GENEVA GRADUATE INSTITUTE

INSTITUT DE HAUTES ÉTUDES INTERNATIONALES ET DU DÉVELOPPEMENT

GRADUATE INSTITUTE OF INTERNATIONAL AND DEVELOPMENT STUDIES

Public Health Evidence on Maternal Health, Midwifery and Home Birth in Europe

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ARP_S-7 Applied Research Project

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15/04/2025

Word Count: 9’578

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1. Introduction

1.1 Contextualizing Maternal Health

Maternal health[1] encompasses more than biomedical outcomes; it reflects a person's full well-being across the reproductive cycle, including access to autonomy, quality care, and dignified treatment (WHO 2018). While traditional indicators such as maternal mortality[2] and morbidity[3] remains critical, they often fail to capture the structural, legal, and emotional conditions that shape perinatal care (UNFPA 2023).

This biomedical framing detracts from a range of psychosocial and institutional factors within which these stages are embedded. The quality of maternal healthcare that pregnant people receive is influenced by access to contraception, legal and bodily autonomy over pregnancy, the right to choose their birth settings with minimal state interference, access to quality health infrastructure that guarantees safety and dignity, and access to appropriate postnatal care (UNFPA 2023).

As international organizations increasingly advocate for a rights-based, woman-centered[4] approach to reproductive health, the ability to choose one's birth setting (with appropriate midwifery support and institutional safeguards) has emerged as a key issue in contemporary maternal care. Knaul et al. (2016) argue that a "narrow conception of maternal health undervalues the burden of illness faced by women, because most women live past the age of childbearing.", which shows the urgency of expanding maternal health frameworks beyond survival metrics to include autonomy, quality of care, and psychosocial outcomes. However, this right is unevenly implemented across Europe, particularly in relation to planned home births, which remain under-researched and often contested despite evidence suggesting their safety for low-risk pregnancies under appropriate conditions.

This study investigates how public health evidence, legal frameworks, and midwifery practices influence the accessibility and legitimacy of midwifery-led care and home births in European OECD countries . Through a comparative case study, we analyze how state regulation, cultural narratives, and professional autonomy shape women's reproductive choices and midwives' ability to support them. The Netherlands and Czech Republic were selected as case studies based on a set of comparative criteria, including population size, availability of public health and legal data, and differing approaches to birth setting regulation. The Netherlands represents a model of integrated home birth care within a

[1] For a definition see Annex 1 "Glossary".
[2] For a definition see Annex 1 "Glossary".
[3] For a definition see Annex 1 "Glossary".
[4] While we sometimes use the term "woman" in this article, it is intended inclusively to encompass all gender identities who give birth. We additionally aimed to use "pregnant individuals" rather than "pregnant woman" if context and sources allowed us to.

publicly funded system, where midwives serve as primary care providers for low-risk pregnancies. In contrast, the Czech Republic maintains a hospital-centered model in which midwifery remains subordinate to obstetrics, and home births are institutionally marginalized despite being legally permitted.

By combining legal analysis, public health evidence, and qualitative ways, this research contributes to broader debates on maternal health, reproductive rights, and the role of midwifery in Europe. Ultimately, our study calls for more inclusive, evidence-informed, and rights-based approaches to maternal healthcare, ones that treat birth not simply as a clinical event, but as a social and political process embedded in structures of power and care.

Our original intent was to apply an intersectional framework to examine how race, migration status, class, and other factors compound barriers to maternal care. However, we encountered significant data limitations: few countries in the European OECD context collect disaggregated public health data that would allow for meaningful intersectional analysis. As a result, our study focuses primarily on structural and institutional dynamics across two national settings, while recognizing that this approach cannot capture the full spectrum of reproductive injustice faced by marginalized communities. We see this as an area for future research that can build upon our findings.

The research was carried out in collaboration with the Center for Reproductive Rights and is situated within a broader commitment to reproductive justice, informed choice, and the de-medicalization of physiological birth.

1.2 Maternal Health in Europe

Despite broad commitments to maternal health across the EU, major regional disparities remain, particularly between Western and Central-Eastern European (CEE) countries. Indeed, the European Institute of Women's Health (2022) urges that maternal healthcare must move beyond mortality prevention to promote the long-term "health and wellness" of mothers. Yet this vision remains unevenly realized. According to WHO (2018; 2017; 2014; 2019), barriers such as poor quality of care, disrespect and abuse, and structural inequities, including income, education, and racial or ethnic marginalization, persist across many European healthcare systems.

Although nearly all pregnant women in CEE states receive some form of prenatal care, the region continues to exhibit higher maternal mortality rates and significantly worse outcomes compared to Western Europe (Miteniece et al. 2018). WHO (2025) notes that maternal mortality in Hungary, Latvia, and Romania is nearly four times the EU average. While CEE countries fulfill basic indicators such as

access to emergency obstetric care and skilled birth attendance, deeper systemic issues remain. Despite professionalization and funding, maternal care often follows "expert-centered" models that neglect patient agency and fail to cultivate trust (Miteniece et al. 2018; 2023).[5] This highlights the significant diversity of quality care available even in a seemingly homogeneous EU setting (UNFPA 2023). Ultimately, these differences call for more tailored policy responses that go beyond surface-level indicators to address the underlying drivers of inequity.

2. Legal Frameworks

2.1 Legal Framework on Maternal Rights

Legal protections for maternal rights in Europe and OECD countries are shaped by both national interpretations and international human rights instruments. In fact, the protection of maternal rights in Europe and OECD countries rests on two main pillars: reproductive autonomy and health protection. Within the human rights framework, these aspects highlight the balance between individual choice and state interest in maternal health. Article 8 of the European Convention on Human Rights (ECHR) serves as a foundation for maternal rights by offering safeguards for private and family life. In *Ternovsky v. Hungary*, the European Court of Human Rights (HUDOC) ruled that a woman's choice of birth location is part of her private life (ECHR 2010). Such a choice exists between the more conventional birth setting of a hospital or alternative birth settings mediated by highly trained midwives at home and in other non-medical maternity units. By contrast, the ECtHR took a more conservative stance in *Dubska and Krejzova v. Czech Republic* (ECtHR 2016), by upholding restrictions on home births and granting the state a wide "margin of appreciation" to prioritize medical safety over birth setting choice. This highlights a broader European divide on home birth rights and the balance between safety and autonomy, which often depends on whether home births are regulated through criminal sanctions or more permissive administrative frameworks. This variation influences how states interpret and apply the ECHR to maternal rights cases (ECtHR 2016).

2.2 Legal Framework on Alternative Birth Settings

The legal landscape surrounding home birth reveals considerable variation across Europe. Indeed, the legal implications of home birth are deeply intertwined with women's reproductive rights, particularly their autonomy in choosing where to give birth. While, from what we can see in our excel sheet[6], most of Europe adopts a more permissive ethos with respect to home births, thereby empowering women to choose their own setting for having children, some nations also impose stern regulations that discourage

[5] For a more detailed discussion on maternal health rights for migrant women see Annex 4.
[6] For further information regarding this case see Annex 2.

individual agency in the matter. These varying regulations reflect each country's policies and priorities regarding women's health, safety, and informed reproductive autonomy. The related international legal framework also plays a significant role in defining the reproductive rights of women. The Convention on Elimination of Discrimination Against Women (CEDAW, 1981) guarantees women the right to make autonomous decisions regarding their reproductive health. General Recommendation No. 28 issued by the CEDAW Committee in 2010 requires that states respect, protect, and fulfill women's reproductive rights, ensuring women's access to both institutional and non-institutional birth settings with no compromise on health and safety (CEDAW/C/GC/28 2010).

In line with CEDAW's recommendations, states must ensure that healthcare systems are equipped to provide safe alternatives to institutional births, such as home births, without undermining women's health or safety (CEDAW 1981). States also have the responsibility to ensure that healthcare professionals respect women's choices and discriminatory practices or mistreatment during childbirth are addressed (ibid.). This includes ensuring that women are not coerced into institutional care due to legal or systemic barriers. While some countries allow home births with minimal regulation, others impose more stringent measures, reflecting differing views on how best to protect maternal and child health. Taken together, these legal obligations and variations highlight the ongoing tension between state control and individual autonomy in childbirth decision-making. [7]

3. Public Health Evidence on Birth Settings

3.1 Variation in Birth Settings

The adoption of midwifery-led care[8] has become a key strategy in enhancing maternity care systems worldwide. In fact, midwifery-led care is a high-certainty, evidence-based strategy to improve maternity care (George et al. 2022). A shift to less interventionist models of care has encouraged some countries to develop alternative models such as the "Midwife-Led Units" (MLUs), where midwives are defined as the main healthcare professionals over medical teams headed by obstetricians (Hunter 2000; Overgaard et al. 2011; Maillefer et al. 2015). Additionally, MLUs provide a space within which midwives can practice to their fullest potential, focus on the individual needs of pregnant individuals, and exercise more professional autonomy than traditional obstetric settings where they are required to conform to the biomedical system of birth (Davis and Homer 2016). MLUs are an example of how the midwifery model of care is being integrated into existing health systems to transform maternal health around the world, thereby reducing primary and maternity care provider shortages and addressing racial, ethnic, and geographic health inequality (Edmonds et al. 2020). MLUs emphasize a woman-centered model of care, humanize childbirth, and promote self-determination for women (Maillefer et al. 2015;

[7] For the views of International Health Organizations with respect to best practices on birth settings see Annex 4.
[8] For a definition see Annex 1 "Glossary".

