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Doulas Going Dutch: The Role of Professional Labor Support in the Netherlands

Monica He

SIT Study Abroad, monica.he@rice.edu

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Douglas Going Dutch:
The Role of Professional Labor Support in the Netherlands

By

Monica He
Rice University

Submitted in partial fulfillment of the requirements for the
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Academic Director: Kevin Connors
Advisor: Marlies Rijnders

Consent to Use of Independent Study Project (ISP)

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Among the many interesting things I discovered while studying the Dutch language, none was more fascinating than learning that the verb *bevallen*, means both to "to give birth" and "to please."

Raymond De Vries, *A Pleasing Birth*

Abstract

This study uses a mixed method approach and medicalization theory to explore the new role of professional doulas in the Netherlands through the perspectives of women who have had doula-attended births. Survey data from the Dutch doula association is first analyzed in order to quantify women's experiences with doula care and characterize their demographic information and birth outcomes. Simultaneously, nine in-depth interviews are conducted with Dutch and non-Dutch mothers who have recently had doula-attended births. The interviews focus on experiences with doula care in the context of the Dutch maternity care system.

Quantitative analysis finds women who had doulas to be older, more diverse and more educated compared to the national average. Moreover, survey results demonstrate that women are overwhelmingly satisfied with doula care. Finally, qualitative analysis of interviews identifies four elements of doula care—continuity, connection, tailoring and essentializing—to be integral to women's reclaiming of birth as their rite of passage. In conclusion, the doula's role in the Dutch maternity system is two-fold: to provide holistic care during birth and to act as a buffer against the tendency to medicalize birth.

Contents

Abstract.....	iv
Acknowledgements.....	vi
Part I: Research Background	
Introduction.....	1
Overview of Maternity Care.....	5
Douglas Going Dutch.....	10
Literature Review.....	13
Part II: Theory and Methodology	
Theoretical Framework.....	17
Data and Methods.....	21
Part III: Results and Conclusions	
Quantitative Results.....	26
Interview Analysis.....	29
Discussion and Conclusion.....	41
References.....	46
Appendix A: Interview Guide.....	49
Appendix B: <i>Bevalregister</i> Template in Dutch.....	50
Appendix C: Client Questionnaire Template in English.....	51

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Introduction

“You know, they’re medieval here,” a Swedish friend told me. We were both from other countries, had Dutch husbands, and were pregnant in Holland. My friend ended up scheduling a cesarean section in a hospital [...]. I chose the traditional Dutch model of homebirth under the care of midwives. (Kikstra and Gaffigan 2007:64)

The Netherlands remains one of the only countries in Western Europe and North America whose maternity care system has escaped the institutionalized medicalization of birth. Based on a midwifery model of care, the Dutch system embraces a *lasses-faire* approach to pregnancy and birth that prides itself in the accommodation of homebirths and low rates of medical interventions. Today, a majority of women in the Netherlands choose midwifery care during pregnancy and about 20% eventually give birth at home.¹ In contrast, despite the recent rise in homebirths, less than 1% of all births in the United States take place at home.² Moreover, medical intervention during birth occurs far less frequently in the Netherlands. The Dutch Cesarean delivery rate is 15.4% compared to the United States record high rate of 32.3%.³ The difference in epidural rate for vaginal births between the two countries is also astonishing—8.1% in the Netherlands compared to 61.0% in the United States.⁴

In recent years the word “doula” emerged in The Netherlands. Originally meaning “female slave” in Greek, the modern-day doula has evolved to gain professional status as a woman who provides continuous, non-medical support during labor and childbirth for the

¹ *Stichting Perinatale Registratie Nederland*, “Perinatale Zorg in Nederland 2008,” pg 116.

² *National Vital Statistics Reports*, “Births: Final Data in 2009,” pg 13.

³ “Perinatale Zorg in Nederland 2008,” pg 6; “Births: Final Data in 2009,” pg 4.

⁴ “Perinatale Zorg in Nederland 2008,” pg 62; partial 2008 U.S. data from 27 out of 50 states (Osterman and Martin 2011).

woman and her family. By providing emotional and physical support, the doula supplements the medical support from other birth professionals—whether it be doctors, nurses, or midwives—and assists the woman in having a smooth laboring process. Moreover, a doula acts as an advocate for the birthing woman, not to be the voice of the woman but to ensure that the woman makes her wishes and desires known in a situation that could become stressful or confusing.

It is a mystery how doulas emerged in the Netherlands and why the demand for doula services is rising. Because Dutch doula care is in its infancy, very little is known about birthing women in the Netherlands and their experiences with doulas during childbirth. This phenomenon may very well reflect problems in the current system with the midwifery model of care. Thus, my research explores the professional doula's role within Dutch maternity care through the perspectives of women who have had doulas. With a maternity care system that is looked upon so favorably, why would women in the Netherlands need the extra support of doulas? Which women are choosing doulas and how satisfied are they with doula care? And what do doulas add to the experience of birth?

This paper will first use survey data to identify women who have had doulas in the Netherlands and evaluate their experiences with doula care. The second goal is to characterize doula support in the Dutch context using theory on the medicalization of childbirth. I argue that four elements of doula care—continuity, connection, tailoring and essentializing—add more holistic support by enabling women to reclaim childbirth as a woman's rite of passage. Furthermore, paradoxes of doula care and implications for integrating doulas into the current system will be discussed. Understanding the role of doulas in the Netherlands can help locate existing problems in the midwifery model of care, establish a niche for doula support and improve the process of childbirth for all women in the Netherlands.

A Personal Journey

I came into this research project with the goal of immersing myself in the doula and birth community in the Netherlands. I believe I left Amsterdam having accomplished that and much more. Little did I know I would also embark on a doula journey of my own. Thanks to the gracious support of two wonderful doulas, I was invited to attend a DONA International doula training workshop with Debra Pascali-Bonaro—one of the most well-known doulas internationally and a true pioneer in doula care—and unexpectedly completed the most cost-prohibitive part of the certification process. Being able to partake in this training has provided me with the experience and legitimacy to continue my doula journey in a more practical manner—pursuing *pro bono* doula work. Much more importantly, in writing this paper I hope to share my knowledge and passion of doulas and profile their recent work in the Netherlands. Without a doubt the best thing that came out of my stay in the Netherlands is being able to proudly say, “I am a trained doula.”

Notes on Terminology

In order to maintain objectivity I have chosen to use more neutral language throughout the paper. The words “uncomplicated” and “low-risk” are used instead of “normal” and “natural,” which are often problematic for carrying value-based judgments.⁵ The word “medical” (and, to a certain extent, “medicalized”) may be neutral given that it can be used in a completely descriptive sense. Its alternatives “high-risk” and “complicated” are considered to be more neutral. Unfortunately my limited vocabulary reflects the dichotomous language used to describe birth statuses. I will be clear in cases where more nuanced descriptions are needed.

⁵ Read more in the “Theoretical Framework” section.

Another phrase that needs clarification is “birth plan,” which is a list of birth preferences women produce with their doulas. Although most women refer to this as a “plan,” I am instead using “preferences” as it allows more flexibility for unpredicted outcomes of birth. I was inspired to adopt “birth preferences” after hearing doulas discuss how “birth plan” can set women up for disappointing “unplanned” events.

Lastly, I would like to explain the word “Dutch” in my paper. In most cases the standalone term “Dutch” is used to describe an ethnically Dutch person—someone who is born and raised in the Netherlands of Dutch origins. This way I am able to differentiate between ethnically Dutch people and Dutch people of different ethnicities, particularly immigrants to the Netherlands. A couple of times I do ambiguously categorize people as “Dutch” and “non-Dutch,” in which case it is accompanied by a clarifying footnote to further explain the difference.

Overview of Maternity Care

What is at stake in care at birth is not the survival of one patient, but the reproduction of society. (De Vries 2004:15)

In order to situate the emerging role of doulas, I will first provide a basic overview of the Dutch maternity care system. The following section will explain the division between the *eerstelij*n and the *tweedelij*n, birth location, postpartum care and insurance coverage for all players in the system.

***Eerstelij*n and *Tweedelij*n**

*Eerstelij*n literally means “first line” and refers to primary care in the Netherlands while *tweedelij*n—“second line”—refers to the area of medical specialty. In the context of birth the division between the *eerstelij*n and the *tweedelij*n of care depends on the designated risk of the pregnancy and labor. Every woman at the beginning of her pregnancy would go to a midwife or her *huisarts*—general practitioner (literally, “house doctor”). If her pregnancy is designated as low-risk, she may choose to be under the care of the *huisarts* or a midwife. Almost all women who are low-risk, however, choose for midwifery care during her pregnancy (De Vries 2004). The practitioner in the *eerstelij*n can also characterize the pregnancy as high risk at the beginning due to the woman’s predisposed conditions or as situations arise during pregnancy. In either case, care is immediately transferred to the gynecologist in the *tweedelij*n of care.⁶

⁶ At the beginning of pregnancy, indications of high-risk pregnancy include having chronic diseases such as diabetes and HIV, and previous birth experiences such as Cesarean section, stillborn (with unknown reason) and premature born or miscarriage. During pregnancy, reasons

Transferred from the *eerstelij*n to the *tweedelij*n can further occur if the labor process becomes high risk. The three most common reasons for transfer of care during labor and delivery in 2008 are, in order: meconium stained water, slow progression of labor and obstruction of labor during the second stage.⁷ Therefore, although some women may be under the *eerstelij*n of care throughout their entire pregnancy, indications for high-risk during labor and delivery can force care to be transferred yet again. National data from 2008 shows that 84.2% of women started their pregnancy in the *eerstelij*n and 15.8% of them in the *tweedelij*n of care.⁸ However, due to the transfer of care, only 32.8% babies are eventually delivered in the *eerstelij*n. Finally, sometimes problems may occur in the immediate postpartum period, where a small percent of transfers takes place. Figure 1 shows how percentages of women under the *eerstelij*n dwindle over the entire process.

