is a midwife who works independently within a private practice and usually works in a group. Many of my informants felt satisfied with the pregnancy services provided by their midwife. They felt respected, appreciated, and were made to feel special. They felt respected in the sense that their midwife treated them in the same manner she would any other patient, whether they were Dutch, Moroccan, or any other nationality. Every patient had to make an appointment when they wanted to check up on their pregnancy without exception. In the eyes of my informants, the performance of the midwife services, which included things such as their polite ways of speaking, their body language, and eye contact, showed that they were really professional in the sense of not treating anyone differently, which reflects that every patient has the right to be treated as well as possible. I believe they held this view because they made comparisons between the Dutch and Indonesians in the sense of midwifery services in general. Some of my informants have said that based on their experiences in Indonesia, sometimes a midwife will give a different quality of service to a patient based on their socioeconomic standing. The richer the patient the better the service they will receive. Even though this has not generally occurred in public services in Indonesia, there is still some of this kind of discrimination happening.

In the Netherlands there is no difference in treatment between the rich and the poor, every person has the right to be treated equally. I’m glad to be here because they lend their services in a way that make you feel respected. Even though I am from the middle class, I am treated the same way as any other patient; you can feel it when you get the service. (Sarah, 27th May 2010)

Furthermore, women feel appreciated in the sense that their midwife or gynecologist always gives them an answer to all of their questions during their consultation and they do not feel hurried. I found that not one of my informants felt unappreciated during their pregnancy consultations, whether it was with their midwife or gynecologist. Indeed, it also felt by informant who can not speak Dutch which I will show you later. Indeed they often prepared their questions before they met with their midwife or gynecologist. They felt free to ask any question regarding issues about pregnancy, and when expressing their feelings or worries. If they felt something was wrong during their pregnancy, such as there suddenly being a blood
spot from their vaginal area, or the baby’s movements not seeming active within the womb, or
even the woman’s stomach feeling pain, etc., the midwife would always respond positively to
their complaints, such as giving a referral letter to the mother so that she could receive a USG
(UltraSonoGraphy) treatment if needed, which could even happen more than two times if it was
necessary. One of my informants felt really impressed with the way her midwife appreciated her
patients. Kelana (a pseudonym) had a problem during her pregnancies with her first and second
child. She often complained to her midwife because based upon her perception, she had unusual
bleeding and asked for a USG treatment from her midwife just to calm herself. Hence, she
believed that the midwife was not only concerned about her in the physical sense but also for
her psychological wellbeing.

I felt impressed with the midwife system in the Netherlands, they gave me a lot of
attention and they never were bored with my complaints about my pregnancy. When I
was pregnant with my first child I bled a little so I was worried about my baby and I told
my midwife and she wrote a letter of referral so that I could receive USG treatment, in
order to see how well my baby was doing inside my womb; then she asked me to get bed
rest for the meanwhile so that I could have my womb be strong again. With my second
child, I had bleeding again, and this time it was worse than before, so my midwife wrote
a referral letter again for me to receive USG treatment and she said that everything was
alright because the bleeding was actually coming from outside my uterus, so it would not
affect my baby. I had then said that I was still worried and couldn’t calm myself down,
and I even started to ask myself “Am I actually pregnant or not? Why is there so much
blood coming out?” Eventually my midwife gave me another USG letter for another
treatment and she told me “Okay, I will give you a letter again so that you can check
through the USG again to make yourself calm and convince you that you and your baby
are okay.” And actually, at the moment I did not have allowance again from my
insurance to receive another USG treatment, but if the midwife gives a letter stating that I
need it again, then the insurance covers it. I really appreciated my midwife’s kindness.

(Kelana, 15th May 2010)
Feelings of appreciation were felt by one of my informants who did not understand Dutch and lacked English skills. As I mentioned above, Aminah could not speak Dutch and her English was very limited. However, the way her midwife gave explanations and attention to her made her not feel inferior. She told me that the midwife always looked into her eyes when she explained information, while her husband always translating the information. She felt that her midwife cared about the condition of her pregnancy. Again, Aminah shared similar feelings with Kelana, both of them felt really impressed with the kindness of their midwife and the service they received during their pregnancy. It seems that barrier of language not give a different impact with other woman who can speak Dutch in sense of feeling appreciation.

In addition, I accompanied one of my informants when checking up on the status of her pregnancy, and I agree with Kelana and Aminah having said that the patient feels appreciated by their midwife or gynecologist. At that moment, the woman who I accompanied was being checked by a gynecologist and junior midwife for her ninth month of pregnancy. The junior midwife asked about her emotions and her problems regarding what she felt in relation to her womb (if there any contractions beginning), as well as her preparation for the delivery day. While asking such questions, this junior midwife looked into her eyes warmly and even with a smile at times. The gynecologist did similarly as the junior midwife did. I did not feel that the woman was uncomfortable with the situation from the expression on her face; she expressed every feeling that she felt openly and freely to the gynecologist and junior midwife. After her consultation was over, the gynecologist accompanied me and her to the reception desk to make the next appointment, and after that the gynecologist and junior midwife shook hands with us to say good bye. Indeed, the way they gave us their services was done warmly and comfortably, and was of course appreciated all the way.

Most of my informants have said that being a pregnant woman in the Netherlands made them feel like a special woman. However, feeling special not only in the sense of how their midwife or gynecologist treated them while pregnant but also their social environment in their neighborhood and office. In their social environment they often received warm greetings from their neighbors who they usually did not know before, they were offered seats by other passengers when they used any kind of public transportation, whenever they needed help in public areas there were always many people willing to help them, and there were baby shops
always giving promotions for pregnant women so they often received baby stuff for free. Almost all of my informants said that this social environment made them feel special, especially during their pregnancy.

Most of my informants work. In the Netherlands, if an employee is pregnant then the office has to give them their rights. All of these rights have to be fulfilled by their office without exception. When employees are pregnant they are not allowed to do physically demanding activities, such as lifting heavy things, work night shifts, and so on. Even if they receive a letter from their midwife stating that they are not allowed to work more than eight hours a day, then her office has to obey and give this right to the woman. Hence, some of my informants, while pregnant, only worked for four hours or less a day, and when the time got closer to their delivery day, they were put on maternity leave. Offices are required to pay a pregnant woman’s salary in full, even if they only work for four hours or even take a holiday until they give birth. Their colleagues also have to support these pregnant women in their works area, they must help to prevent physical injuries from occurring in the office. Some of my informants have even said that their offices gave them physiotherapy treatments as a way to prevent them from getting physical injuries. Their colleagues have to fully understand that if there are pregnant women working there, they need rest longer than them. This regulation made many of my informants happy because it seemed to them that the government in the Netherlands had applied human rights for workers in really good ways. So, this regulation looks to be a benefit for pregnant women and it makes them happy and appreciated as a worker.

Nevertheless, there are still critiques from my informants regarding the midwifery system during their pregnancy. The flexibility problem is a problem some of my informants encountered, they could not make an appointment whenever they really needed one with their midwife or gynecologist. There were times when unpredictable problems occurred during pregnancy, such as suddenly feeling pain in the womb, there would be blood coming from the vaginal region and so on. Most of my informants, especially those pregnant for the first time, had high anxiety about their condition, in the sense that they took care to know every detail of their pregnancy. I think it is normally for newly pregnant women to feel this kind of high anxiety, in case of there ever being a problem then detection would be quick, so then it would not influence their pregnancy. Moreover, most of my informants do not live with their relatives or parents,
who are considered to have a lot of experience in matters of pregnancy. So they do not have a person who they can ask or talk to whenever they want if there is some problem happening, and as a newly pregnant woman of course one lacks experience in problems regarding pregnancy. Hence, the only way for them to check up on the progress of their pregnancy as soon as possible is to check with a midwife or gynecologist so they will know quickly if their pregnancy is still healthy. However, this flexibility can not apply here, just like Kelana said:

*The thing about the Netherlands is that everything has to have an appointment beforehand. Can you imagine if there suddenly was pain in my womb and at that moment I really wanted to check everything as soon as possible and speak directly to my midwife or even go to see my gynecologist, but it couldn’t happen because I’d have to make an appointment first with my midwife, and if I wanted to see my gynecologist I would have to ask my midwife first, then she would have to give me a letter, like a permission, to go see my gynecologist. But the thing is, I am in pain now, and if I couldn’t see them today maybe I’d see them tomorrow, and maybe by tomorrow my pain is already gone and I don’t need them anymore.* (Kelana, 15th May 2010)

Hence, I can conclude, based on all the information from my informants, and my own experience and observation of pregnancy services, that being a pregnant Indonesian woman in the Netherlands is more talking about the impact of professional quality, such as being respected, appreciated, and feeling special. Being a pregnant woman is something special in the context of being in Amsterdam. Pregnant women also have a right to be understood, they have a different condition which has to be treated specially. Pregnant women have rights which reflect from government regulations which are applied in their offices and in public areas surrounding Amsterdam, such as I have explored previously. The fact that experiences with pregnancy itself is full of exiting, remarkable, and joyful feelings only adds to the quality of the midwifery service, social environment and government regulation, which makes a perfect combination. a dream for the pregnant woman. Do these joyful feelings during pregnancy among Indonesian women fall in line with the childbirth experience in Amsterdam? I will show you in my next chapter about the experience of birthing in Amsterdam.