George et al. 2022). They promote non-medicalized pregnancies and labor, and support the natural ability of pregnant individuals to experience birth with minimum to no routine obstetric interventions, which additionally aligns with global efforts to improve maternal care (George et al. 2022; Betrán et al. 2018; Sandall et al. 2024).

3.2 Planned Home Births

Examining the safety of home births through public health research reveals important perspectives into their outcomes compared to hospital births.

Researching public health evidence on the safety of home births unveils country-specific studies going back to a period of almost 30 years that were conducted in Spain, Sweden, the Netherlands, and New Zealand. These studies indicate that low-risk[9] pregnant individuals intending to give birth at home, under the supervision of midwives, do not show different health risks than low-risk pregnant individuals intending to give birth in hospitals (Hutton et al. 2019; Nove et al. 2012; Lindgren et al. 2008). A range of studies conducted in the Netherlands and Sweden have also shown that perinatal mortality rates are generally similar for home births and hospital births among low-risk women (Hutton et al. 2019). In these studies, the rates of adverse outcomes, such as stillbirths and neonatal deaths, did not significantly differ between the two settings. Several studies emphasized that low-risk women who opted for a planned home birth experienced a higher rate of spontaneous births, a lower rate of instrumental delivery, and fewer medical interventions such as cesarean sections and episiotomies compared to those who planned hospital births (Hutton et al. 2019; Nove et al. 2012; Lindgren et al. 2008).

According to Alexander et al. (2003), women giving birth in hospitals are much more likely to experience perineal trauma, such as sphincter or rectal ruptures and the risk of having an episiotomy than expecting individuals giving birth at home. This suggests that the home environment encourages a more natural and less interventionist birthing process for low-risk expecting individuals, lending support to the notion that it may facilitate conditions conducive to the natural progression of labor (Reitsma et al. 2020; van der Kooy et al. 2017). Other studies have indicated an increased risk of adverse outcomes in certain circumstances, particularly when complications arise during home births and/or when pregnant individuals require transfer to a hospital (Hutton et al. 2019). Buekens and Keirse (2012) state that while home births can be safe, they are less so for first-time mothers. For pregnant individuals having their first baby (nulliparous[10]), perinatal outcomes were similar in midwifery-led and obstetric units, but worse for planned home births. In contrast, for pregnant individuals who had given birth

[9] For a definition see Annex 1 “Glossary”.
[10] For a definition see Annex 1 “Glossary”.

before (parous[11]), perinatal outcomes did not significantly differ across birth settings (Buekens and Keirse 2012).

In conclusion, while home births show promising outcomes for low-risk pregnant individuals, especially in terms of reduced interventions, some risks remain, particularly for first-time mothers and in cases requiring medical intervention. Nevertheless, knowledge and data on the issue remain limited, as there is little research on public health evidence pertaining to planned home births for low-risk pregnancies in other European OECD countries.

3.3 Regulation of Planned Home Births

The outcomes of home births are influenced by regulations, qualifications and knowledge of the available practitioners, and availability of emergency care (Comeau et al. 2018). The potential risk of complications in home birth settings which require immediate medical attention, can be used as an argument against the safety of home births. Alcaraz-vidal et al. (2024) insist on the integration of midwife-led home births into the public health sector to affirm its benefits for maternal health. To understand differences in outcomes between studies, it is important to take into account how far home births are integrated within the healthcare system (Comeau et al. 2018). Good integration allows for clearer pathways and more timely access to higher levels of care when complications arise during childbirth (Walker 2017; Comeau et al. 2018). Although there is a general agreement in existing research that home birth integration might positively affect home birth outcomes, there is limited research to provide further data (Comeau et al. 2018).

Past hospital affiliations contribute to the ease with which midwives can transfer from a planned home birth to a hospital in the case of an emergency (Comeau et al. 2018). The Netherlands is a good example of home birth being well connected to the hospital-based healthcare system, whereas Norway and Sweden are examples of home birth being poorly integrated (ibid.). Midwives remain the primary care practitioner after transport from home to hospital in England, while in the Netherlands, the client moves from primary, midwifery-led care to secondary care where an obstetrician becomes the primary caregiver (ibid.).

4. Midwifery Practice and its Role in Home Births

4.1 Role of Midwives

The role of midwifery in maternal care is pivotal, as it emphasizes the importance of skilled, compassionate, and women-centered healthcare (WHO 2002; 2017). This call for "skill" and "education" is also corroborated by the International Confederation of Midwives (ICM), which has set

[11] For a definition see Annex 1 "Glossary".

up a "framework for global standards on midwifery education" and outlined certain "essential competencies" that midwifery professionals must meet (ICM 2019). The ICM outlines essential midwifery competencies in areas such as communication, antenatal care, childbirth, and postnatal support (ICM 2019). In this context, the translation of "midwifery" as "with women" emphasizes the ability to establish consistent relationships with a pregnant individual based on personal and professional values (Thumm and Flynn 2018). The UNPFA (2021) asserts that midwifery has been proven to "avert almost 2/3rds of maternal deaths and deliver 90% of Sexual and Reproductive Health (SRH) services" to new mothers. But midwives barely make up 10% of health professionals worldwide (WHO 2017; UNPFA 2021). Therefore, a major gap persists in delivering quality, women-centered health services to new mothers.

Vedam et al. (2009) show that midwives' exposure to home birth during professional education influences their choice of practice site. Their willingness to practice home births correlates with their beliefs about the safety of planned home births and the confidence they possess in their management abilities (ibid.). Factors which contributed to positive opinions regarding home birth were midwives' experience with home birth itself, their level of education, and personal beliefs that home birth improved the experience and well-being of women and babies (ibid.). The most cited barriers to home birth practice were difficulty in obtaining liability insurance in a home birth practice, perceived a lack of skills specific to the home setting, lack of physicians in their region who would be willing to offer consultation or accept transfers from home birth settings, discomfort with approaching a physician for consultation, restriction of home birth practice by state regulation, the perception that home birth practice is excessively time-consuming, concerns about good standing among peers, and the perception that it is impossible to thrive financially in a home birth practice (ibid.). Addressing the barriers midwives face, such as training and regulatory challenges, is essential for ensuring that pregnant individuals receive high-quality, accessible care during childbirth.

4.2 Midwives' Relations with Birthing Mothers

Analyzing midwife-mother relationships can help policy makers frame midwifery education in a manner that would be more inclined towards increasing minority pregnant individuals' access to midwife-led birthing pathways. Goodwin et al. (2018) use the experiences of migrant Pakistani women in interacting with midwives in the United Kingdom as a case study on such relationships. It talks about midwife-woman relationship as a factor that can make non-medicalized maternal care accessible for the women based on whether the said relationship is positive or negative.[12]

[12] For further information regarding this case see Annex 4.

Interference from family members can hinder the pregnant individuals' free interaction with the midwife and pose an obstacle to the formation of a one-on-one relationship between the two. Goodwin et al. (2018) point to cultural factors that often place the mother at the center of a tussle between mothers-in-law and midwives, both of whose advice can together confuse the pregnant individual. "Whilst women found these family members to be a source of support, midwives, however, perceived this involvement as having a negative impact on midwife–woman relationships" (ibid.). Additionally, the midwives might often take a more negative view of traditional perinatal practices asked by the pregnant individual which can alienate them from the expectant mothers. Working towards bridging these cultural differences experienced by expectant mothers while interacting with midwives in their host countries can therefore contribute to better access to alternative birth settings for pregnant individuals of certain minorities.

5. Methodology

5.1 Operationalization

To establish a foundational understanding of the legal and public health landscapes, this study primarily employs secondary data analysis. Given the ethical sensitivity of engaging directly with pregnant individuals, secondary research minimizes the risk of distress while enabling a broad examination of structural and institutional factors affecting home births.