Place of Birth

A high-risk pregnancy or labor and delivery in the *tweedelij*n would dictate birth in the hospital with a gynecologist. The *eerstelij*n of care gives women more choices in their preferred place of birth. With a midwife or *huisarts* women can

Figure 1. Percentage of women and line of care during different stages of pregnancy and birth ⁹		
	<i>Eerstelij</i> n	<i>Tweedelij</i> n
Beginning of Pregnancy	84.20%	15.80%
During Pregnancy	48.10%	52.40%
At delivery	32.80%	67.70%
Immediately after birth	N/A	+1.10%

give birth in the home (*thuisbevalling*), in the “polyclinic” (*poliklinische bevalling*) or in the birthing center (*kraaminrichting* or *bevalcentrum*). While the concept of homebirths is

such as hypertension, breech position, small gestational age, post-term pregnancy and multiple births can change the status of pregnancy into one that is high-risk.

⁷ “Perinatale Zorg in Nederland 2008,” pg. 63.

⁸ “Perinatale Zorg in Nederland 2008,” pg 115.

⁹ Compiled from “Perinatale Zorg in Nederland 2008,” pg 115.

straightforward, the difference between the polyclinic and birthing center may need further clarification. De Vries (2004:30) describes a *poliklinische bevalling* as “an uncomplicated short stay (i.e., less than 24 hours) hospital birth” with their *eerstelij*n practitioner, which is different from one at a birthing center. In fact, relatively few births occur in birthing centers in the Netherlands. Of all births in 2008, 20.9% occurred at home, 11.4% in the polyclinic, and only 0.1% in a birthing center.¹⁰ For just births in the *eerstelij*n, the numbers are 64.4%, 35.2%, and 4.2%, respectively. Figure 2 shows the distribution for place of birth in 2008.

Postpartum Care

Although Dutch maternity care does not support hospital stay after an uncomplicated birth, it does provide postpartum care for women to facilitate their transition to motherhood. *Kraamverzorgenden* are trained postpartum

Figure 2. Birth locations in 2008 ¹¹		
	All births	<i>Eerstelij</i> n
Home	20.9%	64.4%
Polyclinic	11.4%	35.2%
Birth Center	0.1%	4.2%
Hospital	67.3%	N/A

caregivers who visit the woman at home in the coming eight days after her birth and help with childrearing tasks such as breastfeeding and basic baby care and watch for maternal and infant health.¹² Additionally, they also perform some household chores such as cooking, organizing and cleaning. Women and her family can choose to have *kraamverzorgenden* in the house for as short or as long as they want or feel comfortable with (within caregivers’ working hours) in the eight-day period.

¹⁰ “Perinatale Zorg in Nederland 2008,” 2008, pg 116.

¹¹ Compiled and calculated from “Perinatale Zorg in Nederland 2008,” 2008, pg 116.

¹² While most people the Netherlands use the term *kraamverzorgster* to describe a person who performs this standard postpartum care (and always refers to a woman in this profession), De Vries (2004) prefers *kraamverzorgenden* as it is gender neutral.

Insurance

The details of health insurance in the Netherlands are not going to be described in its entirety here. However, it is important to understand that the logic behind health insurance coverage for maternity care is in accordance with the Dutch support for the midwifery model. For a low-risk pregnancy insurance covers care for a midwife or *huisarts* in the *eerstelij*.¹³ Only women with complications during pregnancy and labor can be covered for care in the *tweedelij*. Therefore, insurance does not compensate for women who have a “normal” pregnancy but wish to be under the care of a gynecologist. Moreover, insurance coverage is dependent on the place of birth and favors homebirths. While it fully covers homebirths in the *eerstelij*, that is not the case with *poliklinische bevalling*. Therefore, an uncomplicated birth in the hospital under *eerstelij* care leaves some of the cost of the delivery room to the responsibility of the mother. De Vries (2004) calculated the 2003 out-of-pocket cost for the delivery room at €244.70 (originally priced at €404.00 with a insurance reimbursement of €159.30).¹⁴ Insurance further covers almost all of the costs associated with the full 64-hours of *kraamverzorgenden* care; women only need to make a small hourly co-pay fee.¹⁵

The emergence of doula care in the Netherlands is explored in depth in the next section, but I will briefly write about doulas in terms of insurance coverage. Currently doulas and their services are not normally included by the Dutch health insurance, although there is ongoing

¹³ Though De Vries (2004) writes about a relatively recent limitation that was put in place to protect midwifery care. In places where midwives are practicing, only midwifery care will be covered in the *eerstelij* and not the *huisarts*.

¹⁴ Note that the data is almost a decade old and some women and some families do indeed have insurance that cover the surplus of a *poliklinische bevalling*.

¹⁵ De Vries (2004) notes a co-pay fee of €3.27 per hour, but again the data is old and the payment has increased. Insurance coverage may also vary depending on the specific insurance and how many hours the woman and her family request the help of the *kraamverzorgende* (whether it is more or less).

discussion to change that fact. One can take a cursory glance at some of the websites of doulas in Amsterdam and learn that doulas generally charge between €700 to €1,000 for a “comprehensive” package that includes at least several prenatal appointments, continuous support during labor and appointments in the postpartum period. Therefore, the cost of a doula is usually much higher than the out-of-pocket medical cost of having an uncomplicated birth. And without insurance support, doulas are not well integrated into the Dutch maternity care system, which carries important socioeconomic implications for access to their services.

Doulas Going Dutch

Historically, women have been attended and supported by other women during labour. However, in recent decades in hospitals worldwide, continuous support during labour has become the exception. (Hodnett et al. 2011:2)

“What is a doula?” is the most common question I hear when I explain my project.¹⁶ The concept of a doula is certainly alien to many in the Netherlands, including many childbearing women and Dutch mothers. This section will explain the occupational role of a doula and trace the emergence of professional doulas in the Netherlands.

Doula Defined

Although childbirth has been a female-supported event long before the rise of obstetrics, only recently did labor support assume the position of a professional caregiver. Originally meaning “female slave” in Greek, the term “doula” was reclaimed in the United States during a social movement in the late-twentieth century in conjunction with supporting scientific evidence of their benefits (Morton 2002).

DONA International, the largest doula association in the world, describes the professional doula in its training workshop manual as a “trained and experienced labor companion who provides the woman and her husband or partner continuous emotional support, physical comfort and assistance in obtaining information before, during and just after childbirth” (DONA International 2006:1.1). Based on the DONA International training I attended and birth stories I

¹⁶ My usual elevator pitch explains the doula as someone who provides continuous emotional and physical support during birth, to which many would erroneously reply, “Oh, do you mean a midwife?”

have heard, doulas typically meet with clients one time or more before the birth to discuss their birth preferences and any other requests they may have. When labor starts, women call their doulas, who will arrive within an hour and stay for the duration of the birth. During the labor, doulas provide physical comforts (e.g. massages, counterpressure, acupressure, position changes) to the birthing woman and emotional support for her and her partner. If complications arise during birth, the doula can help remind the woman of her birth preferences and empower her to make her wishes known to the hospital staff or other medical professionals. After the birth, doulas will meet with women once or more to go over the birth and fill in gaps or explain areas of confusion.¹⁷ What I have illustrated is only one version of the doula story to show the doula's role during pregnancy, labor and in the postpartum period.¹⁸

The Dutch Doulas

The emergence of Dutch doulas can be traced through the creation of the *Nederlandse Beroepsvereniging voor Doula's*—the professional Dutch doula association—(NBvD) and the Dutch doula training course. Currently, there are two ways of becoming a certified doula in the Netherlands—through DONA International or the Dutch doula course in Utrecht. The latter was formed in January 2006 when a group of motivated women came together and created a curriculum for the Dutch doula training.¹⁹ Later that year in September 2006, four women referred as *pufmaatjes* received the first doula certifications in the Netherlands.²⁰ A year later in

¹⁷ Doulas I have met also present the women with a birth story after the birth.

¹⁸ The doula's experience, as well as the range of services she offers, may vary. Doulas may also take on last-minute doula jobs or be a part of a hospital-based doula program that do not allow them to make a connection with the client before labor.

¹⁹ <http://doulaopleiding.nl/content/historie>

²⁰ “Eerste bevallingscoaches geslaagd,” *De Telegraaf*, August 2006, accessed from www.doula.nl November 2011.

2007, the NBvD was formed to uphold high standards of doula care.²¹ Today, the NBvD has around 75 members who have to each assist in two births a year to maintain membership. Due to the nascent nature of doulas in the Netherlands, there is no official data yet on doula-attended births. However, the best estimate comes from the NBvD birth registration forms. Between January and October 2011, 119 birth forms were filled out by doulas and returned to NBvD.²² It is a small number compared to the number of births each year in the Netherlands, which was 177,713 in 2008, but a sizeable one considering the short history of Dutch doulas.²³

²¹ <http://www.nbv.nl/geinteresseerden.html>

²² This mostly includes births attended by NBvD members, though non-members completed a few of those forms. Learn more about the form in the data section of the paper.

²³ “Perinatale Zorg in Nederland 2008,” pg 6.

Literature Review

If a doula were a drug, it would be unethical not to use it. (John J. Kennel, MD)

Existing literature on labor doulas, though sparse, has focused on the effects of continuous labor support on physical birth outcomes as well as their influence on women's social and emotional perceptions of birth. These studies employ a variety of methods ranging from randomized clinical trials to oral history stories. With the exception of meta-analysis studies, most recent research on birth doulas has been conducted in an American hospital setting. Unless indicated otherwise, studies in this review are based in the United States. It is also important to note that the term "doula" varies depending on the study. Some studies only include professionally trained doulas while others consider an untrained woman who provides continuous support during labor as fulfilling this doula role. Overall, these studies emphasize the importance of having continuous support with a female companion during labor, regardless of her official doula status or relationship to the birthing woman.

The landmark study on the effects of continuous support during labor is published by the well-respected Cochrane review (Hodnett et al. 2011). In the meta-analysis, which includes 21 trials in 15 countries with over 15,000 women, several birth outcomes are considered and analyzed. The group finds that women who have continuous labor support are more likely to have shorter births, more likely to give birth spontaneously (without forceps or vacuum), less likely to have pain medication and were overall more satisfied with their birth experiences. These effects of continuous support are more robust when it begins early in labor and when the

doula support is not a part of the hospital staff. Other research boasts similar findings as those from the Cochrane review. In a randomized trial, Campbell et al. (2006) finds that in the group where a minimally trained female friend or relative acts as a doula during labor, women are more likely to have shorter labors and higher Apgar scores than the group of women without doula support. Similarly, Hardin and Buckner (2004) notes in a qualitative study that receiving continuous support from an experienced woman—whether it is a doula, friend or a labor nurse—is important to women who have positive experiences of childbirth. Further research has shown that the effects of continuous support in reducing medical intervention is unique and disappears when support is intermittent rather than continuous (Scott, Berkowitz, and Klaus 1999).