Chapter Five

The meaning of childbirth by an Indonesian woman

“Childbirth is an extraordinary event it's the struggle between life and death”

(Kelana, 15th May 2010)

That is the expression used by most of my informants when asked what they think about childbirth. For them, childbirth is an event that is not only about the biological process, but also about the struggle between life and death. Struggling between life and death means a woman can beat death through the child birthing process. Childbirth is such an event that women are never sure if they can really make it through all the pain, unpredictable conditions, and the possibility of losing so much blood that the woman is put into a dangerous situation which they never could have imagined. Hence, it is no wonder that when they survive through such a big event, they feel really amazed by their ability and starts to believe that they were and are strong and brave enough to have made it through.

The meaning of childbirth for Indonesian women is not just attached with biological values but also spiritual values. As Davis-Floyd (1997) said, childbirth is never a simple biological act when it is in line with Indonesian women. Childbirth has a spiritual meaning which can differ in various religions. My informants include both Muslims and Christians. For my Muslim informants, childbirth is an event which is filled with the idea that God has a destiny for a woman, which includes whether God lets her live or die. A smooth child birthing process is ultimately God’s decision. Therefore, many of my Muslim informants have said that they usually ask for forgiveness, especially from their husbands and parents as a way to make their childbirth run more smoothly. Aside from forgiveness, they also ask their husbands and parents to pray to God for a smooth delivery process. In Islam, the position of the parents and the husband for a married woman are special in God’s eyes. When a Muslim woman marries she then has to obey her husband, and all decisions and their approval have to involve him. The husband is the person who can influence the acceptance of their prayers to God. Moreover, the parent’s position, especially the mother of the woman, has a special position as well in God’s eyes. Prayers from both parents are most likely granted by God.
When my pregnancy was already nine months old and was close to my delivery date, I started to ask for forgiveness more often from my husband and parents, it was one of the ways I was preparing in facing my delivery. I felt that their agreement would make my delivery run smoothly. I so often asked for forgiveness from my husband that he said to me “Why do you always ask me for forgiveness? You know that I will always forgive you and I will always be beside you, don’t be afraid and worry, everything is going to be alright.” And I replied “Yes, but I am worried about my delivery, I just want to calm myself down” And I also asked the same thing of my parents, especially my mother (Kelana, 15th May 2010)

Furthermore, there was an interesting opinion coming from one of my informants’ husbands; who is also Muslim. When I asked what he thought about childbirth, I was surprised by his explanation, which I hadn’t ever heard from any of my informants. He spoke about spiritualism and materialism, which do influence the meaning of childbirth nowadays.

*I think there is a difference between people who believe in God and those that do not. Nowadays, there are many people who have the tendency to be more into materialism than spiritualism, and by materialism I mean when people start to gain in material things and every effort are toward gaining more materials such as money, technology, etc. The relation of that with your question is that many women nowadays have high anxiety about their lives, anxiety that goes beyond what is normal, if you compare it with the past. There once were many women giving birth at home and who were helped by traditional birthing attendants, and they survived, even without any medical intervention. They had a strong belief in God’s help and a strong belief in their own ability. I was even birthed with a traditional birthing attendant present when I was born in my village. What I am trying to explain is that recently women have started to trust their lives more to today’s technology in child birthing, which leads them to not believe in their own ability and in God’s help; they’re just too worried and become too afraid until they are not sure anymore whether God will give them strength or not during the birthing process. My opinion actually is that if they trust God they wouldn’t even need a doctor or midwife to help, even their husband alone is enough help* (Hilmi, 30th May 2010)
My informants who were Christian had a bit of a bit similar view with their Muslim counterparts, they believed that childbirth was attached the idea of God’s destiny as well. But, there was something interesting from one of my Christian informants about soreness during childbirth. Soreness is a common thing which women have to deal with as part of the nature of childbirth. Soreness is a symbol of the atonement done by all women, of the original sin, which was Eve’s mistake that caused Adam to eat the Kurdish fruit which was forbidden by God. Therefore God sent Adam away from heaven and since then he has had to stay on earth; and God decided to punish Eve by giving soreness and pain to all women when they go through childbirth. As good servants to God, all women have to receive this soreness, as it is a natural matter, and should bear the pain without complaint. Hence, based on my informants, there are many women and their husbands as well attach religious significance to aspects of childbirth: to pain and to living religiously and asking close ones for forgiveness as a way to understand and prepare for childbirth.

Above all, most of my informants view childbirth as a natural event that involves a lot of pain. Some of them believe that a natural event means going with or without medical intervention from a doctor or even midwife, and that they can deliver by themselves. Being natural also means that childbirth itself is a cooperation between the mother and her baby, and that when the time comes for delivery, the baby will make pushing movement inside the womb to come out from the pelvic region, alongside the mother pushing as well. One of my informants has said that midwives and doctors just act as facilitators and the main actors are the mother and baby. One of my informants’ husbands has said that “midwives just help the mother when the time is right, to push and to prevent them from harming their vaginal region during the birthing process”. Hence, being natural for Indonesian women also means that they learn to deliver without having done it before, and the cooperation between the mother and baby just happens between both of them naturally, they just do their own task; the baby will automatically encourage the mother to push so that the baby will come out from birth canal. Birthing is one of God’s miracles, as one of my informants has said “when it happens, it just happens”.

Moreover, this opinion is in line with a midwife that I interviewed. There were two Dutch midwives who had similar opinions with my informants, which was that childbirth is a natural process of which the mother doesn’t need knowledge of delivery beforehand. One expression
that one of the midwives quoted was: “even you can deliver just behind a tree without any help from anyone”. Therefore, in the Netherlands, home birthing is a reflection of their perception of natural childbirth, which for them means less medical intervention is a good start for a baby to begin it, is new life on this earth.

_in my opinion there is a different quality to a baby that comes out from a natural childbirth, with little to no medical intervention at all, which is better than with medical intervention. It is a good starting point for baby to begin a new life on earth, then the baby will quickly adapt to his new life, and it is important for the baby to have skin to skin contact with the mother as soon as possible, then he will feel comfort and security; because newborns have senses that are very sensitive, a baby will calm down immediately upon feeling his mother’s skin and smell, due to the fact that the baby stayed inside the mother’s womb for nine months. This contiguity will make the baby calm and build a good emotional relationship between the mother and her baby, and if you have to have a C-section in a hospital then there will be a delay in time regarding the baby’s contact of skin with it’s mother, and for me that can influence the adaptation of the baby in his new world which sometimes can cause the baby to often cry._

(Margareth, 27th June 2010)

From the quotation, we can see that the Dutch midwives pointed out about “naturalness” of childbirth which really attach with health of baby seems better than if the childbirth contaminate with technology. This medical view from midwife looks like more anti-medicalization regarding childbirth event.

Nevertheless, natural events do not mean they come without risk. “Unpredictable situations” are almost always attached with the birthing process, based on most of my informants’ understandings. “Unpredictable situations” seem to transpire more in risky situations, especially when coupled with stories of difficult birthing experiences from friends that were in situations that endangered their lives. In addition, most of my informants also made the connection that in Indonesia there are many unpredictable experiences during child birth so they need something to make them believe that their own childbirth experience will run smoothly and most importantly, is secure. Here is one interesting opinion from one of my informants:
Though I agree that childbirth is a natural event, it can also put a woman in a dangerous situation, for both the mother and her baby as well. A friend of mine, she was a midwife in Indonesia, decided to give birth at home because she thought that childbirth was a natural and secure enough act when you perform it in your home, but I think she was too confident in her opinion, and you know what can happen; she began bleeding and had to be taken to the hospital. That experience acts as a mirror for me, which leads me to believe it would be better if one is not too confident since childbirth is full of risks and anything can happen to anyone, and it can happen to me as well, so I prefer being in a hospital which is equipped with complete medical equipment and medical personnel. (Santi, 3rd June 2010)

From here is looks like that the ‘spiritual side’ to childbirth that I explore in above is viewed by women informants as a way to cope with the riskiness of childbirth, for instance, by asking for forgiveness they can prevent unpredictable (dangerous) situations.