To facilitate comparative analysis, this study organizes data through an Excel-based mapping tool[13], categorizing European OECD countries along parameters such as healthcare accessibility, midwifery autonomy, public health data availability, and birth outcome statistics. It compares maternal and reproductive healthcare policies across European OECD countries, covering areas like birth rights, home births, midwifery, and healthcare access. Countries like Austria, Belgium, and the Netherlands offer more freedom of choice for women getting pregnant and their place of birth, allowing legal home births and midwife support outside hospitals. In contrast, places like Bulgaria, Croatia and the Czech Republic have stricter rules on birth settings and midwife autonomy. Most countries provide free healthcare, but some only offer limited access. All countries have some data on maternal health outcomes, though support for pregnant women varies. However, it was not possible to conduct intersectional analysis, as most national datasets lack disaggregated data by ethnicity, migration status, income, or other social determinants, highlighting a significant gap in the evidence base.

[13] For further information regarding this case see Annex 2.

5.2 Case Selection Through Comparative Analysis

Comparative analysis is an essential methodological approach for this study, as it allows for the identification of patterns, structural barriers, and best practices across different healthcare systems (Hantrais 2009). Some of the parameters analyzed will include the availability of free healthcare in a country, if the midwives have substantial levels of autonomy under the system, whether public health evidence exists on outcomes of home births. The countries that are the closest or least compatible with internationally recommended parameters on midwifery such as (non-)integration into the healthcare system and those with the most amount of data available publicly were selected for our analysis.

Accordingly, the Netherlands and the Czech Republic were chosen due to their similarities in size, data transparency, and healthcare infrastructure, but with markedly different maternity care policies and levels of institutional support for home births. Further, they share a similar average of 1.6 births per woman. While the Netherlands exemplifies a model with high integration of home births within its healthcare system, the Czech Republic has a predominantly hospital-centered approach, with limited acceptance of home births.

5.3 Comparative Analysis of Two Countries

5.3.1 The Netherlands

The Netherlands serves as a critical case study due to its well-established midwifery-led maternity care system and the comparatively high prevalence of planned home births. The country offers a unique healthcare model where home birth is not only legally protected but also systematically integrated into the public healthcare infrastructure. Dutch maternity care follows a tiered model in which midwives oversee low-risk pregnancies, providing an example of a system where home births function within a regulated and well-supported framework. Empirical research demonstrates that in this setting, home births lead to favorable maternal and neonatal outcomes when appropriate selection criteria are met, which we have gone into further detail in this study (de Jonge et al. 2009; Seijmonsbergen-Schermers et al. 2018). By focusing on the Netherlands, this study can draw upon a plethora of evidence to explore how home births, as part of an integrated care system, can be safely supported and their implications for public health policy globally.

5.3.2 Czech Republic

The Czech Republic offers a compelling comparative case due to its contrasting approach to home births, as it exhibits significant restrictions on reproductive autonomy. While home births are legal, access remains limited due to restrictive regulations, midwives' lack of professional autonomy, and the

dominance of hospital-centered obstetric care. Despite the country's capacity to collect and share public health data, midwifery in the Czech Republic operates under legal and institutional constraints that discourage home births. The profession, while regulated, lacks the autonomy in professional functioning found in the Netherlands, with midwives facing significant barriers to practicing independently (Nagy 2024). Additionally, disparities in healthcare accessibility, particularly regarding financial coverage, further restrict home birth options. This contrast allows for an analysis of how institutional frameworks influence maternal health choices, midwifery practice, and the broader public perception of home births.

5.4 Desk Research and Interviews

Desk research is a fundamental step in assessing the regulatory landscape, statistical trends, and public discourse surrounding home births. Our desk research will focus on renowned public health research outlets such as the National Institutes of Health, Research Gate, and ScienceDirect, as these platforms provide high-quality, peer-reviewed studies with a strong emphasis on global health, making them invaluable for understanding the intersection of public health and maternity care.

However, desk research alone cannot fully capture the lived experiences of practitioners or the subtle factors that influence home birth decisions (Guest et al. 2006). While the core of this study relies on comparative policy analysis and quantitative data, one interview with a midwife was included. Although not a central component, this conversation provided a small complement to the findings by illustrating how certain practices are experienced on the ground. For instance, in countries like the Netherlands where home birth is more integrated, such practitioner perspectives help illustrate how the system operates in reality (Jabaaij and Meijer 1996), while in more medicalized contexts like the Czech Republic, they highlight ongoing challenges (Nagy 2024). This limited qualitative input adds a modest layer of depth to the broader desk-based analysis.

5.4.1 Recruitment of Interviewees

Midwives were selected for contact for their central role in home births, given their expertise in managing low-risk deliveries and coordinating with hospitals when needed. Their perspectives would have offered insight into how the home birth model operates within different healthcare systems, such as the supportive Dutch model (de Jonge et al. 2009) versus the more medicalized Czech context (Nagy 2024).

The study aimed to interview 2–4 midwives from the Netherlands and the Czech Republic to reflect different models of home birth care. Participants were to include both independent and affiliated

midwives, identified through national associations like KNOV and UNIPA. However, due to time constraints and limited availability, only one interview was completed, with a midwife from the Netherlands. Despite the limited scope, the interview provided useful context for the broader findings.

6. Ethical Considerations

One of the foremost concerns is confidentiality particularly when midwives discuss patient experiences, interactions with healthcare institutions, or conflicts with medical authorities. To avoid the violation of patient confidentiality, we will ensure that identifiable patient information is not disclosed. Discussions on midwifery autonomy, legal constraints, and institutional barriers can be sensitive and potentially political. Furthermore, because of the legal and professional danger involved in talking about home births, especially in the Czech Republic where home births and midwifery are heavily stigmatized, midwives might be reluctant to talk freely about their experiences. Therefore, it is important to ensure that interviewees feel free to refuse to answer any question without any coercion. Unless specific permission is given, all identifying details will be either deleted or disguised, and the data will be safely retained according to the Swiss Federal Act on Data Protection (FADP).

Additionally, we will carefully consider bias in questioning and ensure that inquiries remain open-ended and neutral to avoid shaping the responses according to what we would like to hear. This is particularly important given the contrasting legal and healthcare structures between the Netherlands and the Czech Republic. In the Netherlands, home birth is an established and state-funded choice within the maternity care system, and midwives have a high level of autonomy under a risk-based categorization system. In the Czech Republic, home birth is a controversial and institutionally marginalized practice, with midwives subject to legal constraints and possible professional penalties for supporting births outside hospitals. These differences must be considered while structuring the interview schedule, and care must be taken to also accommodate the lived experiences of Czech and Dutch midwives with respect to the legal, professional, and institutional frameworks within which they operate, so that the research process doesn't run solely on presumed models of midwifery practice.

7. Comparative Analysis

7.1 Legal Frameworks on Home Births

A comparative examination of home birth legislation in Europe reveals significant divergences in national approaches, particularly between the Netherlands and the Czech Republic. These disparities reflect broader issues of reproductive justice, the role of international human rights bodies, and the influence of sociocultural traditions on childbirth practices.

The ECHR has tried to impose a certain degree of equivalence among OECD European countries, but with little to no success because its penchant towards passing ambiguous and contradictory judgements in the arena of reproductive justice generates incoherent laws and a lack of a unified policy at the international level leading to "no evident European consensus on how home birth shall be regulated" (Nagy 2024). For example, the ECHR's legislation in the case of *Dubska and Krejzova v. Czech Republic*, where the complainants sought legal redress from the state for violation of their right to personal life by not allowing them to avail the services of a midwife (ECtHR 2016). It noted the fragmented legal landscape surrounding home births in Europe and gave "states a broad margin of discretion in their legislation" (ibid.).

To better understand what a more inclusive and rights-oriented approach can look like, one can turn to the example of the Netherlands. The Netherlands possesses a structured legal framework that effectively integrates home birth into mainstream maternity care (WHO 2022). The Dutch state enshrined its institutions of perinatal healthcare within the larger values of women's reproductive rights (Nagy 2024). This includes appropriate training of healthcare workers, compliance with human rights standards during childbirth, ensuring effective redressal procedure in case of violations, and continuous reassessment and development of the system (ibid.). Pregnant individuals are encouraged to actively participate in decisions about their birthing process and reflecting on their needs and expectations for childbirth and discuss them with their partners, midwives, obstetricians, and other care providers, thereby reinforcing their agency and aligning Dutch law with international human rights frameworks (Nagy 2024; van Leeuwen 2024; Dutch Society for Obstetrics and Gynaecology and Royal Dutch Organisation of Midwives 2017). In collaboration with the midwife or obstetrician, it is then assessed whether the preferences are practical and achievable. The Dutch model is centered around respecting women's preferences while ensuring safety and exemplifies how healthcare systems can support alternative birth choices (Vogels-Broeke et al. 2023).

In stark contrast, the Czech Republic presents a case where legal and institutional barriers limit the realization of home birth as a viable option. While the law in Czech Republic does not explicitly legislate on home births, there exists a broader umbrella of legal provisions under which the delivery of healthcare services, including midwifery assistance at home, is prosecuted (Nagy 2024). Midwives are permitted to assist during childbirth according to Czech law, but the potential of being penalized for providing these services at home generates ambiguity (ibid.). A fear of fines deters midwives from providing home birth services and ensures that "the free choice of a woman to decide on the place of birth is formally present but practically not realistically possible to carry out" (ibid.).