Research has also connected doula support with increased infant breastfeeding and more positive perceptions of motherhood. Mothers who had doula-supported births are more likely to have higher rates of breastfeeding in both a hospital-based doula program and a randomized trial of female friends or relatives acting as doulas (Campbell et al. 2007; Mottl-Santiago et al. 2007). In Breedlove's (2005) discussion of doula support for pregnant teenagers, she finds that the teenage mothers who had doulas during birth have better early attachment to their child and more confidence in the transition to motherhood compared to the ones who were not supported by doulas. Moreover, Campbell et al. (2007) reveal that doula-supported mothers are more likely to have positive perceptions of their newborn, themselves and the amount of social support in their environment. Although the mechanisms underlying these relationships are not explored, it is evident doula support has positive effects on women's experience of birth that extends well into their transition to motherhood.

A sizeable portion of the literature has also been dedicated to doula support for underserved populations, which often calls for culturally appropriate care. Results from a

nationally representative survey sent out to doulas and doulas-in-training indicates that most doulas in the United States are white, well-educated married women (Lantz et al. 2005). Because childbearing women in the United States are more diverse than the homogeneous doula population, several doula studies have been conducted on more disadvantaged populations that raise the question of how to provide culturally competent labor support. Doulas can best serve their community when they understand the specific needs of the people (Low, Moffat, and Brennan 2006). In a large Midwestern hospital in the United States, Somali women were trained as doulas to better serve Somali women in labor (Dundek 2006). This not only decreased the language barrier but also helped the laboring woman overcome fears about the culturally different birthing system and potential judgment of female genital surgery. Breedlove (2005) also documents doula participation in assisting pregnant teenagers during labor. Doula support proved pivotal in their continuous support during birth and their relationships with the teenagers before, during and after the birth. Sometimes the doula was the pregnant teenager's only consistent adult support. As previously mentioned, the doula role in this case is related to the teenage mother's confidence as she embarks on her motherhood journey. Furthermore, Schroeder and Bell (2005) describes a prison doula program where doulas accompany laboring women in a prison hospital. Their study shows that incarcerated women can have positive and empowering birthing experiences with the help of a doula. Finally, Pascali-Bonaro (2003) summarizes her experiences with her doula program for widows of the 9/11 terrorist attacks in New York City. She finds doulas to be crucial in guiding women through their period of grieving during the birthing process. These studies illuminate the important role of doulas in facilitating cross-cultural communication and their position at the intersection of medical care and social work.

Most relevant to the current study is literature on the unique nature of doulas in the maternity care. Existing literature has focused on the relationship between doulas and nurses or midwives. Studies based in the United States note that nurses and midwives' concurrent commitments to multiple women hinder their ability to connect with women on the same level as doulas can (Gilliland 2002; Hodnett et al. 2011). In some cases nurses feel threatened by the presence of doulas, while doulas are unhappy about not being fully integrated into the system (Papagni and Buckner 2006). Literature shows that doula support is desirable to women who give birth in a medicalized maternity care system such as the United States because doulas “[provide] unique and exclusive support tailored to meet each woman’s specific needs” (Koumouitzes-Douvia and Carr 2006:38). Similarly, a Swedish study on women’s experiences of doula support finds that doulas are able to offer for women continuity and reliability of care that is missing in midwifery (Berg 2006). Thus, research points to the uncommon element of continuous labor support as vital to women’s positive experiences of birth regardless of where they give birth.

An obvious gap in the literature pertaining to this paper is the absence of doulas research in the Netherlands. While this is understandable due to the recent emergence of doulas in the country, assessing the rising demand of doulas in the Netherlands has important implications for the Dutch maternity care system. This study adds to this literature by investigating why women are choosing for extra doula support in the highly regarded Dutch midwifery model of care.

Theoretical Framework

Medical norms don't describe what is, but what should be. (Hubbard quoted in Riessman 1992:125)

The medicalization of childbirth and critiques of this model will serve as the theoretical framework for this paper. Medicalization refers to the process of socially constructing a previously non-medical event into a problem that now falls under the domain of medicine. This transition from the ordinary to the medical involves “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). Deviant behaviors, such as alcoholism and hyperactivity, as well as normal processes, such as sexuality and aging, can undergo medicalization.

Medicalization has especially focused on aspects of women’s lives, and childbirth is certainly no exception (Conrad 1992). Medicalized childbirth is often characterized by a “routinization of technology” (Oakley 1980:20). Women who give birth in technocratic setting are subject to more medical interventions such as blood tests, urine tests and ultrasounds during pregnancy and pain medication, labor inductions and Cesaerean sections during childbirth (Dalton 2009; Oakley 1980). Even the mere fact that a large majority of births in Western countries take place in the hospital is a testament to the medical monopoly of birth.

The process of medicalization, which extends the scope of medicine, also has grave social implications. Conrad (1992) contends that one of the ominous consequences of medicalization is increased social control and management in the medical arena. Medicalization lends legitimacy to the authority and judgment of medicine, and through it, the medical

community is able to use its new powers to manage and control laypeople without ever causing suspicion. Foucault (1973) further contributes to this discussion with his postmodern critique of the institution of medicine. He rejected the popular notion from modernity that doctors have special wisdom to perceive some sort of truth and can “[restore] dispassionate society to its original state of health” (Foucault 1973:36). According to Foucault, doctors came into this position of power through the establishment of the “medical gaze,” which allowed for medical surveillance and gave them unquestionable authority (Conrad 1992; Foucault 1973). In obstetrics the abundance of surveillance and social control is evident in the continuous management of mother and child from the beginning of pregnancy with prescribed prenatal diet and lifestyle to the postpartum period with proper breastfeeding and childrearing techniques (Conrad 1992; Oakley 1980).

In light of the increasing number of medicalized births, a new feminist birth movement has emerged in many Western countries. Experts from a wide range of disciplines began to write about the negative aspects of a medicalized birth. Close medical management and the heavy use of technology can deprive the birthing woman of control and bar her from a “potentially empowering experience” (Fox and Worts 1999:328). Feminists have also critiqued the medicalization of childbirth for placing the will of (male) doctors above the needs and rights of birthing women. This imbalance of interest is apparent in the indices of reproductive success, which is measured using a medical frame of reference in terms of mortality rates (Oakley 1980). Thus, viewing childbirth as chiefly a medical phenomenon undermines the laboring woman’s human experiences of birth. While a positive birth can empower the birthing woman, a negative birth has far-reaching consequences such as higher likelihood of postpartum depression and anxiety (Oakley 1980).

As a result, many have countered medicalization of childbirth with *demedicalization*, so that childbirth is “no longer defined in medical terms and medical treatments are no longer deemed to be appropriate solutions” (Conrad 1992:224). The midwifery model of childbirth views childbirth more as a holistic process and is an alternative women seek to the medicalized structure of birth (Dalton 2009). Even though the midwifery model is the norm in the Netherlands, the increasing number of medicalized births in the country is a fear that looms over many who seek to preserve the sanctity of the non-medicalized births.

This new birth movement is often referred to as the “natural” birth movement and the “alternative” birth movement in the United States. Although many feminists embrace (and endorse) the idea of a “natural” birth, the movement has also come under fire from a number of feminists. Beckett (2005) explores some aspects of post-structuralist feminist critique of the birth movement. She first sees the use of “natural”—a true buzzword in the movement—as a return to the dualism that is central to patriarchal ideology. By pitting the “natural” against the “medical,” the birth movement inadvertently reinstates the hierarchal binary that situated women in a subordinate position in the first place. Moreover, she challenges the essentialist claims the movement makes about the midwifery model. What she finds especially problematic is the praise for midwifery practice based on the gender of the profession and women’s inherent ability to empathize with other women. Finally, she argues that the veneration for an empowering birth “romanticizes women’s roles as lifebearers and mothers, and assumes an emotional and physical reality [...] that does not exist for many” (Beckett 2005:260). Despite the good intentions of the birth movement to provide women with a better birth experience, some of their rhetoric receives criticism from post-structural feminists. While in the Netherlands women do not have to fight for a “natural” birth as much as those from other Western countries, this type of controversial

language becoming more popular for those who are defending the midwifery model and women-supported care.

This project will therefore assess the Dutch maternity care system using the theories related to the medicalization of childbirth. How do women view the role of doctors, midwives and doulas in light of these theories? Does the Dutch midwifery model serve as an alternative to the medicalization of birth by providing holistic care? Does the Dutch doula change the dynamics of medicalization; if so, in what way? I will revisit the theoretical framework at the end of the paper to answer these questions.

Data and Methods

The twenty-first century has seen a remarkable number of publications that identify themselves as based on mixed methods. (Small 2011:58)

My research questions will be answered using a mixed methods approach which includes quantitative analysis of surveys, qualitative reasoning of in-depth interviews and observations of birth- and doula-related events around the Netherlands.

Survey Data

For the past couple of years the NBvD has been building a modest collection of survey data in order to start quantifying doula services in the Netherlands. The quantitative data analysis thus consists of two documents developed by the NBvD: client questionnaires sent out to women who have hired doulas and *bevalregisters*—birth registration forms—filled out by doulas for each birth they attend. The client questionnaires are filled out by women (with a section for their partners) retrospectively and gather information on demographics, birth details, doula’s role and overall experience with the doula service.²⁴ In addition to these closed-ended questions, the questionnaire also contains several open-ended questions allow women to expand on their experiences with doulas at birth. All in all, 78 women and their partners completed questionnaires in both Dutch and English for births between February 2009 and November 2011.

²⁴ It should be noted that a newer, more extensive, version of the questionnaire replaced the older one in mid-2011. This does not affect the analysis in this study with the exception of women’s educational level, which was only asked in the newer survey and therefore has a much smaller sample size.