Indeed, the meaning of childbirth for Indonesian women is socially constructed within the community in which they live. Even though some of them live for years in the Netherlands, they still see childbirth in a similar fashion to how they always have. Childbirth is an incredible event that is full of pain and can be especially unpredictable which can put women at risk. Indeed, childbirth is also thick with spiritual values from both Islam and Christianity, which the husband of one of my informants made a relation between spiritualism and materialism, which actually for him was a critique for the way Indonesian women now see childbirth. Whereas, the meaning of “natural” is a little bit different from how a midwife defines “natural”. I argue in the light of authoritative knowledge, by Brigitte Jordan; all these meanings are social constructions dependent on which part of society has the authority to define what “natural” means, whether secure or not. Even when childbirth is natural, indeed, naturalness is still a social construction. At the end of the day, authoritative knowledge is not about which knowledge is correct, but more about which knowledge is accepted within society (Jordan 1997:58). However Indonesian women accept which knowledge of childbirth is best for them will influence the way they decide what is best for their delivery and what is the best place for their delivery. Therefore, some of my informants delivered at home, while others delivered in hospitals.
Chapter Six

Experiencing home birth: happy and traumatic birth stories

In this part I will show you three true home birth stories from three Indonesian women. If there is a wise words state that “experience is the most valuable teacher” than these three women really put their own experiences as the most accurate teacher for them and start to influence their peer women friend in choosing place of delivery. Each of them has a different lesson learn, impression and impact from home birth experiences. Indeed, experience of one of them become a center of attention and has huge influence in shifting opinion about home birth as safe place of delivery for most of my women informants. Often, when I ask about what the best place for delivery, most of women informants almost always refer to one of these stories which for them are traumatic story, indeed, is Kelana story. Yet, there is still a happiness story from one of these three stories, is Fatimah story. However, there is also a surprise home birth experience which she never imagine before and makes her feel unbelievable until now, is Maria story. Hence, I will tell you a home birth story of Kelana, Fatimah and Maria.

The first story we will hear is from Kelana. Hers shows by far the most negative experiences with the home-birth system. Kelana almost always trembling and her heart are beating irregularly every time she hears a sound of ambulance. The sound of ambulance always makes remembering the event that made her nearly to death. Indeed, the event is 2 years ago when she delivered second child, but it is still very well recorded in memory of this 34-year-old woman. That was her second home birth after the first one. It is not only happen to her but also her husband. For both of them, they only wish that they never have kind of this experience again in the future and even, the husband start to think to not have a child anymore. Sometimes, during she talks with me, she is sighing for second minutes. Indeed, it is an unforgettable sad story. Since then, this spouse never recommended home birth anymore.

At that moment ... I choose home birth for my second child because before it was okay with my first child ...for my first child everything was going smooth ... when my second pregnancy .. indeed there often a little bit bleeding and I often asked midwife for USG and she give me several times for USG ... the midwife asked me whether I was still want to
deliver in home or in hospital ... and I said I still want to deliver in home because I thought everything was okay so there was nothing which I should worries ... and the day came ... until I felt so painful and I asked my husband to call the midwife because I thought I would like to deliver ... and the midwife came about 10 minutes later and started to call kraamzorg (midwife assistant) and both of them started to prepare all equipments which needed and after that help me to push and after more less 1 hour my baby came out ... everything seemed so smooth and okay ... everybody was happy including me... until my placenta did not come out yet after 20 minutes later ...I was not felt any contraction at all to push my placenta out and I felt there were much blood came out from my vagina ... the midwife tried to push my stomach to make the placenta came out but it wasn’t works and then she inject a stimulant twice but still not worked ... I felt lost too much blood ... the midwife told me that I have to refer to hospital and she started call several hospitals ... unfortunately there were many hospital were full so it was take so many times to call hospital until she got one available hospital ... after that she called an ambulance to carry me and asked my husband went to hospital first to check in the room and register so that the hospital would take care of me immediately when I arrived ... and then the next problem was the ambulance officer was only allow to carry patient in lying straight position and the model of my house was not possible for that and there was no lift ... therefore midwife need to call fire truck so they could use fire stair to carry me down then I carried out by ambulance to hospital ... I didn’t remember anymore ... I lost my consciousness because lost much blood ... when I arrived in hospital ... the midwife there started to do manual as a way to pull out the placenta but it wasn’t work and then they started to put me into operation room ... and then gynecologist operated me to pull out my placenta ... I remembered when I started to loose my consciousness and during the journey to hospital I just pray to God and I felt I went to die and I was thought to entrust my first child to my best friend ... and you know .. my husband also have the same thought with me ... both of us think ... only miracle if I am still alive now ... can you imagine if I was a little bit late when arrived at hospital (Kelana, 15th May 2010)
Based on Kelana story, she is clearly shifting her perception about safety delivery through home birth. Complication can be arising every time during childbirth and there is no one can give a guarantee that everything will go smoothly. Even though, she receives a several USG but still can not give a guarantee. Hence, since then, she needs something as a way to prevent complication such medical technology and medical personnel. Obviously, this is in line with what Davis-Floyd (1994) concept about technocratic imperative. When human need technology to control the nature so that it will be more controllable, safer and secure. I argue in Kelana case then it seems so logical and normal to have this perception, or even, this belief, because it is all about a way to stay alive. Still in Kelana case, I argue it is just beyond about ownership, familiar, comfortable, or very well referral system, when talking about which place of delivery that has a huge opportunity to stay alive after childbirth. Therefore, since then, she give a huge influence to her peer women groups whom most of them are my informants, to choose hospital birth rather than home birth. Moreover, it is also gives a picture that the Dutch health care system also failed in certain ways.

Nevertheless, Kelana story is completely different story with Fatimah. Fatimah is a mother of one gorgeous baby boy. It is her first childbirth experience. She does intend to do home birth since first month of pregnancy and her husband support her decision. She does lot of preparation for her first childbirth with home birth besides checking her pregnancy to midwife, she is also searching for home birth information through internet and she does yoga exercise with her husband. Indeed, she does a very well preparation until she makes a list what she would like her husband do when the birthing time comes, such, put a warm water inside bathtub so that she can soak in it. She manages all situations and she plans really well what she is going to do when the childbirth time is come. During interview, she looks so enthusiastic share her experience while occasionally showing her newborn baby photos to me. Indeed, it is a beautiful happiness home birth story and she recommended home birth as long as the ir house near hospital. Yet, the fact that it is not because of naturalness childbirth reason as a Dutch childbirth perception, indeed, she feel safe because near of hospital where medical equipment and medical person placed.

*I choose home birth even before I get pregnant ... for me home is clearer than hospital cause once I was worked in hospital in Amsterdam before so I knew there were many*
bacteria there ... beside it feel so free ... you can manage your own delivery situation ... even you can watch the movie first during you waiting for complete dilation ... for me .. when the day came ... in the early morning around 2 am my fetal membrane was rupture and I called the midwife and she said she would come at 6 am and she came at 9 am ... she checked my dilation and she said it was still few and she left and she said if the contraction was often every 5 minutes then I should call her again ... I felt so pain at that time ... but I have plans before ... my husband already put a warm water to bathtub so that I could soak my body into warm water that could reduce the pain ... and after that I just sat in WC while read my favorite magazine which I prepared before ... when the contraction felt continue every 5 minutes I asked my husband to call midwife ... and I was sat in special chair for delivery ...yes I would like to deliver in sit position so that there were not to many stub in my vagina ... but it wasn’t work at that moment so midwife asked me to lying down in bed and I asked midwife to put a special lotion which I bought from Swiss so this lotion to help the flexibility of my vagina so that the baby will easier to come out this cream from Switzerland was new to the midwife, that she had never heard of it ... yes it just took 30 minutes for my delivery event and there were no stub at all and my baby boy is so healthy... even 1 hour after delivery I could wake up and walk and cook for dinner  ... indeed it was amazing experience for me .. I like it ... I also have a full power to decide who can be present in my childbirth event ...I just feel that I am the Boss of my own childbirth and it’s feel so great (Fatimah, 9th June 2010)

Fatimah really has an enjoyable child-birth experience because of well-planned preparation. Even though, I wonder if she would have been this enthusiastic had she been in Kelana’s situation. However, indeed, I see this as the beauty of home birth. Fatimah feel empowered because she is the center of everything such as attention, decision and situation. No doubt that she feel comfortable with all situation and condition which she create and manage before. She feels confidence with her ability to deliver because of her and her husband follow yoga exercise so that her husband helps her to remind when to take a breath and when to push when the birthing time comes. Yet, beyond of those factors, she strongly chooses home birth also
because of her house very much close to hospital; it only takes less than 5 minutes by car so still a tendency to give most importance to ‘technocratic imperative’.

Contrary to Kelana and Fatimah, actually, Maria never has a plan to give a birth at home. In fact, home birth never becomes choices of place of birth for Maria. She does definitely choose a hospital as place of birth and that is the only option that exists in her mind. Maria was a fresh graduate master student from one of university in Amsterdam when the moment she got pregnant. It is her first childbirth experience. Similar with Fatimah, Maria is also enthusiastic with her pregnancy as well as her husband. They are new happy couple whom feel blessed because God give them a child in short time after the wedding. For her, the best place for delivery is hospital; therefore, she prepares everything which needed to deliver in hospital. Certainly, Maria really wants to deliver in hospital. Apparently, the plan is not in line with the reality. When the birthing day comes, Maria does not have any choice except have to deliver in her house, indeed, the dilation is complete and the baby will born soon. Hence, since then, Maria said “next time, I will exaggerate the condition when called the midwife, I mean I will say that the contractions are already every 5 minutes even though actually they are not that often yet, so that we can go to hospital earlier”. Indeed, this is a surprise she never wants. Yet, she is feeling happy but misgivings.