These legal uncertainties and inconsistencies are further illustrated by high-profile cases that exemplify the challenges faced by midwives in the Czech Republic. For instance, the cases of *Hana Kubaňová*

and *Königsmarková*: the former was the first midwife to be fined in 2018 for assisting in five home births (Durnová and Hejzlarová 2023). In the latter instance, around 2010, Czech courts legislated against the midwife Königsmarková following a complaint by a hospital accusing her of carelessness, oversight in calling hospital authorities to intervene at the right time, and "inflicting grievous bodily harm through negligence" (Lazarová 2024) on an infant that suffered brain damage after a strenuous home delivery (Durnová and Hejzlarová 2023). Such barriers prevent pregnant individuals from exercising their autonomy in childbirth and acquiring the assistance of midwives who fear legal repercussions.

Legal challenges are compounded by cultural and historical factors that shape how childbirth is perceived and regulated in both countries. In fact, Sociocultural and historical traditions surrounding childbirth also influence the disparity of legislation in the two countries. In the 1970s, the Netherlands introduced the freedom of choice for women with low-risk pregnancies to give birth at home or in hospitals (Wiegers et al. 1998). Since then, Dutch legislation emphasizes patient autonomy as opposed to heavy medicalization of childbirth (Wiegers et al. 1998; De Vries et al. 2013; Baas et al. 2015; van der Waal and van Leeuwen 2022). Dutch cultural norms view pregnancy and childbirth as a natural and physiological process and women are also found to possess similarly aligned strong beliefs against medicalization. Dutch women with low-risk pregnancies can therefore choose whether they want to give birth at home or in a hospital, under the care of their own primary caregiver - either an independent midwife or a general practitioner (Wiegers et al. 1998; Hollander et al. 2019; van der Waal and van Leeuwen 2022).

Meanwhile, historical legacies of socialist governance continue to affect midwifery and childbirth policy in the Czech Republic today. In the Czech Republic, midwives are officially categorized as "obstetrical nurses subordinate to obstetricians within the hospital hierarchy", which detracts from their independent professional standing and knowledge (Hresanova 2014). This is a relic of the socialist reforms that Czech Republic underwent in the 1950s, where the position of biomedically trained obstetricians and gynecologists was stipulated as agents of population control for the post-war welfare state (Durnová and Hejzlarová 2023; Hresanova 2014). Nowadays, there are no midwife-led maternity units outside of the home setting, and those midwives who assist home births are constrained by ambiguous laws (Nagy 2024; Durnová and Hejzlarová 2023). The current social policies surrounding birth in the Czech Republic place a fine of 40,000 Euros over anyone who possesses a degree in medicine and assists home births. By contrast, those births that are headed by midwives can receive insurance money in maternity hospitals (Durnová and Hejzlarová 2023). While these moves appear to validate midwives working in hospitals, their implications for home birthers and midwives in non-medicalized settings only become more difficult to comprehend (ibid.). For example, does the former

policy specifically target obstetricians who are against the over-medicalization and the pathologization of birth? Does the latter indicate subsidies for (and therefore support) midwifery pathways?

The Dutch maternity care system, on the other hand, is defined by a structured and safe division of responsibilities between primary (first line) and specialist (second line) care, which distinguishes between physiological and pathological pregnancies and births (De Vries and Buitendijk 2012; Nieuwenhuijze and Groenen, 2023). The Dutch maternity care system involves primary caregivers and general practitioners, who are responsible for the care of women with low-risk pregnancies. It also includes obstetricians, who provide care for high-risk pregnancies (Wiegers et al., 1998; De Vries et al., 2009; Hollander et al., 2019; Nieuwenhuijze and Groenen, 2023). Independent midwives provide primary care, whereas obstetricians are responsible for secondary care (de Jonge et al. 2009; Nieuwenhuijze and Groenen 2023). Dutch midwives are widely recognized as among the most highly trained and autonomous midwifery professionals globally, particularly within non-biomedical (i.e. not physician-led or hospital-dominated) models of care (De Vries et al., 2009; Overgaard et al., 2011; Nieuwenhuijze and Groenen, 2023). Admission to the country's four midwifery schools is intentionally restricted to ensure that every graduate has a fair chance at secure employment (ibid.). Midwives train for three years, a combination of academic and on-the-job placements, and have regular refresher training in everything from CPR to breastfeeding support (Beddington, 2023).[14]

This comparative analysis shows that the Czech Republic requires clearer policies on reproductive rights and home births to align with international standards that support women's autonomy and midwives' legal protection (Nagy, 2024).

7.2 Risks Associated with Home Births

To evaluate the effectiveness of home birth systems, it is instructive to first examine the Dutch model, which is internationally recognized for its safety and structure.

Dutch law acknowledges the midwives' autonomy, and their training as independent medical professionals enables them to oversee home deliveries (De Vries 2004; Overgaard et al. 2011; Heerema et al. 2023). Since 1959, a comprehensive list of pre-existing, pregnancy-related, and perinatal conditions has been in place to enhance risk assessment and referral processes (Overgaard et al. 2011; Nagy 2024). This guide, known as the Obstetric Intervention List ('VIL'), was developed through collaboration between professionals in primary, secondary, and tertiary care (Overgaard et al. 2011). The "Obstetric Indications List" (OIL) delineates between physiological (low-risk) and pathological

[14] For further reading on how cultural beliefs and socio-political histories shape maternal health in the Netherlands and the Czech Republic see Annex 4.

(high-risk) pregnancies rather than categorizing them as just “high-risk” or “low-risk”. The Dutch model challenges the assumption common in other industrialized countries that all births should be framed in terms of risk (De Vries et al. 2009). Labelling a healthy pregnancy as “low risk” places it on a continuum leading to “high risk,” thereby reinforcing the need for specialist monitoring of not only that pregnancy but all pregnancies (ibid.).

This risk-based framework directly influences midwifery practice and the use of medical interventions. This categorization done by the Dutch midwives prevents medical interventions during pregnancy and childbirth. Dutch midwives are the ones who determine the eligibility for home birth and ensure that home births are only offered to pregnant individuals who meet strict safety criteria (Nagy 2024). However, it serves as a guideline rather than a strict protocol, allowing healthcare professionals to exercise their own clinical judgment. Dutch midwives operate independently and are responsible for managing low-risk pregnancies and childbirth (Wiegers et al. 1996). They are legally not allowed to administer any medical interventions, resulting in the same set of services regardless of the location of birth (Daysal et al. 2015).

Numerous studies support the safety of home births within this system. The Netherlands demonstrates that for women with low-risk pregnancies, planned home births are as safe as hospital deliveries (de Jonge et al. 2013; De Vries and Buitendijk 2012). Home birth for uncomplicated pregnancies led by trained and competent midwives can be a safe choice within a well-functioning health system which ensures timely and appropriate referral to a nearby hospital in case of complications or emergencies (Nagy 2024). Further studies demonstrate that planned home births for low-risk women have comparable or better outcomes than hospital births (de Jonge et al. 2013; Janssen et al. 2009). Research consistently shows that women who give birth at home experience fewer medical interventions, including cesarean sections, episiotomies, and the use of pharmacological pain relief (de Jonge et al. 2013). Planned home births also reported generally lower rates of maternal morbidity (de Jonge et al. 2009; Olsen and Clausen 2012).

The risks associated with home births primarily arose in cases where unexpected complications occurred. The delay in transferring women from home to hospital posed a threat to both maternal and neonatal health (de Jonge et al. 2009). However, the Dutch system’s integration of rapid referral mechanisms ensures that emergencies during home births are managed efficiently, with most women transported to hospitals within 30 to 45 minutes (ibid.). These concerns are therefore mitigated by the Netherlands’ efficient healthcare infrastructure with dense hospital networks, efficient transport, and small geographical area (de Jonge et al. 2009; 2013; Nagy 2024).

The overall success of the Dutch model is not incidental but rather the result of systemic support and interprofessional cooperation (Daysal et al. 2015). Research indicates that adverse outcomes are rare and generally limited to scenarios involving inadequate risk assessment or delays in referral (Daysal et al. 2015; Nagy 2024). By fostering a culture of trust between midwives and obstetricians, the Dutch model ensures that home births remain a safe and viable option for low-risk pregnancies (Nagy 2024).