The NBvD recommends to its members to catalog each birth that they attend by completing a *bevalregister* form. This includes the demographic information of the mother and details of the birth such as medical intervention and place of birth. Overall, 35 doulas filled out 146 *bevalregisters* for births between February 2009 and November 2011, though 119 of these births occurred in 2011.²⁵

Observations

From September through November, I attended three different birth-related events in Amsterdam and Den Haag in order to better contextualize the role of doulas in the Dutch landscape. At the end of this journey I truly feel that I fully immersed myself in the Dutch birth movement and met with key figures in both the doula community and the expatriate mothers community in the Netherlands. Because these communities are so small, I will weave overarching themes from these events into my paper rather than use individual quotes and stories for confidentiality reasons.

In October, I attended a two-day birth workshop in Amsterdam with Americans Elizabeth Davis and Debra Pascali-Bonaro called “Creating, Supporting and Nurturing Safe, Satisfying, Pleasurable births.”²⁶ Over 20 birth professionals and midwifery students attended this workshop that aimed to create more pleasurable birth experiences based on the concepts from the book and film “Orgasmic Birth.”²⁷ At the workshop I met a doula who graciously invited me to attend a

²⁵ The *bevalregisters* indicate that with the exception of a couple, almost all of the doulas who fill this out are members of NBvD.

²⁶ I was fortunate to attend the workshop free of cost in exchange for volunteering.

²⁷ Elizabeth Davis is an American midwife and author, and Debra Pascali-Bonaro is an American doula and film director of “Orgasmic Birth.” Together they collaborated to write the book *Orgasmic Birth*, which was recently translated to Dutch and “launched” at the workshop in Amsterdam.

two-day DONA International training course taught by Debra a few days later. In the following couple of days I traveled to Den Haag and participated in the training with about a dozen other aspiring doulas.²⁸ Finally in November, I attended a seminar sponsored by the American Women’s Club of Amsterdam called “Giving Birth in Holland.” The event is geared toward American and English-speaking expatriates who are pregnant or expecting parents and want to learn more about maternity care in the Netherlands.

Interviews

I conducted semi-structured, in-person interviews with nine women who have recently given birth in the Netherlands with a doula present. The mothers gave birth between three and a half months and just over two years before the interview. I received most of my contact information through several doulas who asked their clients if they were interested in participating in my research. Additionally, I met a woman at the “Giving Birth in Holland” event, another through an ad I posted on the *Doulacollega’s* Facebook group, and one more through one of my interviewees who later became a trained doula and attended the birth of her friend. The nine women represented birth experiences with seven different doulas in the extended Amsterdam area.²⁹ The interviews took place in the women’s homes (and a houseboat)—seven in Amsterdam and two in Haarlem—and lasted between 45 minutes to over an hour and a half.³⁰ Although I only interviewed the mothers, their partners and children were sometimes

²⁸ Even though I went to the course with the intention of observing as a researcher, I eventually actively participated in the training and received a training certification despite not having paid for it.

²⁹ One woman had her backup doula at the birth, so I included both the original doula and her backup. I also included the interviewee who later became a doula.

³⁰ I went to Haarlem for my interview expecting to interview one woman. However when I arrived, my interviewee introduced me to her friend who also recently gave birth with a doula, and I ended up doing an interview with both of them.

intermittently or continuously present in the same room. I did not find this to be a source of distraction or bias for the interviews. Language did not pose an issue since Dutch people learn English at school from a very young age, though Dutch women sometimes had to search for words, especially medical jargon.

In terms of demographics, four of the women I interviewed were born and raised outside of the Netherlands. Three were from the United States and one was from another Western European country. Of the five Dutch-born women, four are of Dutch origin and one woman was second generation Moroccan-Dutch. The women were between 32 and 41 years old and were all married or partnered with the exception of one. Four women had given birth before and five had their first birth with a doula. The range of birth experiences in regards to birth location and care professional (in *eerstelij*n or *tweedelij*n) was diverse and well represented in my interviewees. Finally, all women were extremely satisfied with having a doula at birth and would have a doula at a birth in the future.

Quantitative Methods

Although the aforementioned NBvD forms have been in circulation since 2009, this paper marks the first time that the data is analyzed. I used Excel as the primary tool for data organization and statistical calculation in order to examine the characteristics of women who had doulas during birth, their birth outcomes and overall satisfaction. First, separate databases for the questionnaires and the *bevalregisters* are created on Excel. The two databases are then individually matched for the same birth record on the basis of childbirth date, doula name and mother's postcode. In combining the two datasets I have obtained a larger sample of women who had doulas, and in matching the records I am able to analyze data from both databases without

any duplication from the two. Afterwards, statistical analysis is performed for the client questionnaires using Data Analysis Toolpak on Excel to gather descriptive statistics for the characteristics of the women and their satisfaction with doula services. Then the Graphpad online resource is used to statistically compare the sample of the women who filled out the client questionnaires to ones who did not. Discrepancies between the two can undermine the results on satisfaction with doula care. Finally, statistical calculations are made to compare characteristics of women and their births from the entire doula group to the most recent national data.

Qualitative Reasoning

Qualitative analysis focuses on the nine interview but incorporates some aspects of the survey. First, answers from three open-ended questions in the client questionnaires are translated and used to develop interview questions. Two native Dutch speakers—my advisor and the homestay coordinator at SIT Study Abroad—translated the written texts in the client questionnaire, which is mostly in Dutch. The questions ask why the women chose to have a doula, the most important contribution of their doula to the birth and any additional comments to improve doula care.³¹ The questionnaires built a strong foundation for the interviews which help characterize doula care in the Netherlands. Interviews are conducted in English, recorded and later transcribed and analyzed.

³¹ Only the new version of the survey asked why the women choose to have a doula, leaving fewer answers for that question. And due to misplacement of questions, some partners, and not the women, filled out the question that asks for the most important contribution of the doula.

Quantitative Results

*She was worth every penny (euro cent)!
(Client questionnaire)*

The client questionnaires and the *bevalregisters* are analyzed using Excel and Graphpad. Below are the results for client satisfaction of doula services and the comparison of the characteristics of the doula group to national data.

Satisfaction with Doula Care

Based on the answers to the client questionnaires, women and their partners are overwhelmingly satisfied with their doulas. Women rated their satisfaction with doula services an average of 9.7 on a scale of 10, and their partners rated an average of 9.5.³² All of the 75 responses also indicate women and their partners “feel that the presence of a doula contributed to making the birth a more pleasant experience.”³³ Moreover, almost all of the women (92.3%) agree or completely agree that they will have a doula at their next birth, and a large majority (75.6%) feels that a doula should be at every birth.

The caveat to the results above is that those who responded to the client questionnaires do not represent the entire sample of women who had doulas at births. The responders (n=78) and the non-responders (n=119) differ in certain demographic characteristics and birth outcomes. Using the z-test on Excel to compare means, age is found to be slightly statistically significant

³² Because this rating question was introduced in the newer version of the survey, only 18 women and 12 partners responded. Nonetheless, it gives an overall indication of client satisfaction.

³³ See appendix for blank survey form.

($p < .10$) between the two groups. Women who filled out the questionnaire are slightly older (35.2 years) than women who did not (33.7 years). Results from a Chi-Square test on Graphpad for a 2x2 contingency table show that women who filled out the questionnaire are significantly ($p < .05$) more ethnically Dutch (73.1%) than women who did not (56.8%). In terms of birth outcomes, the same Chi-square test finds that women who filled out the questionnaire have significantly ($p < .01$) higher rates of spontaneously delivered births (69.2%) than those who did not (50.4%).³⁴ The two groups of women are not significantly different in terms of parity, length of pregnancy, birth location, medical caregiver (*eerstelij*n or *tweedelij*n) or use of pain medication. Nonetheless, the discrepancies between the responding and non-responding populations undermine the positive responses from the client questionnaires and suggest that neutral or negative feelings toward doula care may be underrepresented.

The National Comparison

The characteristics of the women who had doulas and their birth outcomes are not very different from those in the most recent national data. One-sample tests of proportions and means are used to compare the doula sample to the 2008 national birth data from *De Stichting Perinatale Registratie Nederland (PRN)*—the Netherlands Perinatal Registry. Results show that women who had doulas at births are significantly older (34.3 years, $p < .001$) than women who gave birth in 2008 (31.0 years). The doula group is also significantly less Dutch (63.3%, $p < .001$) than women from the 2008 national data (78.4%).³⁵ With the exception of those two demographic characteristics, the doula sample did not achieve statistical significant difference in

³⁴ “Spontaneously delivered” means no use of surgery and instruments such as Cesarean deliveries and those with forceps or vacuums.

³⁵ A point of clarification, “Dutch” here describes ethnicity and does not include Dutch-born women from other places of origins.

its parity, birth location, line of care, transfer of care or spontaneous delivery compared to women in the national data. Additionally, available data indicates that women who use doulas in the Netherlands are exceptionally highly educated.³⁶ Of the 42 women who responded, 30 are highly educated and only two have low levels of education.³⁷

These preliminary findings suggests that women and their partners are generally very satisfied with having a doula, although those results are undermined by women who did not respond to the client questionnaires. Compared to the national data, women in the doula sample are not much different except that they are older, more educated and less Dutch. It appears that more differences exist more between the responders and non-responders to the client questionnaires than between the entire doula sample and the national data. Therefore, data from the past two years demonstrate that doulas in the Netherlands have attended births of women whose characteristics and birth outcomes are not too different from those of the birthing population in the country.

³⁶ The question of education level is only introduced in the new version of the client questionnaire, and there is no comparable information in the 2008 national data.

³⁷ Educational level is grouped as follows: low—none, basic high school (e.g. LTS, VMBO), standard high school (e.g. MAVO, MBO-kort, VMBO-t); middle—standard high school/vocational (e.g. MBO-lang, MTS, BOL, BBL, INAS) and advanced level high school (e.g. HAVO, VWO, Atheneum, Gymnasium); and high—college/vocational education and university.

Interview Analysis

I'm 41 now, and I thought this is really my last chance and this has to go right. (Margarétha)

In the following section, I will first establish the meaning of birth for my participants and then explore elements of doula care that help them experience birth as a woman's rite of passage.