\textit{I am very happy when I knew that I was pregnant ... since then ... I was often searching any information ... because I felt have a huge curiosity about pregnancy so that I search from internet everything to make my pregnancy went well ... actually my birthing time was faster than the prediction time ... you know eventually I was birthing in my house not in hospital such I planned before ... unbelievable for me ... I was surprise but at that moment I didn’t have any choice ... so at that day ... I felt so painful in my womb and then I asked my husband to call midwife and in phone ... the midwife asked whether the contraction was often or not so the midwife told my husband to wait until the contraction felt every 5 minutes then we could called the midwife again ...indeed .. At that moment ... we really counted whether the contraction felt every 5 minutes or not ...when the contraction felt so often ... once again I asked my husband to call the midwife and the midwife came 15 minutes later and when she came she wasn’t directly checked my vagina but she talked with me ... and after 5 minutes then she checked the dilation in my vagina}
and she said that the dilation was complete ... it was 10 already so she said that I could not went to hospital otherwise I would deliver during the journey ... then ... she asked me where I would like to deliver ... because at that time I was in my living room ... and I said I would to deliver in my room and she asked me where was my kraampakket (delivery packet which every pregnant women received it from insurance company) ... and then she prepared everything in my bed from kram packet and I felt the baby was coming out ... she helped me to take a breath and push ... and then after one hour the baby was born ... and the midwife immediately gave the baby to me to my breast ... and I told her ... I thought the placenta would born so she helped me to push once more ... after that she looked into my vagina ... there were many stub and she wasn’t allow to stitch ... so ... she told me that she has to carry me to hospital to stitch stub in my vagina .. She called hospital and she brought me to hospital with her car because she said it would take long time to wait ambulance and my husband carried my baby with taxi to hospital... after the midwife in hospital stitch stub in my vagina ...after 1 hour they let me went home ... and we went home with taxi ... it was such an exhausted moment for me and my husband ... though we were glad everything was fine (Maria, 8\textsuperscript{th} June 2010)

Even though, her home birth experience went well, she was still not sure about a home birth because in the end she was referred to hospital and she thought that she was saved because of luck. She still believes that childbirth is a risky event so she prefers to deliver at a hospital. Therefore, next time, she will exaggerate her condition so that she can deliver in hospital. Moreover, in contrast to Fatimah, Maria’s story shows that she is not the owner of her childbirth. Indeed, she prepares everything but it is all preparation for hospital birth not home birth. However, she cannot perform her childbirth in hospital because she does not know anything about the dilation which put her into a position of no choice and powerless. The midwife seemed to have the power to manage almost all her childbirth. It is in line with authoritative knowledge concept by Brigitte Jordan (1997), when midwife has “authority” to define when is time to deliver, where delivery will take place, what delivery position will performs and so on. The home birth situation in Maria case, even though, it performs in home, in my opinion, it does not means that the woman becomes the owner of her childbirth. Then, the ownership just like in
Fatimah case suddenly disappears in Maria case. Indeed, it is also disappears in Kelana case when complication arise.

In conclusion, for all women seem safety and health are the most important aspects of child delivery and that hospitals are thought to provide the safest environment for child birth. Fatimah only wants a home delivery when a hospital is nearby; Maria wants her next child to be born in hospital even when her home delivery went fine. Women seem to get greatest fulfillment out of ‘owning’ the delivery process such as Fatimah’s successful story of thorough preparations and remaining in full control of the process – even more in control than the midwife, because she had pain-relief methods that the midwife had never heard of. ‘Ownership’ of the delivery process can quickly change: Kelana lost ownership when she had complications and had to be transferred to hospital and Maria lost ownership when she had to deliver at home. As I mentioned in literature review, ‘authoritive knowledge’ in these stories of child birth in the Netherlands, is fully in hands of the midwives; they decide when women should be transferred to hospital and when woman can stays at home such as Maria who actually really wanted a hospital delivery. This is why Maria plans to exaggerate her condition next time.
Chapter Seven

When there are two choices: Home birth and Hospital Birth, what will they choose?

Most women informants had similar experiences with home birth since they had come to the Netherlands, especially when they got pregnant and went to a midwife for care. Before coming to the Netherlands, the idea of a home birth did not exist in their minds as an option for delivery. Indeed, as I have mentioned, Selasih, the mother of Maria who accidentally had a home birth, was shocked to know that her lovely daughter delivered at home rather than in a hospital. Even though Maria delivered her baby in Amsterdam, Selasih was in Indonesia and she told me that she felt deep pity and shame for Maria.

In fact, I also feel the same as Selasih, I am shocked as well when I know that many women in the Netherlands do not even deliver their babies in a midwifery clinic. Therefore, my curiosity was one of reasons that lead me to conduct this research. When there are two choices between home birth and hospital birth, what will they choose? Why? And what are the factors that influence them in choosing a place of birthing? That is what I will show you in this chapter. As Davis-Floyd (2008) mentioned in her article, as a researcher, I will specify, contextualize and render meaningful the choice that Indonesian women make in all their diversity and then I will tell you what my Indonesian women informants know about home birth in the Amsterdam context.

The Perception of Safety

The idea of safety was the most expressed concern my informants brought up to me when I asked them what the best place for delivery would be. I will explore their perspective on safety in the many senses, which relate to choosing a place of delivery, whether it be at home or in a hospital. In my previous chapters I relayed the home birthing stories of three Indonesian women, one of which was Kelana, whose story was about her near death during the birth of her second child. Indeed, it was the “unpredictable situation” possibility during a home birth that gave much insight to many of my informants. “Unpredictable situations” are viewed as situations that can risk one’s life because they can happen so unexpectedly. Even though most already received several USGs (ultrasonography), they still believed that unpredictable situations could’ve
happened at any time. The “Unpredictable situation” eventually lead them to perceive childbirth as natural but risky at the same time. Therefore, they needed a guarantee that risky situations could be prevented. This guarantee for them would encompass complete medical equipment and medical personnel, such as a gynecologist. Certainly, these two factors are associated with hospitals rather than with home birthing.

*I for one don’t want to put my life in a risky situation; you see, in Kelana’s case, she used to be confident with the idea of home birthing, and she had said it was safe enough because she was also a midwife, but you never know what could happen in the birthing process. It’s never good to be too confident, especially considering what happened to Kelana in her last child birth experience, I just kept thinking about what could’ve happened if she would’ve reached the hospital too late, she could have died, whereas if she made it to a hospital and a problem arose, then she would have received help immediately from the medical personnel on staff. Besides, when already in a hospital one doesn’t need to waste time on the streets.* (Erna, 3rd of June, 2010)

Indeed, for most of my informants, the idea of home birthing had them feeling less secure. However, there are no problems with the referral system, which is well integrated. There are many hospitals which can be reached within several minutes, and the ambulances are fast enough when they are needed, though traffic is certainly a hindrance. However, in my informant’s eyes, those factors were not enough to convince them that home birthing is a safe process. One of my informants had said:

*Why should we waste our time with the referral process when we don’t actually need it, especially when in a hospital and risky situations such as severe bleeding occur and we are put in a position where we can be near death.* (Aisyah, 30th of May, 2010)

Moreover, the perception of safety lies in the sense of there being a lack of an urgent situation, especially when giving birth. Because of these reasons, many of my informants have said that home births are not really safe because if there are complications then there aren’t any treatments to immediately solve an emergency situation, except if they should be referred to a hospital, yet they always worry that anything can happen during an emergency that can put their
health at risk. Thus, if they were to choose to have a home birth and they would end up in a hospital then the question begs why they didn’t just go to the hospital to begin with. Wono, Kelana’s husband, emphasized this matter to me.