By contrast, the Czech Republic presents a very different picture, with legal ambiguities and insufficient infrastructure impacting the safety and viability of home births. Indeed, the little data that exists on the safety of home birthing pathways in the Czech Republic points to a significant set of complications that plague birth in non-hospital settings. The most common of these illnesses and injuries sustained in the post-birth period include "postpartum hemorrhage, neonatal asphyxia, placental retention, birth injury, neonatal hypothermia, placental birth, labor obstruction, fetal hypoxia, bleeding during labor, preeclampsia, and fetal malformation" (Krepelka et al. 2023).

The Czech Republic faces complications in the management of patients in home settings because birthing mothers can need surgeries or blood transfusions at a moment's notice, and these interventions are adequately available only within hospital settings. It was found that, "the risk of perinatal death was seen to increase when planned home birth required an emergency hospital transfer" because Czech midwives were unable to navigate transfers in a legal setting that provided them little support or political certainty (Krepelka et al. 2023; Nagy 2024).This raises the question of whether poor maternal health outcomes are a consequence of the limited legality and state support for midwifery (ibid.)

This was also made evident in the heavily publicized case of *Königsmarková* when a hospital reported a midwife for negligence and the death of a child whose birth she had assisted through very grave complications (Durnová and Hejzlarová 2023). The ambiguity of laws surrounding midwifery creates a lacuna of "professional assistance in planned home births", which further exacerbates the need for a system of risk categorization of pregnant women in the Czech Republic for easier transfers to the hospital setting when complications arise (Krepelka et al. 2023). At present, however, research doesn't indicate the presence of any such identificatory mechanism.

In the Czech Republic, pregnant people who chose to give birth at home had a relatively higher rate of complications as compared to those who chose the hospital (Krepelka et al. 2023). Without guaranteed professional medical attention, monitoring the fetal condition, and making sure that emergency medical assistance is available, the odds of these complications significantly increase (ibid.). Pregnant women opting for home birth must experience professional supervision at least for the first few days post-birth, proper documentation, and planning to make sure that the appropriate levels of perinatal care are sustained even in the postpartum period (ibid.). However, not only does the legal system in the Czech

Republic plant distrust between midwives and hospital staff, as illustrated in the *Königsmarková* case, but it also makes leads to "expectant women unwilling to cooperate with care workers in hospital-based perinatal care", because the existing system doesn't provide them a means to choose their own birth setting (Krepelka et al. 2023; Durnová and Hejzlarová 2023).

These challenges highlight the importance of legal and logistical support for managing emergencies during home births. 18.1% of the transfers to hospital settings in Czech Republic occurred while the labor was in process, largely due to the obstruction of labor or fetal distress. Krepelka et al. (2023) research demonstrated that delays in transfer to the hospital lead to very high rates of perinatal mortality and morbidity. This raises the question of how willing a midwife would be to undergo this transfer in a situation where there is no legal certainty protecting their work from being penalized (Nagy 2024). Summarily, the ambiguity of laws over home births exacerbates the impacts of potential perinatal injuries by imposing barriers upon easy transfers to hospitals.

Interestingly, hospital-based maternity care in the Czech Republic has also been found to be plagued by distressing issues and questionable practices. Women delivering in hospitals have often recalled being put in semi-recumbent or flat positions without an understanding of what labor positions would best suit the female anatomy (Hresanova 2014). Caregivers said that women giving birth at home, on the other hand, were encouraged to stay standing while giving birth, a position proven to be less painful (ibid.). Several mothers delivering in hospitals suffered from chronic post-traumatic stress disorder caused by averse childbirth experiences and poor relationships with obstetricians and nurses in hospitals (ibid.). In the Czech Republic one of the biggest concerns of women giving birth in hospitals was the attitude of obstetricians and they often recalled experiences of "rude and arrogant behaviors by birth care providers" (ibid.). Most women reported unpleasant experiences in their dealings with the hospital staff, where they found it difficult to ask questions, seek information, or even request for basic comfort without being berated by the nurses and doctors on duty. The women shared feelings of "frustration, depression, anger, desperation, helplessness, and powerlessness" (ibid.). The overall perception of the pregnant women going through hospital births in the Czech Republic was that they felt compelled to reserve their emotions in a system that trivialized feelings as 'hysteria' and treated them less as patients requiring care, than as 'client-bodies' that needed to be mechanically managed (ibid.). These made them reluctant to seek out professional help during future pregnancies. This cycle persisted, further aggravating poor maternal health outcomes and showing that more needs to be done to change current practices to foster a respectful maternal health system in the Czech Republic (Begley et al. 2018).

Home births in the Czech Republic present risks due to insufficient state support, while hospital births pose challenges that may make women reluctant to choose them. A profound sense emerges that a human element is increasingly missing from institutionalized birth care in the Czech Republic. By

contrast, the Netherlands has established a well-functioning system that effectively supports both options, thereby facilitating informed choice.

7.3 Public Framing of Home Births

Perceptions of childbirth are shaped by cultural metaphors, media narratives, and professional discourses, which influence public opinions on biomedical birth settings and affect women's ability to choose freely. These narratives determine whose knowledge is seen as authoritative, often sidelining women's own experiences (Durnová and Hejzlarová 2023). To ensure inclusive and respectful perinatal care, childbirth must be approached through an interdisciplinary lens that values emotional and experiential knowledge alongside clinical data. As Durnová and Hejzlarová (2023) have argued, birth is a deeply personal and emotional experience where prioritization of women's bodily and emotional integrity can lead to better outcomes. Centering emotions can challenge dominant biomedical models and expand our understanding of what constitutes a safe and respectful birth.

In the Netherlands, home birth is culturally accepted for low-risk pregnancies, yet mainstream media often portrays it as unsafe, casting doubt on midwife-led care (De Vries 2004; de Jonge et al. 2009; Mohangoo et al. 2008). This framing has contributed to a decline in home births and an increase in medicalized childbirth, despite robust evidence supporting the safety of home births within structured healthcare systems (Luce et al. 2016; Vogels-Broeke et al. 2023; Hutton et al. 2019; Hendrix et al. 2009; Evers et al. 2010; Wax et al. 2010). Although many widely cited studies lack methodological rigor, their findings have been amplified through sensationalized media coverage, fostering public skepticism (De Vries and Buitendijk 2012; Hutton et al. 2019; Luce et al. 2016). Media narratives tend to dramatize risk and privilege hospital-based birth as safer, often neglecting evidence in support of home birth. These portrayals are shaped by underlying gender norms, professional interests, and cultural biases disguised as neutrality (De Vries and Buitendijk 2012; Luce et al. 2016; Hutton et al. 2019).
Similarly, home births in the Czech Republic are challenged by certain narratives in popular media that create an image of hospital-based birth settings as more scientific, valid, and 'rationally' driven than others (Durnová and Hejzlarová 2023). In the Czech Republic, there is a confrontation over birth between the advocates of bio-medicalization (such as obstetricians), and those who advocate for less medical intervention and greater choice and autonomy (such as potential mothers and midwives). There is a public debate "between a system-oriented expertise defining birth through medical safety and a women-oriented expertise that focuses on civil rights and mothers feeling safe," which ultimately becomes a dichotomy between rational and scientific, biomedical birth as opposed to emotionally driven perinatal practices (ibid.). In the Czech Republic the obstetric profession is given more respect than midwifery due to the idea of biomedicine being perceived as a cold, precise, scientific, and emotionally detached discipline (ibid.).

While midwife-led births are derided for their focus on emotionality. Within these constructs, midwifery is effectively disenfranchised as a professional practice. Childbearing discourse in the Czech Republic thus overshadows alternate providers of maternal healthcare. Medical doctors were found to be the dominant voice in birthing practices while midwives and women were less represented in popular media and public discourse because "expertise [was] publicly framed as being detached from emotions and "emotional" [was] a discursive label to delegitimize professional opinion" (Durnová and Hejzlarová 2023).

Public discourse in the Czech Republic thus displayed an unwillingness to pay sound attention to voices that promoted emotional support for women during the childbirth process (Durnová and Hejzlarová 2023). Media framings almost demonized the practice of midwifery in popular perception (ibid.). However, bringing emotional approaches to discussions in policy could disrupt the biomedical monopoly and stimulate a broader understanding of safe, respectful perinatal care. Both midwives and proponents of home birth are immediately rendered scientifically invalid because affective opinions are seen as unprofessional and untrustworthy (ibid.). This gendered experience of producing expertise generates an inequality in knowledge production and consumption, especially since obstetrics is a male-dominated field, and obstetricians end up being the more powerful voice, while midwives and pregnant individuals continue to struggle to be heard (ibid.).

8. Interview Analysis

An essential element of the Dutch maternity care system is the autonomy granted to midwives and the central role they play in managing low-risk pregnancies.