Meaning of the childbirth

American anthropologist and feminist Davis-Flyod (2004) famously described childbirth as a rite of passage. She critiques the American medical system for having taken control of a process that should rightfully be in the power of women. The same sentiment was expressed at many of the birth events that I attended in Amsterdam. At the Giving Birth in Holland seminar, a birth professional emphasized the importance for the woman to feel empowered at birth so that after the birth she is able to say, "I did it my way." The workshop I attended in September also focused on the concept of a "pleasurable birth" and how birth professionals can best help women achieve that birth experience for themselves.

Similarly, the women view childbirth as one of the few rites of passages for women, which they believe can be empowering or traumatic depending on how it is experienced. For these women taking ownership of the delivery process is essential to a transformative birth experience for the mother. Sonia, a Dutch mother of two, explains: "I think the possibility of really delivering yourself in this life-changing event can give a woman so much strength that can really make you a woman. It can give you a lot of force, a lot of confidence in yourself." The mothers often feel that the readily available technology distracts women from their ability to be

“really delivering” themselves. Sarah, an American who has had three homebirths, comments on technology and birth, “You feel good about yourself knowing that you didn’t need lots of beeping machines, people in white coats to help you out of your predicament.”

Childbirth is not only a rite of passage for women as they transition into motherhood, but each time it is also seen as an initiation into life for the newborn child. Sonia describes these transitions during birth:

I really felt like giving birth is such a great impact for yourself, especially for the child that’s being born. It’s so important for the child. I mean, from there it’s such an initiation to come into the world, and I thought I want to have it to be as much care as I can. [...] I think it’s your first really big initiation in life, for the baby. To come out, it’s such a magical thing, and life-changing event for everyone.

Yet, women are wary of the trauma that can occur at birth with potential consequences for both the mother and baby. Courtenay, an American mother of one living in Amsterdam, explains how she sees trauma at birth: “We are all just a collection of our experiences, including our own births. I really believe that trauma incurred at birth can be carried along with us into our lives. I wanted as little trauma as possible for [my baby].” At the end of the day, Stephanie, a Dutch mother of one, reminds us about this precious moment: “[birth] is a very important time that you will never have a chance to do over again—I mean, you can do it with the next child, but not with the same one.”

Elements of Doula Care

Most women who participated in this study were very confident in the medical care they received from their midwives or gynecologists. In fact, women see their medical practitioner primarily there for the health of the baby and their doula for meeting the mother’s needs. Sarah elaborates on the difference between a doula and a midwife: “A doula’s there for you, and a

midwife's there for the baby. [...] The midwife's there primarily for the baby or for your *physical* wellbeing, to make sure that nothing bad happens with you *medically*. Their role is not to make everything lovely for you." Extending this relationship to the hospital staff, Margarétha, a Dutch mother who has had two hospital births, remarks: "The people in the hospital think about their own needs, not that much about your needs. They want to have the baby in time and healthy, and that's about it. They're too busy to think about other things." Thus, women seek out doula care so that their needs are met during this important life transition. In the following subsections I will identify four main elements of doula support that are essential to women as they embark on their birth journey.

1. Continuity of care

One of the most desirable and consistent features of doula care is the continuous support doulas provide during labor. In a typical midwifery practice a midwife would not be at the birth for the entire time, either due to shift changes or having a busy schedule. Sonia remarks on the inconsistency and unpredictability of midwifery care: "When [the midwives'] shift is ending, they're going to hand it over to a colleague. In that way, that can make a disturbance as well. You don't know who is coming because they have a team of midwives, and you don't know who will be there." As an expecting mother for the first time, Courtenay also explains why the default option did not appeal to her and her husband:

At some point [the midwife will] show up, and she'll check how you're doing, and she'll leave if you're not progressed enough. And she'll come back, and she'll leave, and she'll come back. And that thought of just us being here on our own waiting sounded a little bit scary. [...] That was a big reason we chose a doula. You know, that she would be there start to finish. Everybody else could switch shifts, could be gone, whatever, would not show up, we knew that no matter what she would be there.

Stephanie adds her perspective in a hospital birth: “The main thing of a doula is that there is one person present who’s there the whole time because doctors come in shifts, everybody is there, you know, it’s hectic. She’s a sort of constant professional factor, and that was extremely important.”

When the woman is progressed enough in labor for the midwife to stay, she could still lose her contact with her midwife if complications arise and transfer of care is needed. Courtenay found herself in this situation and reflects on losing her primary care provider:

Here, I have my midwife if I’m going to deliver at home. But once there’s anything complicated in the hospital, I’ve lost that person who was with me. And I think that’s a real tragedy, you know, because it’s kind of that point where you actually need more support, you get less, you know, because you don’t know that person. So that relationship you built up, that trust you built up is now gone.

However, the continuity of doula support is really two-fold: during labor as well as throughout the entire birth process. The latter is often a neglected aspect of doula support. Not only is a doula the sole consistent care provider during labor, she is also usually the only birth professional who works with the woman and her partner during pregnancy, labor and in the postpartum period. The current structure splits the responsibility of maternity care among midwives, doctors and *kraamzorgenden* depending on the woman’s medical needs and her stage in the birthing process. Women who did experience more consistency with their midwifery care truly saw their cases as exceptions. Both Courtenay and Sarah looked for an independent midwife who takes fewer clients and thus has the schedule for more consistent care. Influenced by her birth experiences in the United States, Sarah explains her motivation for wanting an independent midwife:

I wanted to see the same midwife throughout the pregnancy as I would have at the birth. And that’s what I had in America—that’s what everyone had in America, of course. I was used to that idea of, you know, I’m gonna see one person during my whole pregnancy

and that's who's going to come to my birth. And I wanted that to happen again. So when I got here and found that [...] you don't know who's going to show up, just whoever's on call, that didn't appeal to me. So I looked for an independent midwife.

Similarly, Sonia saw herself as “really lucky” because her good friend was her midwife during both of her births. She goes on to say: “My midwife stayed with me the whole time because she was my friend. Normally in the system, they don't stay because they don't have the time for it. And I think that is really crucial, and I've heard a lot of women who are feeling lonely and would like support.”

2. Deeper connection with a birth professional

Compared to their medical caregivers, women find themselves connecting with their doulas on a deeper level. Having this special connection with their doula enables women to open up about their fears, aspirations and other feelings during an important life transition. In many instances women compared their doula to a spiritual guide leading them through their birth journey. Courtenay describes her doula as such:

My relationship with [my doula] was much more of a, what you would feel with like a spiritual leader or your yoga teacher. It's somebody who's touched you more internally about, you know, your hopes and your dreams and what matters to you. Just in the conversations we've had three or four times, she was more like a guru.

Courtenay's description rings true for Sonia whose doula was her yoga teacher. Sonia says, “Because I was doing yoga with her, I knew she could really be a guide, a spiritual guide.”

In contrast, women often experienced very impersonal care with their medical birth professionals. After her care was transferred to the hospital, Courtenay experienced mechanical treatment from the hospital staff:

Once we got to the hospital it was, “we're treating the symptoms, we're treating this part of you. The contractions aren't hard enough, so we're going to give you this drug for

that.” So it was always, you know, you almost feel like a piece of meat in a butcher shop. They don’t know who I am, they don’t know what my dreams and aspirations are, they don’t know what my—I’m not even sure if they read the birth plan that I provided, you know what I mean? It was more like, “we have a job to do, you lay there and we’re going to do this job with you. It was very matter-of-fact.

Courtenay continues to describe how this cold treatment harshly contrasted with the personal care she had throughout her pregnancy:

A little bit more of a connection [with the hospital staff] would have been better. And I think maybe even would have helped me deliver better because I didn’t feel a connection with a person who was encouraging me, pushing me, you can do it, blah blah blah. If you don’t feel like you’re on the same team, like they’re there for you, that you even can connect with them, then I don’t think you can have the same emotions about it when someone’s yelling at you rather than encouraging you. They could be saying the same thing but it’s just the way you take it in.

Silvia shares similar experiences with her midwifery team, which she sees as medically focused:

The midwife was more technical and it was just more cut-and-dry. Basically like, “okay, here’s a heartbeat,” you know. [...] I kind of saw the midwives as kind of a Dutch doctor, per se, where they would just say, “oh, just do this, it’ll be fine.” You know? Where [my doula] would really listen and be like, “okay, well, why don’t you try this, why don’t you try that?”

In other cases, due to personnel changes, women were never even given the chance to establish any relationship with their medical caregiver. Margarétha explains:

Because we had so many different doctors, there is hardly any relationship. With the doula, there is a personal relationship. [...] You share your worst fears that are often too personal to share with your doctor. [...] I felt we connected, we understood each other, that I could open up with her.

At the core of this issue, birthing women do not perceive midwifery in the Netherlands as a profession that usually provides care beyond the medical. Women employ doulas because they feel doulas truly want to be there for them whereas midwives are just there to fulfill an occupational duty. Sarah, who has worked with midwives in both the United States and the Netherlands, gives her perspective on American and Dutch midwives:

To be a midwife [in the U.S.], it's so under fire that you have to be an activist. You have to be totally dedicated. You have to believe in it so fully, to be a midwife there. Because it's a really crappy job in many, many ways. [...] Here, it's great, you know. Lots of people have homebirths, it's very normal. On the downsides though, that means the people who are serving you are just regular people who need to get a job, and at the end of high school they go to their career counselor and they say, "Oh you can be a midwife." "Oh, I can be a midwife." It's not like you have to be driven and committed. So you have a whole set of midwives, who, you know, it's just their job, whatever. They don't feel passionate about it. Whereas in America, you really have to be passionate about it because it's just too shitty of a job. So it's very, very different in my experience. So I have looking for that kind of committed person. [...] I just wanted a midwife who would be as into being a midwife as you have to be in America to be one. There are so many more of them here, I just wanted to get the same top 5% sort of person.

Women frequently use the phrase "being there" to describe the devotion and commitment of their doulas. The act of "being there" extends beyond being in the same vicinity as the birthing woman. In an intimate time of their lives, women feel doulas are truly there for them out of a love for what they do, not because it is something the job requires of them. Sonia illustrates how her doula was actually "there" with her compared to her friend-midwife who was also present for the birth:

With my doula I felt more embraced, more being cared for. [...] I remember with my other birth, my midwife was doing her administration, and I felt a little lonely. With the doula there, they're with you. And normally it's even worse, the midwife would just leave. [...] The doula] is really there for you. She's present, she's not doing her own thing when she's there with you. She's there, and she's there wholeheartedly. Things are just in the background, and she's there with you.