_In the case of my wife, I ended up traumatized, and since then I couldn’t possibly recommend home birthing to anyone anymore. The best place for delivery is a hospital, no matter what, even if one doesn’t have the money for it, in the end life is the most important thing, money can easily be attained, but not one’s life with their wife and child. When my wife was bleeding severely, to the point where her face was pale from the loss of blood and her placenta was not coming out directly, I saw that there was no emergency treatment the midwife could provide. Though she tried to help my wife by pushing on her womb and by giving her two stimulant injections, nothing was really working, and in my opinion, the midwife could have manually tried to pull out the placenta with her hands, but maybe that was something the midwife was not allowed to do. She had no equipment with her that could have helped in the critical event, we just had to wait for the ambulance, and we also had to wait for a hospital to become available, because at that moment there were several hospitals that we called and were all full, it was such a waste of time that could have ended up with my wife succumbing to death. Therefore, since that nightmare of an experience, I believe it would be better to be in a hospital to begin with, because if something were to go wrong you’d already be in a hospital and receive immediate help. (Wono, 17th of June, 2010)_

Along the lines of the aforementioned problem comes an interesting opinion from Helena, who was nine months pregnant when I interviewed her. She was pregnant with her second child at the time, her first child being born initially through a home birth with a midwife. She began delivering her first child through home birth but ended up in the hospital because there were complications, and so since then, for her second child, she had to deliver in a hospital. She said “Once you have the experience of birthing in a hospital, you will deliver in a hospital for your next child”. Based on her first home birthing experience, her main critique is that it takes too long to receive proper service if a complication arises and so it is ultimately not effective. Because of how long it took for her to get help in her situation, she became completely exhausted
and the skin of her first child was already pale because of being inside her womb for too long. Hence, she concluded that being in a hospital from the beginning is the best shortcut from taking the long way of waiting for an ambulance to take you there. Here is Helena’s story:

_When I delivered at home, my dilation was complete very quickly and my water broke, but I didn’t feel any contractions until several hours in, that’s when the midwife started to massage my womb in order to stimulate the baby to come out but it wasn’t working, and so she injected me with stimulant fluid to help induce contractions but that wasn’t working either. Eventually she started to call various hospitals and it took several minutes until a hospital became available, she called ambulances as well and then I finally arrived at a hospital. When I arrived, the midwife there started to treat me, she started manual labor, which meant that she tried using her hands to induce labor and when that didn’t work then she gave me a vacuum, but that wasn’t helping either. I felt my baby become stuck inside my womb, and since all these efforts were not working they put me in an operation room and the gynecologist decided to do a c-section. When my baby came out I saw that his skin was so white which was most likely because he remained inside my womb for so long, I also heard the gynecologist say to the midwife “Why didn’t you put her directly into an operation room when you know that the only way to induce delivery in that situation is through a c-section?” and I saw the midwife, she seemed to be in denial and she insisted that she did everything needed to help me._ (Helena, 9th of June, 2010)

This was her second pregnancy and her first child was born in a home birth. She delivered her first child through home birth but ended up in a hospital because there was a complication and therefore, for her second child she has to deliver in hospital. She said “once you have childbirth history in a hospital then you will deliver to hospital for your next child”. Based on her first home birth experience, she critiques that the sequence of childbirth service if there is complication which arises and the management at home is too long and not effective. Because of this long sequence of care, she became tired, and she thought the skin of her first child was peeling because of being in the womb too long. Hence, she concludes that being in a hospital will create shortcuts in her birth sequence.
Indeed, my informants’ perspective on safety brings me to what Davis-Floyd (1994) has said about technocratic imperative concepts, which is when human technology is used to control the limitations of nature so that it is more predictable, controllable, and therefore safer. In Davis-Floyd’s sensibility my informants noticed that Kelana’s story was a reflection of the limitations reproductive bodies have when encountering complications which unexpectedly arise during childbirth. Therefore, reproductive technological equipment is needed and of course, the medical personnel who can use this technology. Both things can not be separated and belong to a hospital rather than in a home with a midwife. In the perception of safety, most of my informants strongly chose hospital births over home births which they perceived as a risky choice.

In addition, if I use the lens of authoritative knowledge, then my informants have the authority to define which is riskier, home births or hospital births. “Authority” by Brigitte Jordan (1997), is also about power relations within particular communities. Obviously, in “the community of my informants”, Kelana seemed to have the power to define home births as riskier than hospital births. She seemed to have this power because of her near death experience during her home birth; her peers, who were also most of my informants, consciously or subconsciously, allowed Kelana this “authority”, which held more power when backed by her husband. Kelana’s husband is an “ustadz”, which is a religious leader whom many people ask advice from for all kinds of Islamic issues. Hence, as I mentioned before, authoritative knowledge is not about correctness but more so how it is perceived, in this sense Kelana’s knowledge was perceived as correct. Hence, my Indonesian informants followed a general ‘medicalization’ trajectory: the construction of childbirth as a risky event that needs medical attention (Jordan’s authoritative knowledge), supported by the ‘technocratic imperative’ idea that a body has its limitations and needs technological intervention during delivery (Davis-Floyd, 1994). This adherence to the medicalization trajectory is increased by stories that circulate about actual risky situations that occurred during home delivery (such as Kelana’s story). The overall perception thus is that hospital deliveries are perceived to be safer than home deliveries.
The Ownership of Childbirth

Home birthing is often chosen by women due to issues regarding ownership. Issues of ownership often come from key informants, such as midwives. Women should be the owner of their own delivery, not medical personnel, such as gynecologists. Ownership is also related with empowerment and feeling powerful. Hence, childbirth must be approached in a fashion that makes women feel empowered, feel powerful, and feel as though they own the process of their own delivery. As one midwife has said:

*Delivering a child is a thing of power. It is important for a birthing woman to feel powerful, as this power comes from deep inside of her. For instance, the position of lying on one’s back makes a woman feel vulnerable, like one is lacking in power and is exposed. When one is sitting or squatting, one feels more powerful, which is the sentiment the women I helped felt, for them delivering by sitting or bathing was a better experience. It is important that during this time of a woman’s life no trauma is caused to the woman.*

(Martha, 30th of June, 2010)

Home births seem socially situated to make women feel empowered, and in contrast hospital births seem to make women feel powerless and lacking in privacy, given the situation. Indeed, it is true, the stories from my informants are split between those that have experienced delivering at home and those that have given birth in a hospital, which brought me to real examples of ownership, empowerment, and feelings of power and powerlessness. It then lead me to ask certain questions, such as, is ownership or in other words empowerment a privilege which is only experienced by those who go through a home birth? Who has the “authority” to define which woman has more empowerment than another? Can ownership and the perception of feeling secure among Indonesian women be felt by both sides of the birthing spectrum? If not, then which one is most important in their eyes?

For the first question, as I explored before with Kelana, Fatimah, and Maria’s stories regarding ownership issues - ownership is then applied and perceived depending on the situation. Before Kelana’s experience with her delivery complications, indeed she seemed to feel empowered in the sense that she was the one who decided where she would deliver, who was
allowed to be there during her delivery, and what situation she felt most comfortable in where she could feel free to scream as loud as she wanted. Indeed, it was similar to how Fatimah felt with her home birthing experience. However, Kelana’s empowerment suddenly disappeared when the complications arose, she seemed to not have any freedom of choice, all she could do at that point was follow the midwife’s decisions of what was best for her until she reached a hospital. This loss of power also happened to Maria during her home birthing experienced.

Nevertheless, the consequence of delivering in a hospital is powerlessness. This insight I heard from my Indonesian informants who delivered, or eventually delivered in a hospital. There are several issues, which reflect powerlessness. First, a lack of privacy, some of informants said to me, there are many people, who look like medical personnel because they are wearing white clothes and can watch the childbirth process in birthing room. Indeed, based on my informants’ information, they have right to refuse or not allow other people to see their childbirth. But when woman are more focused on delivering their baby and feeling an incredible pain such as struggling with death and life, then, how can these women tell these people to go out of the birthing room. These happened to my informants who spoke fluent Dutch so imagine the informant who cannot speak Dutch and barely has English skills—they are more powerless.

When I was birthing my baby in the hospital … I was surprised because suddenly there were many people who came inside the birthing room and saw my childbirth process … I was ashamed at that moment and in that situation I couldn’t ask them to go out cause I felt so painful and focusing on my energy to deliver my baby … and my husband as well, he paid more attention to me not to them … indeed, I felt regret but I can’t exercise my rights and you know actually it is also about aurat (term in Islamic, that there is only particular people allow to see the vagina of the woman and it is prohibited for others) … but at that moment I more think about my life and my baby and that moment my Dutch language was still bad and my English suddenly left my mind (Nabila, 28th May 2010)

Second, another issue is unresponsive service whether from a doctor or a midwife in the hospital. Unresponsive service is a sense of a slow response to a complaint. Often, my informants said that they should have exaggerated their actual condition so that they would receive the services they needed from the midwife during their hospitalization. Because of this
slow service, many of my informants said that they felt it was inconvenient to stay in the hospital after birthing their child. For instance, the story from Alira below:

After delivering my baby in the operating room ... I felt so cold until I was trembling a little bit and I felt a headache and I told the midwife that I was feeling so cold ... and she just said “yes ... it is okay .. you feel cold because you didn’t eat food” I was upset and you know until the blood pressure equipment in operation room was beeping because my blood pressure was too low and I said once again that I felt so cold ... and after that the doctor asked the midwife to give me a blanket, then I felt a little bit warm (Helena, 9th June 2010)

Third, in the majority of my informants’ opinion, an important problem was the hospital services’ strict regulations. Strict regulations included the right time to go to the hospital when the time of birth was near and duration of a stay in the hospital. These two issues were reported most frequently by my informants who had experienced childbirth in a hospital. They did not have the power to decide when they wanted to go to the hospital because their cervix was not adequately dilated when they arrived at the hospital, they were told to go home again and only come back when their contractions were every 5 minutes signaling that their dilation was almost complete. Moreover, after childbirth most women reported feeling exhausted but they could not decide how long they might stay in the hospital or even, whether or not they could stay. This was the midwife’s decision not the woman’s decision, unless they wanted to pay extra money for the costs the insurance company would not cover. Undeniably, these two regulations make many of my informants feel powerless; the fact that they do not have power at all in this sense, except just to follow the regulations. In contrast, in Indonesia, in Jakarta, based on one of informant’s experience, as long as they can pay the fee for the room, they can stay for at least for five days after delivery, and for a C-Section, they can stay longer. Hence, the women in Indonesia feel that have a power to decide whether they would like to stay in hospital or not.