Indeed, the Dutch maternity care system is built on a model that strongly supports midwifery autonomy and community-based care. One of its core features is that the default path for low-risk pregnancies begins with a primary care midwife. As the interviewee noted, "Over 90% of women start their pregnancy with a primary care midwife" (p.2 §6)[15]. This structure allows midwives to function as autonomous professionals, maintaining independence from hospitals and collaborating directly with health insurance providers. "The midwifery profession is really an autonomous profession" (p.3 §1), she emphasized, highlighting how this independence shapes the profession's identity and practice.
Despite the strengths of this system, midwives face considerable challenges, particularly when it comes to workload and work-life balance. Many leave the profession within a few years, often around the time they start families of their own (p.4 §4). "On average, midwives only work for about eight years in

[15] We have adapted the quotes to the level of language in this preliminary report.

primary care... because it is sometimes hard to combine having a family and being on call" (p.4 §4). The nature of the work is intense, with midwives frequently working long on-call shifts. "Around 106 pregnant women a year is the equivalent of a full-time job for a midwife... every four days or so, you would help with delivery. And that is too much" (p.4 §6). These pressures raise critical questions about the sustainability of a system that, while successful in outcomes, depends heavily on the personal sacrifices of its midwifery workforce.

There is also a growing tension between the midwifery philosophy of natural, non-medicalized birth and modern women's preferences for hospital births. Many women now view hospitals as the safer option, even though this often leads to a cascade of medical interventions. "Many more women nowadays prefer to give birth in a hospital because they feel like that's the safer option... we know that there's a so-called cascade of interventions" (p.5 §2). This shift sometimes conflicts with the midwifery approach, which values physiological birth and minimal intervention. "That is something where our midwifery mindset clashes a little bit with, like, the modern woman's wishes" (p.5 §2). Nonetheless, midwives remain focused on supporting women's autonomy and informed decision-making. "Even if she ends up in a hospital birth with lots of interventions, that's fine, as long as she feels like it was her choice" (p.6 §2). This illustrates how midwives continually navigate the balance between professional ideals and evolving societal expectations.

Although home birth rates in the Netherlands remain relatively high by international standards, they have decreased significantly over the past few decades. "In the 1980s, the 1990s, it was... 30 to 60 percent giving birth at home... now it's 13 percent" (p.9 §2). However, the COVID-19 pandemic briefly reversed this trend, as more women chose to avoid hospitals during the crisis. "The number of home births went up quite a lot during COVID... our whole home birth percentage went up to like 22%" (p.13 §3).

A unique and valuable aspect of the Dutch system is its use of a national risk classification guideline that determines whether care should be led by a midwife or an obstetrician. "We have this sort of list of... conditions that make somebody middle or high risk" (p.10 §5). However, this document, which dates to the early 2000s, has become a point of contention among professionals. Midwives, obstetricians, and pediatricians struggle to agree on a revised version. "The current list that we have dates from 2001 or 2003... this is definitely a difficult thing" (p.11 §6). These disagreements are not purely clinical but also financial, with both midwives and obstetricians reluctant to lose patients and the associated income. "There's money involved because if you lose patients, you lose money, so this is also a sort of financial incentive that comes into place" (p.12 §1).

9. Discussion

The distinction between the home birth law and public policy in the Netherlands and the Czech Republic is indicative of more general socio-cultural, historical, and institutional policy orientations toward maternity care. As noted in the literature review, the Netherlands provides a system that incorporates home births as a possibility for women with low-risk pregnancies to autonomously choose their birth setting. This model emphasizes autonomy and informed consent, aligning with international human rights standards such as CEDAW (Nagy, 2024). By contrast, the Czech Republic's approach to home births is far more restrictive, shaped by historical and institutional barriers. The Czech legal framework continues to constrain midwives and birthing individuals, limiting reproductive autonomy and undermining the possibility of home birth as a legitimate option (ibid.).

The Dutch maternity care system relies upon a risk-selection model, designed to encourage midwives to practice autonomously with low-risk pregnancies, leading to safe and publicly funded home births. The Obstetric Indications List is central to classifying pregnancies and reducing risk, while maintaining maternal autonomy (de Jonge et al., 2009). In the Czech Republic, midwives are still working under severe legal and professional constraints, resulting in a situation where hospital births are the more socially and legally sanctioned option (Durnová and Hejzlarová, 2023).

The comparison between these two systems highlights the impact of professional autonomy and clear regulations. In the Netherlands, midwives are regarded as integral parts of the healthcare system and are empowered to manage low-risk pregnancies and births, whether at home or in a hospital (Vogels-Broeke et al., 2023). The Czech Republic, on the other hand, remains largely medicalized, with obstetricians exercising dominance over the birth setting, which reduces midwifery autonomy and stifles the possibility of offering safe and respectful alternatives (Nagy, 2024). These differences underscore the importance of not only clear legal frameworks but also of a cultural understanding that values the expertise of midwives and women’s reproductive autonomy.

Despite the success of the Dutch system in integrating home births, public perceptions remain vulnerable to media framing. The literature review pointed out that negative portrayals of home births in the media, questioning their safety, have contributed to a decline in their popularity (Luce et al., 2016). This was corroborated in the interview with the Dutch midwive, who noted a significant shift in the population's preference toward hospital births, even though home births for low-risk pregnancies remain as safe as hospital births when conducted with professional midwifery care (p. 5). This shift also highlights the growing tension between the philosophy of midwifery, which values physiological birth with minimal intervention, and modern women’s preferences for hospital births (p. 5).

In the Czech Republic, the situation is even more complicated. As noted in the comparative analysis, while home births are legal, the lack of clear regulations and legal protections for midwives, as well as the overwhelming dominance of biomedical obstetric care, results in fewer women opting for home births, despite evidence suggesting that home births are safe for low-risk pregnancies (Nagy 2024). This not only limits a pregnant individual's reproductive autonomy but also exacerbates the challenge of offering pregnant individuals the option of home births, which could be a viable and safe alternative if adequately supported by the system.

The cultural framing and media portrayal of home births play a critical role in shaping public opinion. In the Netherlands, the growing skepticism about home births, fueled by media reports, demonstrates how media framing can undermine long-standing models of care, even in a system with well-documented evidence supporting home birth safety (de Jonge et al. 2013; Vogels-Broeke et al. 2023). Similarly, in the Czech Republic, media narratives continue to prioritize the authority of obstetricians over midwives, delegitimizing midwifery care and framing it as less trustworthy or scientifically valid (Durnová and Hejzlarová 2023). This shows the need for more balanced and inclusive media portrayals that recognize the expertise of midwives and support pregnant individual's right to choose their birth setting.

In conclusion, the research highlights the critical role of professional autonomy, legal frameworks, and cultural narratives in shaping maternity care outcomes. The Netherlands provides a strong example of how midwifery-led care, integrated into the healthcare system, can offer safe, low-risk birth options at home, supporting pregnant individual’s autonomy in childbirth. However, the decline in home birth rates due to negative media narratives suggests that even well-established models can be vulnerable to shifting public perceptions. In contrast, the Czech Republic’s restrictive approach to home birth reveals the barriers women and midwives face in a system that prioritizes biomedical care over midwifery and women-centered care. The findings suggest that for countries like the Czech Republic to align with international standards of maternal rights, clear legal protections for midwives, and a more supportive environment for home births must be established. There should be more studies made that focus on Czech midwifery as their birth settings beliefs are still biased in today’s research landscape.

10. Limitations

Although this research provides important perspectives on the role of cultural stories, media portrayal, and professional discourse in how the public views childbirth, there are limitations to the research. For instance, notwithstanding the significance of the Netherlands and Czech Republic as a unique opportunity for comparative perspectives, they represent an arbitrary capture of the "diversity" of childbirth experiences related to socio-medical contexts elsewhere. The research relies on secondary

data such as media analysis or published literature - these data sets do not incorporate the accounts or lived experiences of birthing women, midwives, and/or healthcare workers who may provide more direct accounts. The research includes a notable consideration of media bias and framing effects that identify reporting of dominant narratives may be related to editorial slant rather than a researched position on what constitutes the ideal or preferred practice for birth. Another restriction of research is there is no longitudinal component to this research; therefore, we are unable to capture feedback on changing opinions, practices or policies over time.

The second key limitation is that the study only examines expertise as gendered and does not investigate the relationship with additional intersectional variables, such as race, class, and socioeconomic status, which can have their own impacts on birthing preferences and care access. Finally, although the study criticizes biomedicalization of birth, it does not necessarily interact extensively with policy makers and obstetricians, whose voices can provide a fuller picture of the institutional powers influencing maternity care. Future research should consider qualitative methodologies (e.g., ethnographic approaches or interviews) and broaden its scope in terms of the number of healthcare systems and policy contexts, to offer a fuller representation of the experience of birthing.

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Annex

Annex 1: Glossary

- Maternal health: the health of women during pregnancy, childbirth, and the postnatal period.

- Perinatal period: twenty-two weeks post gestation to seven days after birth. The period of time encompassing pregnancy and the first year after childbirth.