Although both the doula and midwives are compensated, Silvia, an American mother of one, feels that her doula was making a personal sacrifice to be "there" for her at the birth:

[The midwives are] not there for me from the minute it begins, you know. They're just there to check in on you, you know. Yeah, they heard the heartbeat and checked up on the pregnancy but they're not *there*. The doula is. She's invested, she's personally invested in this, you know. This is a chunk of time that's been taken out of her life, you know. So it's a huge investment, per se. At least that's what I had in my head. So for me it was like she's investing so much of her time in me.

This combination of devotion and professionalism makes the doula what Francis and Hanna refer to as a “specialized friend” and what Stephanie describes as a “professional friend.” To the women, a doula represents an experienced friend who wants to support them at their birth. The doula’s professional veneer also gives them an extra sense of security and erases any fear of potential judgment. Kiek, a first time Dutch mother who had her doula-trained friend Sonia attend her birth, explains the added benefit of undergoing doula training: “Next to the part that she is my friend, that also I could trust upon her. And because she did this [doula training] course, she is more than a friend in that way. Otherwise, if she didn’t do this course I wouldn’t have asked her.” Courtenay further explains how the doula relationship is different from a friendship:

[With the doula] there’s no baggage and there’s no embarrassment. One of the things that was hard for me is that I’m quite a modest person. One of the things I was worried about was being naked. I don’t like to change in the gym, I don’t go to saunas, I don’t like it when people are naked where I need to be naked. I just don’t—I feel very self-conscious about that. And so with a friend or female relative, I wouldn’t feel comfortable being in the birth pool with no clothes on. I would have been embarrassed and worried about that. With [my doula], well she’s a professional, and while we have a relationship with her, it’s not like we had a relationship before that where I have to feel like judged or anything. So I think with people you have before and after with relationships there’s a worry it might change the relationship but also that you might be insecure about the situation you’re in.

3. Tailoring to birth preferences and the discourse of the “natural”

Women also found doulas helpful in honoring their preferred birth experiences and tailoring their care to best achieve those outcomes. By and large women preferred to have a “natural” birth without medical intervention whenever possible. Stephanie explains her motivation to have a “natural” birth: “I really liked to experience all the part of birth. Although it’s painful, it’s also nice in a way to go through without too much medicalization.” When prompted about the meaning of “natural,” women gave a myriad of definitions, examples and

analogies. A recurring theme from women is the discussion of pregnancy and birth as a normal physiological process, rather than a disease. Sarah elaborates:

To me, pregnancy is not an illness, so just like any other bodily function, you don't seek out somebody else's help to complete it. [...] If you say, "could you help me poop?" What could somebody do for you? That's how I see it. It's not something that can be helped with. [...] You have to do it yourself, and there's not way around that.

Courtenay also provides examples of "natural" childbirth:

Drug-free, I think is natural childbirth. And without vacuums, forceps, obviously surgery. Those things I think cross the line outside of natural because they are getting in the way of the process of just what nature would do. If you were alone on a mountaintop giving birth to a baby, those things wouldn't be present.

Sarah later adds to that analogy, "To me the kind of birth you could be having on your own next to a tree, that's a natural birth." For Margarétha "natural" childbirth is simply, "Putting the baby into the world myself."

Although women feel that the system accommodates their wishes to have a "natural" birth, women nonetheless sought the extra support of their doulas to reinforce those original preferences. During a time of confusion and stress, women were often afraid they would give up on their preferred birth experience. Margarétha talks about her experience coping with pain at her first birth without a doula and at her second birth with a doula:

[At my first birth] I really had my principles. I didn't want to have any pain medication, for instance. But within one hour, I asked for pain medication. That was fast! I totally lost control. [The second time] at moments when I'm not that strong anymore, she knows what I want and tries to stick to it when I lose my way. Because she supported me emotionally so well, it was easy to not shout about pain medication. She made me stronger.

Doulas often met with the women to discuss their birth preferences before the birth, and together they would anticipate any unexpected scenarios. Margarétha continues to explain how her doula helped her cope with a possible Cesarean delivery after a prolonged labor:

At first at home she asked me, “when you’re in pain and want a Cesarean, what do I need to say to convince you to stick to your original wishes?” And I said, “Well, I heard that you can’t hold the baby in your arms in first weeks if you have a cesarean because it hurts too much, your tummy hurts too much. And you can’t carry your baby.” So at the birth, she said, “do you want to hold your baby in the first weeks?” And that was enough for me.

In the hospital doulas have the added responsibility of ensuring that hospital staff honors the preferences of women. Margarétha again notes the added value of a doula during her second birth in the hospital:

The first time I didn’t have too much ideas about the way I wanted to give birth, but the second time it was different. The doula tried to discuss those things with the medical staff and tried to achieve them. For instance, the baby was lying upside down in my case, and I wanted to give birth naturally, if possible. And I think because I had a doula, they really gave that a chance. Otherwise they wouldn’t have done that.

Similarly, Stephanie reflects on her experience giving birth in the hospital: “Because of the preparations with [my doula], I liked how it went. Like that it would be calm and I had asked not too many doctors would run in and out.”

Other women simply need the support of a doula to achieve their ultimate goal, which is to deliver a healthy baby. Silvia talks about how her doula prepared her for birth and later kept her focused during the birth:

We just kind of talked about, you know, how to keep me centered and how to keep me focused on my goal, per se. [...] She was my rock, basically. Her sole focus was to keep me centered, and that’s exactly what she did. She was just this calm, energy and force. All I had to do was look at her and, “okay, calm again,” you know?

The same resonates with Francis, who feels that her doula “gave [her] the strength to finish.”

4. Essentializing childbirth as a women’s experience

The essentializing of childbirth refers to a subset of essentialist thought which views childbirth as a process only women can experience on the basis of an inherent biological and

gendered divide (Brown 2006). In this study women told their birth stories in a way that attested to their essentialist beliefs of childbirth. By essentializing the experience of birth, women feel that they are best able to share this rite of passage with their doula—a fellow woman and mother. Stephanie recounts how she felt the need to reach out other women on her way to expecting her first child:

I think [childbirth is] a very primary experience in life which also creates a bond among women. For me it was my first child, and I felt the need to share that with other women because it's such a feminine thing. I really wanted to profit off the wisdom of other women who had already been through that experience. And that felt nice, like being taken into a sort of community. [...] I wanted to share the experiences that came into me just by being pregnant. My attitudes toward life changed. It's a very physical, very basic, very back-to-nature experience. And I wanted to share that to make the most out of it because it was a very nice time.

Moreover, Silvia explains why she was unable to connect with her male midwife during her pregnancy:

Having [my doula] there with me I truly felt that instinct that, you know, primal, like, "I know you've done this, I know you've seen this a million times, and I trust that you know how to help me when I need it." Men can't do that, and I had a male midwife as well, not at my birth but part of the team. And every time I was hoping he would be my midwife. But when it came down to it I was kind of glad he wasn't because I was thinking, "What does he really know?" I mean I'm sure he's great about what he does. He was actually one of my favorites because he had this really calm, peaceful personality and whatnot. But when it came down to it, I was like, "what does he really know?" 'Cause every time we had an interaction he's like, "Yeah, I know my wife has told me this, and I've heard this from other women." And I'm like, "yeah..." It really didn't sell it to me. [...] For me, I'm more convinced when people, like, you know, like about kicking, like about the baby kicking and whatnot. You can describe it to somebody, but you really don't know what it's about until you feel it yourself.

And for Francis, giving birth with her doula present was the first time she experienced—or care to experience—female bonding: "I'm not a feminist or anything but with my doula I really had an amazing experience of bonding with another woman. It was like magic. [...] I wanted to feel this women contact."

The women I interviewed also consistently described their doulas as possessing an “intuition” during the birth. They believe this intuition is inherent to the doula’s experience as a childbirth professional, mother and woman. Silvia largely attributes her doula’s intuition to her biological makeup:

I just think it’s that woman-to-woman connection, especially women that’s been through birth like that. That’s also where the intuition comes. You can’t beat that with a stick. It’s just incredible the effect it has on the birthing woman and the process. [...] I think, as women, I think we’re all born with this mother instinct and this intuition.

A key component to this is the doula’s ability to act intuitively, something that women did not expect from their partners and thus was much appreciated in a time of stress. Silvia continues to describe her doula’s intuition and why it was crucial during birth:

She was very intuitive and, um, I found that I didn’t have to tell her “touch me” or “do this to me.” She would just do it, and that I was so appreciative of. Because that’s one thing that I, you know, when I get stressed out, I get really closed off, per se, and it’s really hard for me to articulate what I need. And that’s also what’s in the back of my head at way in the beginning. It’s because I knew that of myself, and I’m like, I need someone that can basically read my mind because I’m going to bite my poor husband’s head off ten times, twenty times a day or whatever because he’s not going to know what I need. And she did, and she was great about it. And she would tell him too, you know, about what he could do and whatnot.

Similarly, Francis found the feminine touch of her doula to be irreplaceable: “[My doula] had soft hands and knew how to touch another woman. She massaged my back, and it was like *[making smooth gestures and sounds]*. And then my husband took over and it was like *[making rough sounds and gestures]*.” Courtenay makes the analogy to the rhythm of a dance:

[My doula] would say, “Courtenay, what do you think about eating something?” And I’d be like, “Oh yeah, I’m really hungry.” So she was anticipating my next move. [It was] very much like a dance, like she would see me coming this way and so she would move that way with me. And she would see me moving that way and would follow me in that direction. Always in line with what I was doing. Never like I’m going this ways and she’s like, “but I think you should be over here!” Never like that. It was always in the direction I was going.

Discussion and Conclusion

Yeah, there were some scary moments. Yes, there was some pain. But I would do it again, I would gladly do it all over again. (Silvia)

This last section will examine some final aspects of doula care in the Dutch context through a discussion of its paradoxes, theoretical reframing and research shortcomings. I will also conclude with a discussion of integrating Dutch doula care.