My membrane fluid was broken at that time and of course I thought I was about to deliver my baby so that my husband and I went to the hospital ... and you know what after I arrived and they checked my dilation and I said that my contractions weren’t regular yet ... they asked me to go home again ... it made me so disappointed because
actually I would like to have stayed waiting until my dilation complete ... and I didn’t have choice except to go home and go back again to the hospital ... and yes ..my delivery process was running successfully and even though I still felt tire and my blood was not yet dried after birthing, they asked me to go home cause they said that my baby and I were healthy so we did not need to stay in hospital ... then I was disappointed again for the second time ..I felt pain in my vagina and my heart at the same time then I started to cry (Farah, 1st June 2010)

By hearing these stories of empowerment issues based on home birth and hospital birth experiences, then, even though a delivery at home seems to be the most empowering situation, Kelana and Maria show that that is not necessarily the case. As long as all is well and there is no risky situation, women feel more empowered at home. But in case of emergency, empowerment dissolves. In hospitals the greatest loss of empowerment is felt. Ultimately, power seems to rest with either midwives or gynecologists.

At the end, I come into my third question, if my informants notice that being empowered was likely to be found in home birth rather than in a hospital birth, then, what is a more important consideration—feeling secure or being empowered? The quotation below will answer it.

For me, the most important thing is saving your life no matter how and whatever must be sacrificed ... and for me ... still the hospital is the best place for delivery ... even though my husband can not perfor beside me during childbirth I think it is okay because with or without him ... he can not help me in reducing the pain and also delivering my baby ... and if something happens .. I just want to be beside the equipment and medical personnel ...(Aisyah, 30th May 2010)

In my opinion, for my Indonesian informants safety is more important that ownership during childbirth. Childbirth is perceived to be a risky event that needs technological intervention so more informants consider the medicalization of childbirth. Even though, women feel less empowered during hospital deliveries, they prefer hospitals as a place to give birth.
Perception of comfort and familiarity

Perception of comfort and familiarity in choosing place for delivery is also a significant consideration for most of my informants. The way they see home birth and hospital birth is also from these two factors: comfortable and familiarity. These two factors actually lead them to choose a home as a place of delivery, which is more convenient than a hospital. However, indeed, eventually, they make a comparison between home birth and hospital birth through the lens of comfortable and familiarity.

In my informants’ opinion familiarity can create a comfortable situation. When I asked what their opinion was about hospital birth, I often heard their answer at first is that it “is troublesome”. Troublesome in the sense that the services that they received in hospital such as having to leave and return to hospital several times because their dilation was not yet complete or there were no contractions, and the short time they were allowed to stay in the hospital after childbirth. In contrast, all of these troublesome issues were not found in home birth care. Hence, I will explore these themes of inconvenience in receiving care services.

Some informants said that their complaints in the hospital did not receive an immediate response. As I mentioned earlier, unresponsive services makes most informants feel powerless; then, it also makes them very uncomfortable. Some informants even felt traumatized. They felt traumatized because they did not receive, in their eyes, proper service. Sarah’s story is below.

When the day I was delivering my baby in the hospital, the midwife asked me to stay for one night and I replied that I would like to go home ... she replied “no you have to stay here and don’t be worrids because if you need anything you just call the midwife” ... actually, I really want to go home because my husband couldn’t stay at hospital so I thought I would be so lonely during the night ... but, however, eventually, yes I stayed in hospital for three days ... and you know it was really not comfortable ... they said that there is midwife who would accompany me if I wanted to take a shower, but, in fact, I had taken a shower by myself and if I didn’t take a shower they (midwives) got angry with me ... and when I needed them during night to ask for some medicines in order to reduce pain there was no midwife ... maybe because there is only one midwife for a whole room
I mean patient room in that area which I stayed so she was busy giving service to everybody .. but I needed medicine ... my baby was beside me ... I was so tired ... and my baby was crying all night and there was no action at all from the midwife ... I told them that I was so tired and my body was feeling warm so I was afraid to breastfeed ... then because no one helped me at that moment ... you know it felt so painful in my heart I felt like they were ignoring me ... I felt really poor ... and indeed, I was crying all the night and regretted that I agreed to stay at the hospital ... (Sarah, 27th May 2010)

Sarah pointed out about that it is an uncomfortable feeling when staying in hospital, but, this issue also makes others feel uncomfortable, in the sense that they cannot stay in the hospital despite feeling tired after delivery process. Some informants said that it was uncomfortable because they had to go home feeling exhausted and their bleeding had not yet stopped after delivery. Imagine if in that condition, you had to walk up stairs because there is no lift in your apartment.

Another issue regarding the uncomfortable perspective is leaving and returning several times to hospital because the dilation is not yet complete and there are no contractions. This complaint was especially noted by informants who did not have a car. Hence, they had to reach hospital by taxi or public transportation. It felt troublesome because in the moment to reach hospital, most of informants said they were in a really painful condition, so it was not comfortable for their body itself. Then, the tension of this uncomfortable escalated when they had to take a taxi and when they arrived at the hospital, they had to go home again. Indeed, actually, because Kelana did not have a car when she was pregnant, she chose a home birth rather than a hospital birth, even though, actually she and her husband wanted to deliver in a hospital.

Most of informants noticed that if they delivered at home, all of these troublesome issues did not exist. Most of informants, also agreed that a home birth was more familiar, more relaxing, and more flexible in the sense of being free from troublesome issues I explored above. Indeed, all these feelings make the women feel comfortable and consider home birth as a better place to deliver. Kelana, eventually, chose a home birth because she felt more comfortable. Then, especially for those who feel traumatized, such as Sarah and Helena, they thought and
started to think about delivering at home, if the next time their pregnancy was healthy and normal. Yet, some of women still considered a hospital delivery, even though they knew it would not be comfortable. They thought, in their perception, that being alive was more important than a disputed sense of comfort.

**Economic Reason**

Most informants did not have a significant problem with financial matters regarding their choice of a place of birth. I argue, maybe, because most of them are working so they have insurance. Indeed, some of my informants are not working and are housewives, but, their husbands, have good jobs, such as a bank consultant, a nurse or airplane worker, so that their husbands do not have a problem paying for insurance for their wives.

Indeed, there are a variety of insurances in the Netherlands. Most informants had insurance to cover payment for delivering in a hospital for a normal delivery. Yet, even though not all informants had that kind of insurance, those who delivered in a hospital had a medical indication decided by midwife, so that they did not have to pay extra money themselves. Indeed, those who perceive that economic reasons dictate where you deliver are from my women informants. When I asked if they have a problem with financial matters, or in other words, do not have insurance to cover payment delivering in a hospital especially for delivery without a medical indication, then, did they still want to deliver in a hospital? One of them said:

*for me, the life of my baby and I are the most important rather than anything in this world ... so I don’t want to barter it with money .. even though I don’t have money or my insurance can’t cover payment in the hospital for a normal delivery ... maybe I’ll borrow some money from my friend ... but as far as I know there is also a hospital which receives patients who are poor so that the payment services will free of charge ... hence ... I don’t think it should be a matter ...* (Renita, 7th June 2010)

Nevertheless, an interesting opinion came from husbands as informants, who said that actually if they could choose they prefer that their wives deliver in their home rather than a hospital, not only because they can accompany their wife during childbirth process but also because it is cheaper.
I wonder why there are many women willing to deliver in hospital … for me, honestly, I would like my wife deliver in home because I can accompany her during childbirth process but also it is cheaper … why we should pay a lot of money if actually we don’t need too … (Hilmi, 18th June 2010)

Indeed, an economic reason did not seem to be a problem for most of my informants, or they not see it as a problem, or something that they considered. One of my informants gave me an example of the advantages of insurance, because she did not feel that they paid for all services from antenatal care until post partum care. Then, she said:

That it is good so that every women can receive service from midwife, or even a gynecologist without worries about payment so that they can be cared for during their pregnancy very well including their health during post partum period  (Sarah, 27th June 2010)

I argue that Sarah said this, because in Indonesia, it is not common for people to have insurance for accessing midwifery care, and most times, based on my research experiences in several cities in Indonesia, people do not have the ability to pay for services from a midwife or a gynecologist. Indeed, it is expensive to access service especially from gynecologist, for instance, based on one of informants experience when she was in Bandung, Indonesia, in 2008. She had to pay approximately Rp. 80,000, or approximately 7 euro, per consultation with a gynecologist, excluding medicine, and in addition she paid Rp. 25,000 (2 euro) for administration fee. Hence, in total she paid 9 Euro for each consultation, excluding medicine, which also needed to be purchased. Indeed, in my own experience, in Jakarta, 9 Euro is equivalent to six days of my expenses to eat three times per day; certainly, it is expensive.
Chapter Eight
Conclusion and Discussion

As I mentioned before being a pregnant woman in Amsterdam, based on illustrations from my women informants, seems to be such a dream comes true. Every woman wants to be treated as a special person who is carrying an incredible new little human being inside their womb, not as a weak woman because of her pregnancy. They feel respected, appreciated, and feeling special when receiving pregnancy services, whether by a midwife or a gynecologist. It is not only the pregnancy services which make them feel full of joy, but also the social environment and government regulations, which in their eyes, are a mirror of human rights application for pregnant women.