- Maternal morbidity: any complications suffered throughout the pregnancy as well as experiences of illness and injury post-birth. Maternal morbidity refers to any complications suffered throughout the pregnancy as well as experiences of illness and injury post-birth (WHO 2018).

- Maternal mortality: the annual number of female deaths from any cause related to or aggravated by pregnancy and/or its management during the 42 days post childbirth. Unaddressed maternal morbidities correlate with higher maternal mortality rates and addressing these entwined factors together can broaden the scope of maternal health rights. According to the WHO (2025), "four pregnant women die for every 100,000 live births in the European Union".

- Low-risk pregnancy: minimal likelihood of complications […] (during) pregnancy for a healthy woman without chronic illnesses, previous pregnancy complications, or conditions like hypertension or diabetes.

- Midwifery: "with women", emphasizing the ability to establish consistent relationships with women based on personal and professional values. Skilled, knowledgeable and compassionate care for childbearing women, newborn infants and families that is provided by educated, trained, regulated, and licensed" professionals.

- Nulliparous: Someone who has never had a previous pregnancy that resulted in a live birth.

- Parous: Someone who has had a previous pregnancy that resulted in a live birth.

- Perinatal complications are health problems affecting the mother, fetus, or newborn between the 22nd week of pregnancy and 7 days after birth. The United Nations Population Fund (UNFPA 2023) also states that globally one pregnant woman dies of perinatal complications

for every 20-30 others who suffer from lifelong and severely disabling maternal morbidities, injuries, and infections.

Abbreviations

1. WHO: World Health Organisation
2. UNFPA: United Nations Population Fund
3. OECD: Organisation for Economic Cooperation and Development
4. CEE: Central and Eastern European
5. ECHR: European Court of Human Rights
6. CEDAW: Convention on Elimination of Discrimination Against Women
7. MLU: Midwife Led Unit
8. ICM: International Confederation of Midwives

Annex 2: Comparison between Countries of OCED Europe

Country	Reproductive Autonomy / Is it legally allowed to give birth / abort however you'd like ?	Variations in birth settings (home birth/ hospital/ both/ either)	Legal Home Birth	Midwives outside of hospital legal	Free healthcare available	Healthcare system support	Evidence on MMM outcomes	Regulation and Professionalization of Midwifery	Level of Autonomy of Midwives	Is there public health evidence on the viability of planned home births?	Can something be said about ethnic/racial Minority
Austria	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Belgium	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	NA
Bulgaria	Yes (but highly restricted)	No	Yes	Yes	No (limited free healthcare)	Not really	Yes (limited data)	Yes	No	Yes	NA
Croatia	Yes (but highly restricted)	No	No	No	No (limited free healthcare)	No	Yes (limited data)	Yes	No	Yes	NA
Cyprus	Yes (but highly restricted)	Yes (limited)	Yes	No	Yes	No	Yes	Yes	No	Yes	NA
Czech Republic	Yes (but highly restricted)	Yes (limited)	Yes	Yes	No (limited free healthcare)	No	Yes	Yes	No	Yes	NA
Denmark	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA
Estonia	Yes (some restrictions apply)	Yes (limited)	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	NA
Finland	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA
France	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA
Germany	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Greece	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	NA	Yes
Hungary	No	Yes	Yes	No	Yes	No	Yes	NA	NA	Yes	Yes
Iceland	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes
Ireland	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	No	Yes
Italy	Yes (but highly restricted)	No	Yes	Yes	Yes	No	Yes	Yes	Yes	No	Yes
Latvia	No	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	NA	No

Lithuania	No	No	No	Yes	Yes	No	Yes	Yes	Yes	No	No
Luxembourg	Yes	Yes	Yes	Yes (limited data)	Yes	Yes	Yes	Yes	No	NA	No
Netherlands	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes
Norway	Yes	Yes	Yes	Yes	Yes	Varies	Yes	Yes	Yes	Yes	Yes
Poland	Yes (but highly restricted)	Yes	Yes	Yes (limited data)	Yes,	No	Yes	Yes	No	Yes	Yes
Portugal	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	No	Yes (limited data)	Yes
Slovakia	Yes (but highly restricted)	Yes	Yes	Yes (limited data)	Yes	No	Yes	Yes	No	Yes (limited data)	No
Slovenia	Yes	Yes	Yes	Yes (limited data)	Yes	No	NA	Yes	No	Yes (limited data)	No
Spain	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Sweden	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Switzerland	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes
Turkey	Yes (but highly restricted)	Yes	Yes	Yes (limited data)	Yes	No	NA	Yes	No	Yes	Yes
United Kingdom	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Romania	Yes	No	No	No	Yes	No	Yes	Yes	No	Yes	NA

Annex 3: Interview Guideline

Interview Guideline: Czech Republic

General Theme	Public health evidence of alternative birth settings
Specified Theme	Evidence of midwifery behavior and maternal experience in alternative birth settings in the Netherlands and Czech Republic.
Research Question	How does available public health evidence on home births support women's choice and midwifery practice as a part of maternal health?
Objectives of this Interview	This interview is made to understand the role of midwives in the Dutch health care systems, focusing on their autonomy, obstacles, and decision-making in planned home births settings. We want to learn the point of view of midwives on safety and risks, autonomy and the choice of women. By hearing about their experiences, we hope to fill out the gaps in our desk research and understand how the healthcare systems in both countries support or limit alternative birth options.
Ethical Considerations	We recognize the sensitive nature of midwifery practice and the importance of maintaining professional confidentiality and patient privacy. If at any point during the interview, the midwife feels that answering a question would violate professional secrecy, be too personal, or compromise a patient's medical privacy, we will explain that she can let us know and refrain from answering. We'll present our ethical considerations to every interviewee before starting the interview to ensure that ethical concerns such as voluntary participation, confidentiality, consent, and the right to withdraw are clearly communicated in an accessible and professional manner. Additionally, we'll ask for their oral consent before the interview.
Sample	Midwives who have worked in The Netherlands and have worked in alternative birth settings *Why midwives?* Midwives are extremely important in maternal care, especially for alternative birth settings and planned home births specifically. They care for pregnant women, assist

	with childbirth, and make important safety decisions. Working closely with both mothers and the healthcare system, they see the issues, benefits, and outcomes of home births firsthand. Their experiences help us add on to the public health evidence on hospital births and planned home births, specifically in the Netherlands.
Interview Process	
Presentation of our research	Hello, and thank you for taking the time to speak with us today. My name is Louise, and I will be asking you the questions during this interview. I'm joined by Kenza and Samya, who are also part of our research team. Louise and Kenza will later handle the transcription of our conversation. We are conducting a student research project in collaboration with the Center of Reproductive Rights on home births and midwifery practices in the Netherlands and Czech Republic focusing on how public health evidence supports both midwives and women's birth choices. Since midwives play a key role in maternal healthcare, we want to learn from your experiences, how you navigate decision-making, the challenges you face, and how healthcare policies affect your work.
To be said before the interview regarding ethical guidelines	Before we begin, we want to emphasize that your participation in this interview is completely voluntary, and you are free to skip any question or stop the interview at any time without providing a reason. Our research aims to understand midwifery practices and the role of home births in maternal healthcare, and we deeply appreciate your willingness to share your experiences. We also want to assure you that confidentiality is a priority, your responses will be anonymized, and no identifying information will be included in our final report unless you explicitly agree otherwise. If any question touches on sensitive topics, such as specific patient cases, professional challenges, or legal concerns, please feel free to let us know if you prefer not to answer. Additionally, all data will be securely stored in accordance with research ethics guidelines. If at any point after the interview you have concerns about what was shared, you are welcome to reach out to us to discuss any necessary revisions or withdrawals. Do you have any questions before we begin? Do you verbally consent to this interview?
Presentation of the participant	We will give the opportunity to the midwife to present herself and her professional background

Questions	
Theme 1: Roles, Practices and Obstacles of Midwives in the Healthcare System	How do you perceive your role and positionality in the healthcare system as a midwife within the Czech maternity care system? What are the key challenges of practicing midwifery independently in the Czech Republic? What do the discrepancies in the practice of maternity care in home and hospital births look like from the point of view of a midwife?
Theme 2: Autonomy and Decision-Making in Birth Settings	What does influence your decision-making regarding home births?
Theme 3: Birth Settings Perspectives	For experienced midwives only: Have you noticed any shifts in attitudes toward home births over the years? If so, what do you think has influenced these changes? From your experience, what are the most common reasons women choose home birth over hospital birth?
Theme 4: The Healthcare System	What factors influence complications in home birth settings? Follow-up question: How do they get mitigated?
Theme 5: Choice of Pregnant Women and Free will	What is your view of home births? If there's time, follow-up question: Under what circumstances and for whom would you support home birth?
Theme 6: Policies and Legal frameworks	How could the legal environment be improved to allow women to make informed decisions about where they wish to give birth without fear of legal repercussions or lacking qualified assistance?