Paradoxes of Doula Care

In her interviews with American doulas, sociologist Morton (2002) identifies five dilemmas that challenge doulas in their care for birthing women. One of the dilemmas is what she refers to as “pricing a priceless service” that originally was provided free of charge by women in the community (Morton 2002:15). Hanna, one of the two women I interviewed who received free doula care, brings up this paradox almost verbatim: “It’s putting a price on a priceless service.” In talking with these women, I repeatedly noticed that in discussing their utmost appreciation for their doulas, few women brought up the monetary transaction that was necessary for the service to occur in the first place. Perhaps women feel that if they focus on the business aspect of doula care, they would undermine what they believe to be a doula’s wholehearted devotion to birthing women.

The second paradox in doula care lies in the emphasis of experience on a process that is inherently unpredictable. Women gain a peace of mind knowing that their doula is “experienced” at childbirth—either by number of deliveries attended or having birthed before. Yet, no two

births are the same and the only way to experience it is to watch it unfold each and every time. Regardless of the number of births the doula has attended, she can never attend enough births to fully understand this physiological process. When Margarétha was about to undergo a Cesarean, her doula made the mistake of telling her that it was the first breeched Cesarean she has attended, which added to Margarétha's apprehension at the moment. Margarétha remembers joking with her doula afterwards: "I said to her, 'Maybe you shouldn't have said that during giving birth!' At that moment I thought maybe she didn't have that much medical background." For women it seems the most comforting option is to blindly trust that a doula's experience as a birth professional and mother would be enough to support them through their own birth experiences.

Revisiting Theory

I now revisit the theory on the medicalization of childbirth in order to contextualize the Dutch maternity care system in light of those theories. While women view the doctor's role solely as medical, they acquiesce in the limits of a doctor's duties rather than criticize the situation. Stephannie explains how it is logistically impossible for the doctor to provide additional support: "The gynecologist cannot be there for 12 hours continuously. I mean, that would be far too costly and also that's not his job. His job is not to mentally support women in labor but to do all the medical things well." Similarly, Margarétha accepts the limitations of a doctor's role:

I also accept that doctors have their part in giving birth and that they can't be good at everything, but they don't have time for emotional support during the birth of the child. They have to focus on the health of the child. I understand that emotional support is second. It's not a complaint towards the medical system. That's just the way it works.

Dutch midwives occupy a more ambiguous position in this discussion. As explored in the interview analysis, women's problems with midwives do not stem from them being "medical" as much as "impersonal." With midwives women feel they clearly had a choice in steering the

direction of their birth. However, women who wanted a “natural” birth were frustrated at the midwife’s eagerness to transfer the case to the doctors. When that happens, women feel that they have been neglected and that their wishes are not the midwife’s priority. Thus, Dutch midwives often do not provide holistic care or act to reverse medicalization of childbirth. Perhaps this is because, as Sarah explained, midwifery care is much more normalized in the Netherlands, resulting in a group of midwives who are less devoted. I would also argue that Dutch midwives lack the fervor and commitment to demedicalize birth as it is theorized for modern midwives in other medicalized countries such as the United States.

Furthermore, the women I interviewed clearly essentialized the experience of birth as a “woman-to-woman” bond shared among women and, in particular, mothers. Although this thought often comes under post-structuralist feminist criticism, the overwhelming response I got from women seems to suggest that essentializing birth is an integral aspect of this life-changing event for them. However, perhaps this would change had I interviewed women from different socioeconomic statuses. Since seven out of the nine women paid for the full costs of doula service, it is hard to gauge whether the essentialist ideologies would exist if this is a service available to all women regardless of financial barriers.

In terms of theoretical considerations doulas in the Netherlands add to the maternity care system by providing more holistic and personal care that is theorized to be under the scope of midwifery but is not carried out in practice. Doulas also can act to buffer the medicalization of birth by honoring the birth preferences of women who want a “natural” birth. Moreover, because so few pregnancies end in the *eerstelij*n, the Dutch maternity care system is already more medicalized than it is perceived to be, further reinforcing that need for doula care.

Limitations and Further research

As established in earlier sections, the results of this study are limited to a sample of older, highly educated women. My interviewees would be considered to be in a high socioeconomic bracket using educational or occupational measures. Many women I interviewed are in managerial positions, and others talked about writing their thesis for university or Master's. (There are also two stay-at-home mothers whose husbands are technology professionals, placing their households in a high socioeconomic bracket.) Perhaps women who are significantly less educated or wealthy would hold different sentiments regarding doulas and childbirth. Additionally, this study only includes perspectives from women who preferred to have a "natural" birth even though all of the women believe doula care should be provided for everyone regardless of birth outcomes. Future doula research in the Netherlands should focus on the experiences from a broader range of women in terms of socioeconomic status and birth preferences. Research should also examine doula care from the perspective of doulas and how they deal with the paradoxes of their occupational duties.

A place for doulas?

Although this study has established a place for Dutch doulas, they nonetheless face structural and social barriers in attempting to be integrated into the Dutch maternity care system. Doulas cannot be institutionalized unless insurance companies fully cover or partially subsidize their care. However, in order for that to happen, insurance companies must first see the cost benefit analysis of hiring doulas before they are willing to cover doula services. Secondly, doulas need to be socially integrated and accepted by the other members of the maternity care system. In smaller cities especially, midwives sometimes perceive doulas as a threat or believe women

who hire doulas do not trust in their expertise. This happened for Francis whose midwife, upon seeing her doula, reminded her that she has “over 30 years of experience.” Better knowledge and understanding of doulas and what they do can alleviate these existing tensions.

This study has explored the emerging role of birth doulas in the Netherlands through the perspectives of women who have had doulas at their births. First using survey data from the NBvD, I profile women who have had doulas and also demonstrate that they are overwhelmingly satisfied with their doula care. The second part of this paper analyzes nine in-depth interviews with women and concludes that four elements of doula care—continuity, connection, tailoring and essentializing—are integral to women’s reclaiming of birth as their rite of passage. In conclusion, unlike doctors and midwives who are perceived to be medical and impersonal, extra doula care gives women more holistic support and buffers against the tendency to medicalize birth in the Dutch maternity care system.

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Appendix A: Interview Guide

On maternity care:

- I'd like to know your impressions of the Dutch maternity care system. As an expecting mother, did you find it supportive of your needs?
- In what ways did Dutch maternity care not meet your needs as an expecting mother?
- What was your ideal birth, and what did you see getting in the way of it?
 - PROBE for “natural,” “medicalized” and “medical”

On doulas:

- How did you first learn about birth doulas and what was your impression of them?
- What was the most important factor in your decision to have a doula at birth?
- Before you decided on having a doula at birth, did you have any hesitations about making that choice?
- What kind of questions did you ask your doula at your prenatal appointments?
 - PROBE for fears
- What was your doula's biggest contribution to your birth experience?

Doulas in context:

- What was your relationship with your doula compared to that with your midwife/doctor?
- Did you feel you could talk about some things with your doula but not your midwife/doctor?
- How did your doula add to your experience in ways that your midwife/doctor couldn't or didn't?
- How was having a doula different than having a partner/best friend/female relative?
- Was there anything you didn't like about your experience with your doula?
- What kind of women do you think should have a doula at birth?
- Is there anything else you'd like to talk about that I didn't cover?

Demographic information:

Parity, marital status, occupation (woman and partner), years in the Netherlands (if not Dutch) and race/ethnicity

Appendix B: Bevalregister Template in Dutch

[Reformatted for ease of reading]

naam:
status:
datum bevalling:
Leeftijd client:
Postcode client:
Zwangerschap:
Zwangerschapsduur:
Afkomst:
plaats bevalling:
reden medische indicatie:
Apgarscore:
opname_neonatologie:
reden_opname_neonatologie:
hoelang_opname_neonatologie:
eindverantwoordelijk:
medicinale pijnbestrijding:
wanneer_begonnen_weeen_datum:
wanneer_begonnen_weeen_tijd:
wanneer_arriveerde_doula_datum:
wanneer_arriveerde_doula_tijd:
wanneer_geboren_datum:
wanneer_geboren_tijd:
doula_vertrokken_datum:
doula_vertrokken_tijd:
medisch_ingegrepen:
voorgesprekken:
aantal_voorgesprekken:
nagesprekken:
aantal_nagesprekken:
opmerkingen:

Appendix C: Client Questionnaire Template in English



Research questionnaire and evaluation of doula support

The benefits of a doula are well recognised in many countries. However, the Dutch obstetrics system is organised differently from many of these countries so it is difficult to apply those results to the Netherlands.

It is therefore not clearly known what the effect the doula has on the birth, and how the doula support is received by the woman and her partner in the Netherlands. For this reason the Dutch Association of Doula's (NBvD) has the ambition to gather as much data as possible on the effect of the doula.

On behalf of the NBvD and your doula who supported you during your pregnancy and birth we request that you fill in this questionnaire and return it via email to: formulieren@nbvd.nl.

This is a confidential questionnaire, and all your information will be processed anonymously. If you would prefer to print the questionnaire and fill it in, you can send it via post to the address listed at the bottom of the questionnaire.

	General	
1	Today's Date:	
2	The date you gave birth:	
3	Total length of your pregnancy:	weeks days
4	Did you have a son or daughter?	
5	How many times have you given birth (this birth included, but not including miscarriages)?	
6	In what year were you born?	
7	What are the first four digits of your postal code?	