Furthermore, when talking about the meaning of the childbirth event, most of my Indonesian informants believe that childbirth is all about the struggle between life and death. The moment of birth places them into a vulnerable situation where life and death have equal possibility. This perception seems to lead to the idea of an increase in the possibility of being alive after undergoing childbirth which strongly believed that suddenly complication will attack in the middle of childbirth process. Indeed, most of them said that it is not nice to be too confident, or in my words, not nice to be arrogant, in the sense of ignoring the fact that complications could arise during childbirth. Whereas, what I grasp from their answers seems to be that complication during childbirth are something beyond their knowledge, it us God’s destiny which they can not predict. Yet, though, they notice that not many of their friends have complications during childbirth, but still complications can happen to anyone, including them, during their own childbirth.

However, the meaning of childbirth is indeed socially constructed within the community where they live. Even though some of them have lived in the Netherlands for years, they still see childbirth in a similar fashion to how they always have. I then argue, in the light of authoritative knowledge, by Brigitte Jordan, that all of these meanings are social constructions dependent on which part of society has the authority to define what “natural” means, whether secure or not. At the end of the day, authoritative knowledge is not about which knowledge is correct, but more about which knowledge is accepted within society (Jordan 1997:58). However, my Indonesian women informants receive knowledge of childbirth as an event associated with risk, so they need
medical technology and medical personnel as a guaranteed of making childbirth safer for them. Indeed, this perspective is in line with the concept of technocratic imperative as I mentioned before.

Moreover, for most of my informants, a safe place for delivery has to have aspects of safety and health attached; these aspects are the most important aspects of child delivery and the hospitals are thought to provide the safest environment for child birth. Despite this, most of them were aware that when choosing a hospital birth, they would be more powerless, uncomfortable and definitely unfamiliar with hospital situation. But, most of them have strong belief that a hospital birth is the best place, a place where they can trust their life when going through a childbirth event. Then, it is normal and logical for them to sacrifice their empowerment and a comfortable situation, and no matter how much money will be spent, they will always be choose a hospital birth.

However, if we use an authoritative knowledge and technocratic imperative concept, when disadvantages of home birth seems often promoted within their community as a place causes risks of complications; . In fact, a woman may feel powerless during a home birth and often, home births end up as hospital births because of unexpected situations when the midwife does not have sufficient equipment or the ability to manage an emergency situation. It is expedient that there is no need to waste time getting a referral to a gynecologist or hospital services, which could bring a woman to the brink of death if there was severe bleeding. A hospital is not always available when a midwife calls in an emergency situation. The most important issue is being alive and healthy which is more important than feeling empowered, in charge of your own childbirth and comfortable being in a familiar situation that is thick with family values. If issues surrounding home birth are constantly promoted within a particular community, then, I argue that Indonesian women will always choose a hospital birth no matter how long they stay in the Netherlands, even if a home is perceived to be safe because of the short distance to a hospital, a sufficient number of hospitals, a well-integrated referral system and a professionally trained midwife. So, the authoritative knowledge in regard to childbirth for Indonesian women is mainly their peer group/Indonesian networks. The trend of medicalization and technocratic imperative are already prevalent, but the circulation of certain scary stories about risky home deliveries in
Indonesian women’s networks in Amsterdam strengthened the conviction of my Indonesian informants that hospital births are preferable and home births are unpopular.

Hence, for Indonesian women living in Amsterdam, perceived safety is paramount. This is congruent with medicalization and with a technocratic imperative. The ‘authority’ in perception of safety lies with the peer group. ‘Authority’ in regard to actual safety usually lies with midwife and gyneocologists (who send women to the hospital whether they want to or not, or send them home, etc). Yet, women retain some form of ‘ownership’ by ensure they deliver in a hospital (by exaggerating complaints, etc).

For some Dutch women the importance of a natural childbirth and empowerment during childbirth, may allow them to consider supporting the anti-medicalization of childbirth, yet, home birth in the Netherlands as mentioned in the literature review is still influenced by medicalization, although less by medical intervention. In the end, the concept of authoritative knowledge as described by Brigitte Jordan (1997), gave me insight into the difference between medicalization or anti-medicalization, as well as to think about who has the “authority” and power to bring knowledge that is trusted and legitimate about what is a safe and good childbirth to pregnant Indonesian women within a community, wherever they are.
Abbreviations:
IDHS : Indonesian Demographic Health Survey
MMR : Maternal Mortality Ratio

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Annexes-1

Topic List for In-depth Interview and Interview Couple

Home delivery in the eye of Indonesian women in Amsterdam, the Netherlands

The research purposes are to explore and understand the Indonesian woman living in Amsterdam and her perspective on:

1. Experience in pregnancy services
2. Perception, attitude and insight toward notion of childbirth
3. Perception, attitude and insight in home delivery
4. Experiences in home delivery and the way they perceived it
5. Factors that influence in choosing place of birth
6. Compromising process of home delivery which different with their conflicting perception of place of delivery

Main question:

1. How do Indonesian women experience with pregnancy services in Amsterdam?
2. How is the meaning of childbirth event among Indonesian women in Amsterdam? Does this meaning in line with home birth?
3. Does home birth fulfill Indonesian women expectation of safe childbirth?
4. How do the women experience the Dutch home delivery system, which is different from their Indonesian perception of an appropriate place of delivery?
5. What are their perception and attitudes toward home delivery system?
6. What influences the decision for Indonesian women to choose a hospital or home birth?
Sub questions for in-depth interviews and Interview Couple

Indonesian mothers, husbands, Indonesian married women with no children, and newly married couples

Personal characteristics of Indonesian mothers:

1. Age
2. Education
3. Occupation
4. Husband’s occupation
5. Nationality of husband
6. Parity (Number of deliveries)
7. Number of children and place of birth for each children
8. Duration living in Amsterdam
9. Religion

Questions:

1. Would you like to tell me, what is in your mind if you hear about childbirth?
2. Would you like to share with me about your experience in childbirth? How do you feel about that?
3. How do you see your body in delivery events? Do you think what happen in your body?
4. What is your belief about childbirth? Please tell me more about that? What do you think about that?
5. What do you think we should do to make our delivery process run smoothly? Why? What do you think about that?
6. What do you think about Indonesian childbirth culture? Please tell me more about that? Why do you have that opinion?
7. Since you in Amsterdam, what is your opinion about childbirth? How do you see childbirth here? What do you think about childbirth here?
8. Would you like to share with me, how was your experience in your delivery process in Amsterdam? What is your opinion about that? What is your feeling about that?
9. Where do you think is the best place to give birth in Amsterdam is? Why?
10. What made you decide to do home delivery? What factors influenced you? What is your opinion about that? How was your husband’s and family’s opinion about home delivery?
11. How was decision making process within your family? How did you bargain for deciding what best for you?
Sub question for In-depth Interview

*Midwives, Gynecologists and Midwife assistants*

Personal characteristics of midwives/gynaecologist/midwife assistants:

1. Age
2. Education
3. Religion
4. Duration of being a midwife/gynecologist
5. Nationality

Question for midwives/gynecologists/midwife assistants:

1. Would you tell me how the home delivery system works in the Netherlands? What is your opinion about it?
2. What do you think facilitates or acts as a barrier to the home delivery system? How can we solve the barriers?
3. What is the midwife/gynecologist’s position in home delivery system?
4. How do you feel or what is your opinion if there is a failure in giving birth at home such as if the mother has to be referred to a hospital?
5. What would you do if there was a complication during home birth (for midwives)?
6. Where do you think is the best place for giving birth based on your own opinion as health provider?

Topic List for Participant Observation

*Home delivery in the eyes of Indonesian women in Amsterdam, the Netherlands*

Immunization, Antenatal and post partum care in midwife clinic

1. All services by midwife during consultation and check up process during pregnancy or post partum period
2. Situation and condition in midwife clinic
3. Interaction between midwife and mother/family (including: communication, body language, sharing information)
**Annex 2**

Informants’ MOTHERS’ characteristics for “Home delivery in the eyes of Indonesian women in Amsterdam, the Netherlands”  

<table>
<thead>
<tr>
<th>No</th>
<th>Name</th>
<th>Age (year)</th>
<th>Education</th>
<th>Occupation</th>
<th>Husband Occupation</th>
<th>Nationality of husband</th>
<th>Number of Deliveries</th>
<th>Number of Children/Place of birth</th>
<th>Duration living in the Netherlands (years)</th>
<th>Religion</th>
<th>Current City</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Sarah</td>
<td>36</td>
<td>Diploma Nursing in Indonesia</td>
<td>A nurse for old people</td>
<td>Accountant assistant</td>
<td>Dutch</td>
<td>1</td>
<td>1/Hospital *(Actually wants to deliver at home)</td>
<td>11</td>
<td>Moslem</td>
<td>Amsterdam</td>
</tr>
<tr>
<td>2</td>
<td>Nabila</td>
<td>35</td>
<td>Diploma in technology in Indonesia</td>
<td>Cashier in grocery store</td>
<td>Bank consultant</td>
<td>Dutch</td>
<td>1</td>
<td>1/Hospital</td>
<td>9</td>
<td>Moslem</td>
<td>Amsterdam</td>
</tr>
<tr>
<td>3</td>
<td>Kelana</td>
<td>34</td>
<td>Diploma in Midwifery in Indonesia</td>
<td>A nurse for old people</td>
<td>A nurse for old people</td>
<td>Indonesia</td>
<td>2</td>
<td>2/Home Delivery</td>
<td>8.5</td>
<td>Moslem</td>
<td>Amsterdam</td>
</tr>
<tr>
<td>4</td>
<td>Farah</td>
<td>26</td>
<td>Bachelor of International Relationship Study in Indonesia</td>
<td>Housewife</td>
<td>A nurse</td>
<td>Indonesia</td>
<td>1</td>
<td>1/Hospital</td>
<td>2</td>
<td>Moslem</td>
<td>Amsterdam</td>
</tr>
<tr>
<td>5</td>
<td>Aminah</td>
<td>24</td>
<td>Diploma in Nursing in</td>
<td>Housewife</td>
<td>A nurse</td>
<td>Indonesia</td>
<td>1</td>
<td>1/Hospital</td>
<td>1.2</td>
<td>Moslem</td>
<td>Amstelveen</td>
</tr>
</tbody>
</table>

1 All names on this table are fictitious. There are no characteristics for midwives and gynecologists because they did not give any to me.
<table>
<thead>
<tr>
<th>No</th>
<th>Name</th>
<th>Age (year)</th>
<th>Education</th>
<th>Occupation</th>
<th>Husband Occupation</th>
<th>Nationality of husband</th>
<th>Number of Deliveries</th>
<th>Number of Children/Place of birth</th>
<th>Duration living in the Netherlands (years)</th>
<th>Religion</th>
<th>Current City</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Santi</td>
<td>45</td>
<td>Bachelor in Mathematics in Indonesia</td>
<td>A teacher</td>
<td>Officer in GWK (Money Changer)</td>
<td>Dutch</td>
<td>2</td>
<td>2/Hospital</td>
<td>14</td>
<td>Moslem</td>
<td>Amsterdam</td>
</tr>
<tr>
<td>7</td>
<td>Helda</td>
<td>39</td>
<td>Diploma Nursing in Indonesia</td>
<td>A Nurse in pediatrics at St. Lucas Hospital</td>
<td>Officer in Airline company</td>
<td>Indonesia</td>
<td>2</td>
<td>2/Hospital *1st child in home delivery</td>
<td>8</td>
<td>Moslem</td>
<td>Amsterdam</td>
</tr>
<tr>
<td>8</td>
<td>Renita</td>
<td>25</td>
<td>Diploma in Business Administration in the Netherlands</td>
<td>Housewife</td>
<td>Researcher in Indonesia</td>
<td>Indonesia</td>
<td>1</td>
<td>1/Hospital</td>
<td>25</td>
<td>Moslem</td>
<td>Amsterdam</td>
</tr>
<tr>
<td>9</td>
<td>Maria</td>
<td>29</td>
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<td>Housewife</td>
<td>PhD Student</td>
<td>Indonesia</td>
<td>1</td>
<td>1/Home Delivery</td>
<td>4</td>
<td>Christian-Protestant</td>
<td>Amsterdam</td>
</tr>
<tr>
<td>10</td>
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<td>35</td>
<td>Diploma in Nursing in Indonesia</td>
<td>A nurse for old people</td>
<td>A Nurse for old people</td>
<td>Indonesia</td>
<td>2</td>
<td>2/Hospital *1st child home delivery</td>
<td>7</td>
<td>Moslem</td>
<td>Amsterdam</td>
</tr>
<tr>
<td>11</td>
<td>Fatimah</td>
<td>31</td>
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<td>Director of Investments</td>
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<td>1</td>
<td>1/Home delivery</td>
<td>15</td>
<td>Moslem</td>
<td>Amstelveen</td>
</tr>
<tr>
<td>12</td>
<td>Sandra</td>
<td>29</td>
<td>Diploma in Nursing in Indonesia</td>
<td>A nurse for old people</td>
<td>A nurse for old people</td>
<td>Indonesia</td>
<td>1</td>
<td>1/Hospital</td>
<td>7</td>
<td>Christian-Catholic</td>
<td>Amsterdam</td>
</tr>
<tr>
<td>13</td>
<td>Melisa</td>
<td>27</td>
<td>Senior High</td>
<td>Housewife</td>
<td>Owner of</td>
<td>Dutch</td>
<td>1</td>
<td>2/Hospital</td>
<td>2</td>
<td>Christian-Catholic</td>
<td>Amstelveen</td>
</tr>
<tr>
<td>No</td>
<td>Name</td>
<td>Age (year)</td>
<td>Education</td>
<td>Occupation</td>
<td>Husband Occupation</td>
<td>Nationality of husband</td>
<td>Number of Deliveries</td>
<td>Number of Children/Place of birth</td>
<td>Duration living in the Netherlands (years)</td>
<td>Religion</td>
<td>Current City</td>
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<td>----------------------------------</td>
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<td>----------</td>
<td>--------------</td>
</tr>
<tr>
<td>14</td>
<td>Kestari</td>
<td>51</td>
<td>Senior High School</td>
<td>Housewife</td>
<td>Officer at Schipol</td>
<td>Morocco</td>
<td>4</td>
<td>4/Hospital</td>
<td>30</td>
<td>Moslem</td>
<td>Amsterdam</td>
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</tbody>
</table>

Informants’ COUPLES’ characteristics for “Home delivery in the eyes of Indonesian women in Amsterdam, the Netherlands”

<table>
<thead>
<tr>
<th>No</th>
<th>Name</th>
<th>Age (year)</th>
<th>Education</th>
<th>Occupation</th>
<th>Nationality</th>
<th>Duration living in the Netherlands (years)</th>
<th>Religion</th>
<th>Currently City</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Bambang</td>
<td>30</td>
<td>Diploma Nursing in Indonesia</td>
<td>Officer in restaurant</td>
<td>Indonesia</td>
<td>5</td>
<td>Moslem</td>
<td>Amsterdam</td>
</tr>
<tr>
<td>2</td>
<td>Aisyah</td>
<td>31</td>
<td>Diploma in Nursing in Indonesia</td>
<td>A nurse for old people</td>
<td>Indonesia</td>
<td>8</td>
<td>Moslem</td>
<td>Amsterdam</td>
</tr>
</tbody>
</table>
Informants’ HUSBANDS’ characteristics for “Home delivery in the eyes of Indonesian women in Amsterdam, the Netherlands”

<table>
<thead>
<tr>
<th>No</th>
<th>Name</th>
<th>Age (year)</th>
<th>Education</th>
<th>Occupation</th>
<th>Nationality</th>
<th>Duration living in the Netherlands (years)</th>
<th>Religion</th>
<th>Currently City</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Brian</td>
<td>31</td>
<td>Master of Geology from VU</td>
<td>PhD Student</td>
<td>Indonesia</td>
<td>4</td>
<td>Christian-Protestant</td>
<td>Amsterdam</td>
</tr>
<tr>
<td>2</td>
<td>Hilmi</td>
<td>32</td>
<td>Diploma Nursing in Indonesia</td>
<td>A nurse for old people</td>
<td>Indonesia</td>
<td>7</td>
<td>Moslem</td>
<td>Amsterdam</td>
</tr>
<tr>
<td>3</td>
<td>Wono</td>
<td>36</td>
<td>Diploma Nursing in Indonesia</td>
<td>A nurse for old people</td>
<td>Indonesia</td>
<td>9</td>
<td>Moslem</td>
<td>Amsterdam</td>
</tr>
</tbody>
</table>

Informants’ MIDWIFE ASSISTANT characteristic: “Home delivery in the eyes of an Indonesian women in Amsterdam, the Netherlands”

- Name: Serena
- Education: Senior High School
- Duration living in the Netherlands: 33 years
- Duration being a Kramzorg: 11 years
- Religion: Moslem
- Nationality: Indonesia
- Current city: Amstelveen