8	<p>Which ethnic group do you identify yourself with ?</p> <p><i>check only one box</i></p>	<input type="checkbox"/> ¹ Dutch <input type="checkbox"/> ² Western European <input type="checkbox"/> ³ North American <input type="checkbox"/> ⁴ Moroccan <input type="checkbox"/> ⁵ Turkish <input type="checkbox"/> ⁶ Dutch Antilles <input type="checkbox"/> ⁷ Suriname <input type="checkbox"/> ⁸ other ethnic group, namely
The Birth		
9	<p>Where was your baby born?</p> <p><i>check only one box</i></p>	<input type="checkbox"/> ¹ At home <input type="checkbox"/> ² In a birth centre or maternity hotel (Kraamhotel) <input type="checkbox"/> ³ In the hospital with a midwife, without a medical indication (poli clinic) <input type="checkbox"/> ⁴ Started labour at home with my midwife but due to medical indication during labour, my care was transferred to the gynaecologist in the hospital. <input type="checkbox"/> ⁵ Planned hospital or birth centre birth with my own midwife, but during the labour due to medical indication my care was transferred to the gynaecologist <input type="checkbox"/> ⁶ In the hospital under the care of a gynaecologist, (for example due to a medical indication during the pregnancy or prior to the beginning of labour) <input type="checkbox"/> ⁷ Other, namely ...
10	<p>If your care was transferred to the hospital staff during the birth, what was the reason?</p> <p><i>check as many boxes as apply.</i></p>	<input type="checkbox"/> ¹ the length of your pregnancy was too short or too long. <input type="checkbox"/> ¹ the dilation didn't progress <input type="checkbox"/> ¹ the pushing phase lasted too long <input type="checkbox"/> ¹ the baby showed signs of distress <input type="checkbox"/> ¹ meconium (baby pooped in the amniotic fluid) <input type="checkbox"/> ¹ I wanted pain medication <input type="checkbox"/> ¹ occurrence of excessive blood loss during dilation and/or pushing <input type="checkbox"/> ¹ my membranes ruptured and I had no contractions for an extended period of time <input type="checkbox"/> ¹ other, namely
11	<p>How did you give birth?</p> <p><i>check only one box</i></p>	<input type="checkbox"/> ¹ naturally (no interventions) <input type="checkbox"/> ² naturally in water <input type="checkbox"/> ³ with drugs for augmentation or induction <input type="checkbox"/> ⁴ forceps assisted <input type="checkbox"/> ⁵ vacuum assisted <input type="checkbox"/> ⁶ a planned c-section <input type="checkbox"/> ⁷ an emergency c-section <input type="checkbox"/> ⁸ I don't know

12	<p>Did you receive medical pain medication?</p> <p><i>check as many boxes as apply.</i></p>	<input type="checkbox"/> ¹ no <input type="checkbox"/> ¹ yes, an epidural <input type="checkbox"/> ¹ yes, remifentanil pump <input type="checkbox"/> ¹ yes, a pethidine injection <input type="checkbox"/> ¹ yes, but I don't know what kind <input type="checkbox"/> ¹ yes, something else, namely
13	<p>Can you indicate the level of pain throughout your entire labour with a number between 0 and 10?</p> <p><i>The number 0 being no pain and the number 10 the worst possible pain.</i></p>	<p>My numerical indication of the level of pain during my whole labour is</p>
14	<p>At any moment during the labour did you think that your baby was not okay?</p>	<input type="checkbox"/> ¹ No <input type="checkbox"/> ² Yes, because ...
15	<p>At any moment during the labour did you think that you yourself were in danger?</p>	<input type="checkbox"/> ¹ No <input type="checkbox"/> ² Yes, because ...
The Doula Support		
22	<p>What is your doula's name?</p>	<p>...</p>
23	<p>Is your doula a member of the Dutch Association of Doula's?</p>	<input type="checkbox"/> ¹ yes <input type="checkbox"/> ² no <input type="checkbox"/> ³ I don't know
24	<p>In your own words, please indicate what you found to be the most important contribution the doula made to your experience at the birth of your child.</p>	<p>Most important to me was:</p>
25	<p>During the pregnancy did you have one or more appointments with the doula who accompanied you during the birth of your baby?</p>	<input type="checkbox"/> ¹ no <input type="checkbox"/> ² yes, number of appointments: .. (please also answer question 18)
26	<p>Were this/these appointments beneficial for you?</p> <p>If yes, could you briefly explain why?</p>	<input type="checkbox"/> ¹ no <input type="checkbox"/> ² yes

27	<p>During the labour, when did your doula arrive?</p> <p><i>check only one box</i></p>	<input type="checkbox"/> ¹ at the beginning of dilation (*) <input type="checkbox"/> ² during dilation (*) <input type="checkbox"/> ³ directly before I started to push <input type="checkbox"/> ⁴ during the pushing phase <input type="checkbox"/> ⁵ other, namely
	<p>(*) if you know how far you were dilated can you please fill that in.</p>	<p>I had approx. .. cm. dilation.</p>
28	<p>Did you consult with the doula present at your birth after the birth? If so, how many consultations did you have?</p>	<input type="checkbox"/> ¹ No (proceed to question 27) <input type="checkbox"/> ² Yes, number of appointments: ... (please also answer question 26)
29	<p>Did you find the consultation(s) after the birth beneficial? If so, please explain briefly in what way these consultations were beneficial to you.</p>	<input type="checkbox"/> ¹ No <input type="checkbox"/> ² Yes
30	<p>In your own words, please indicate what you found to be the most important contribution the doula made to your experience at the birth of your child.</p>	<p>Most important to me was:</p>
31	<p>Circle or underline in the list below the words that apply to the support you received from your doula during the birth. (circle or underline as many as apply)</p> <p>sensitive witty attentive inventive</p> <p>hurried unhelpful supportive restless</p> <p>insensitive nonchalant polite protective</p> <p>awkward warm informative nervous</p> <p>bossy helpful patronizing calm</p> <p>Is there another appropriate word for the support you received from your doula, that that is not mentioned above?</p> <p><input type="checkbox"/>¹ no <input type="checkbox"/>² yes</p> <p>If you answered YES, what word(s) would you use....</p>	

KIND OF SUPPORT FROM THE DOULA

Please indicate in the list below what kind of support your doula provided during the labour and birth.

The left column lists the actions the doula might have performed during the birth process. Please indicate whether the doula performed these actions during labour, during the dilation phase or during the pushing phase of the birth process.

32	Actions performed by doula	During the dilation		During the pushing	
		<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No
	guiding breathing skills	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No
	counter pressure in the back	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No
	massaging back/legs	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No
	support under shower / in bath	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No
	providing help with birth 'tens'	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No
	providing acupressure	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No
	giving tips as to labour position	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No
	providing acupuncture	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No
	providing aromatherapy	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No
	providing food & drink	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No
	support using words	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No
	providing birth ball	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No
	other, namely	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No
	other, namely	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No
	other, namely	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No
	other, namely	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No

33	<p>Please indicate which of the above mentioned forms of support were the most effective. Please indicate using a grade from 0 to 10 (with 0 representing not, or hardly effective to 10 representing most effective)</p>	<p>The three most effective forms of support for me were:</p> <p>1. grade:</p> <p>2. grade:</p> <p>3. grade:</p>
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34	<p>Did you and your partner (if you have a partner and he/she was present at the birth) feel that the presence of a doula contributed to making the birth a more pleasant experience?</p> <p>What grade would you and your partner give for the doula support overall? The number 0 represents very bad support and the number 10 represents excellent support.</p>	<p><input type="checkbox"/>¹ No <input type="checkbox"/>² Yes</p> <p>Grade from woman:</p> <p>Grade from partner:</p>
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CONTACT WITH DOULA AND OTHER CARE PROVIDERS					
The next question has to do with the <u>contact</u> you have had with your doula and the other care providers <u>during your birth</u> . For each care provider indicate how often this occurred. Please mark the correct answer for each care provider. N/A means Not applicable, for example if you did not have this kind of care provider.					
35	Where this explained in an understandable way?				
	Doula	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
	Midwife (midwives)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
	Nurse(s)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
	Doctor(s)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
36	Where you treated with respect?				
	Doula	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
	Midwife (midwives)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
	Nurse(s)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
	Doctor(s)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
37	Did you have the feeling you were in good hands?				
	Doula	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
	Midwife (midwives)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
	Nurse(s)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
	Doctor(s)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
38	Were you included in the decision making for your care?				
	Doula	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
	Midwife (midwives)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
	Nurse(s)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
	Doctor(s)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
39	Did you feel supported?				
	Doula	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
	Midwife (midwives)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
	Nurse(s)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
	Doctor(s)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
40	Did you receive information that was contradictory to other information?				
	Doula	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
	Midwife (midwives)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
	Nurse(s)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A
	Doctor(s)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always <input type="checkbox"/> ⁵ N/A

41	Could you contact the care provider whenever you wanted?					
	Doula	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always	<input type="checkbox"/> ⁵ N/A
	Midwife (midwives)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always	<input type="checkbox"/> ⁵ N/A
	Nurse(s)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always	<input type="checkbox"/> ⁵ N/A
	Doctor(s)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always	<input type="checkbox"/> ⁵ N/A
42	Did you receive clear information about your labour and birth?					
	Doula	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always	<input type="checkbox"/> ⁵ N/A
	Midwife (midwives)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always	<input type="checkbox"/> ⁵ N/A
	Nurse(s)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always	<input type="checkbox"/> ⁵ N/A
	Doctor(s)	<input type="checkbox"/> ¹ Never	<input type="checkbox"/> ² Sometimes	<input type="checkbox"/> ³ Generally	<input type="checkbox"/> ⁴ Always	<input type="checkbox"/> ⁵ N/A
YOUR PARTNER						
The following questions should be answered by your partner, if he/she was present at the birth. Please skip the following questions if there was only a doula present at the birth of your child.						
43	Please indicate whether you experienced the doula's presence as supportive.					
	<i>The left column lists a number of actions that the doula performed that might have been beneficial to you. If you experienced the doula's actions as supportive, please indicate in the next column. Also, please add a grade according to the extent of support you experienced. With 0 representing poor support and 10 representing excellent support).</i>					
	possible assistance offered by doula	received		grade		
				(between 1-10)		
	explanation / information	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No			
	assistance massaging partner	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No			
	assistance providing acupressure partner	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No			
	providing food & drink	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No			
	suggestion about what you can do	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No			
	comforting	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No			
	other, namely	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No			
	other, namely	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No			
	other, namely	<input type="checkbox"/> ¹ Yes	<input type="checkbox"/> ² No			
Lastly, we would like you to indicate whether you agree or disagree with below statements about doula support at a birth.						
44	I think that a doula should be present at every birth. <i>check only one box</i>	<input type="checkbox"/> ¹ completely agree <input type="checkbox"/> ² agree <input type="checkbox"/> ³ disagree <input type="checkbox"/> ⁴ completely disagree <input type="checkbox"/> ⁵ no opinion				
45	At my next birth, I will use the services provided by a doula again. <i>check only one box</i>	<input type="checkbox"/> ¹ completely agree <input type="checkbox"/> ² agree <input type="checkbox"/> ³ disagree <input type="checkbox"/> ⁴ completely disagree <input type="checkbox"/> ⁵ no opinion				
46	Please provide us with any additional information that you think would improve the assistance of the doula.					