Closing and Conclusions	Thank you very much for this constructive exchange. Do you consider that there was a point that we did not address this morning/afternoon and that you would like to raise and/or comment on? Your responses are invaluable in helping us fill out the gaps in public evidence regarding birth settings and address the challenges faced by midwives in countries less open to alternative birth settings. We want to remind you that all the information you provided will remain strictly confidential and will be used solely for research purposes. Your contribution is an important step toward shedding light on the information available on alternative birth settings. We thank you very much for your participation in this interview.

Interview Guideline: The Netherlands

General Theme	Public health evidence of alternative birth settings
Specified Theme	Evidence of midwifery behavior and maternal experience in alternative birth settings in the Netherlands and Czech Republic.
Research Question	How does available public health evidence on home births support women's choice and midwifery practice as a part of maternal health?
Objectives of this Interview	This interview is made to understand the role of midwives in the Dutch health care systems, focusing on their autonomy, obstacles, and decision-making in planned home births settings. We want to learn the point of view of midwives on safety and risks, autonomy and the choice of women. By hearing about their experiences, we hope to fill out the gaps in our desk research and understand how the healthcare systems in both countries support or limit alternative birth options.
Ethical Considerations	We recognize the sensitive nature of midwifery practice and the importance of maintaining professional confidentiality and patient privacy. If at any point during the interview, the midwife feels that answering a question would violate professional secrecy, be too personal, or compromise a patient's medical privacy, we will explain that she can let us know and refrain from answering. We'll present our ethical considerations to every interviewee before starting the interview to ensure that ethical concerns such as voluntary participation, confidentiality, consent,

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Interview Process	
Presentation of our research	Hello, and thank you for taking the time to speak with us today. My name is Louise, and I will be asking you the questions during this interview. I'm joined by Kenza, who is also part of our research team. Samya and Kenza will later handle the transcription of our conversation. We are conducting a student research project in collaboration with the Center of Reproductive Rights on home births and midwifery practices in the Netherlands and Czech Republic focusing on how public health evidence supports both midwives and women's birth choices. Since midwives play a key role in maternal healthcare, we want to learn from your experiences, how you navigate decision-making, the challenges you face, and how healthcare policies affect your work.
To be said before the interview regarding ethical guidelines	Before we begin, we want to emphasize that your participation in this interview is completely voluntary, and you are free to skip any question or stop the interview at any time without providing a reason. Our research aims to understand midwifery practices and the role of home births in maternal healthcare, and we deeply appreciate your willingness to share your experiences. We also want to assure you that confidentiality is a priority, your responses will be anonymized, and no identifying information will be included in our final report unless you explicitly

	agree otherwise. If any question touches on sensitive topics, such as specific patient cases, professional challenges, or legal concerns, please feel free to let us know if you prefer not to answer. Additionally, all data will be securely stored in accordance with research ethics guidelines. If at any point after the interview you have concerns about what was shared, you are welcome to reach out to us to discuss any necessary revisions or withdrawals. Do you have any questions before we begin? Do you verbally consent to this interview?
Questions	
Theme 1: Roles, Practices and Obstacles of Midwives in the Healthcare System	How does the Dutch healthcare system support your role and practice as a midwife? What are the key challenges of practicing midwifery independently in the Netherlands?
Theme 2: Autonomy and Decision-Making in Birth Settings	How do you balance respecting patient autonomy while ensuring the safest possible birth outcome? How do you ensure that women are fully informed about their options and potential risks when choosing between home and hospital birth? If there's the time, follow-up question: What do you think would be needed to ensure that? How much does your autonomy influence your decision-making regarding home births?
Theme 3: Birth Settings Perspectives	For experienced midwives only: Have you noticed any shifts in attitudes towards home births over the years? If so, what do you think has influenced these changes?
Country-Specific Questions: The Netherlands	What is your stance on the Dutch risk categorization system? Follow-up question: Are there any adaptations or changes needed for risk categorization system? If there's the time, follow-up question: How do you handle disagreements with

	obstetricians regarding the classification of a pregnancy?
Closing and Conclusions	Thank you very much for this constructive exchange. Do you consider that there was a point that we did not address this morning/afternoon and that you would like to raise and/or comment on? Your responses are invaluable in helping us fill out the gaps in public evidence regarding birth settings and address the challenges faced by midwives in countries less open to alternative birth settings. We want to remind you that all the information you provided will remain strictly confidential and will be used solely for research purposes. Your contribution is an important step toward shedding light on the information available on alternative birth settings. We thank you very much for your participation in this interview.

Research Ethics Approval Form

Basic Information

- Project title: **Public Health Evidence on Alternative Birth Settings in the Netherlands and the Czech Republic: A comparative analysis**
- Project duration (proposed start and end date): **September 2024 – May 2025**

- Name of principal investigator (s): **Louise Alberti, Samya Verma, Kenza Benkheira**
- Partner institution(s) (if applicable): **Center for Reproductive Rights**
- Budget (total amount and funding source[s]): **Student project**

- Name(s), function(s) and location(s) of additional researchers involved in the project: -
- Number of and type of participant(s) likely to be involved: **Midwives, 15 to 20 with an even number for both parties**
- Location(s) where the research will take place: **online, via Webex through personal Graduate Institute account**

- In case approval by the Graduate Institute's Ethics Review Committee is required to secure external grant funding, specify the funding agency and the date/stage at which approval is needed: -

- In case the project has already been approved by an ethics committee external to the Graduate Institute specify the name of the Committee, the date and outcome of the decision (attach formal correspondence): -
- Provide a brief project summary (500-700 words), outlining the theme and research questions, specifying individuals and groups, who will be the subject of research and methods to be used (attach project proposal if available):

Through the interviews we aim to find more evidence of midwifery behaviour and maternal experience in alternative birth settings in the Netherlands and Czech Republic to tackle the following research question: How does available public health evidence on home births support women's choice and midwifery practice as a part of maternal health? The interviews serve to understand the role of midwives in the Dutch/Czech health care systems, focusing on their autonomy, obstacles, and decision-making in planned home births settings. We want to learn the point of view of midwives on safety and risks, autonomy and the choice of women. By hearing about their experiences, we hope to fill out the gaps in our desk research and understand how the healthcare systems in both countries support or limit alternative birth options.

Midwives are extremely important in maternal care, especially for alternative birth settings and planned home births specifically. They care for pregnant women, assist with childbirth, and make important safety decisions. Working closely with both mothers and the healthcare system, they see the issues, benefits, and outcomes of home births firsthand. Their experiences help us add on to the public health evidence on hospital births and planned home births, specifically in the Netherlands and Czech Republic. We therefore specifically aim to interview Czech and Dutch midwives who have assisted planned home births in their respective countries individually and ask them questions on their autonomy, policy considerations and the choice of women. These interviews will fill out the gaps in our desk research where we have conducted a comparative analysis of the legal considerations, the autonomy of midwives, the public framing of home births and the choice of women in those two respective countries. This will help us get a thorough analysis on the differences and similarities between two countries with opposing ideas on planned home births.

Integrity and Safety of Participants

If the research involves topics that could be perceived as politically or culturally sensitive (e.g. sexual behavior or preference, experience of violence or abuse, mental health, use of medical data, ethnic status, religious belief, criminal offences), describe how this may be the case and what precautions will be taken to avoid harm and minimize risks.

The talk on midwifery autonomy, legal constraints, and institutional barriers can be sensitive and potentially political. Therefore, it is important to ensure that interviewees should be free to refuse any question without any coercion. The confidentiality is absolute; unless specific permission is given, all identifying details must be either deleted or disguised and the data should be safely retained according to the Swiss Federal Act on Data Protection (FADP). Furthermore, because of the legal and professional danger involved in talking about home births, especially in the Czech Republic, where home birth midwifery is heavily stigmatized, midwives might be reluctant to talk freely about their experiences. To mitigate this, we as researchers will not provide any personal information about the interviewee, use pseudonyms, and especially emphasize that midwives can refuse to answer any question.

State any potential adverse consequences for vulnerable groups of people or communities that may result from the research or its outputs and what precautions will be taken to avoid harm and minimize risks.

In the Czech Republic, home birth is a controversial and institutionally marginalized practice, with midwives subject to legal constraints and possible professional penalties for supporting births outside hospitals. While Czech midwives may discuss legal battles, social stigma, or institutional hostility toward out-of-hospital births. As researchers we'll ensure that participants feel supported, emphasizing that they can pause, skip questions, or withdraw at any time.

Recruitment of Participants and informed Consent

State how the participant(s) will be recruited (attach copies of any recruiting materials if used). In case participants are remunerated for their participation (e.g. being paid for interviews) provide details and state reasons for payment.

The participants will be recruited through email, from the professional email addresses they have listed on their websites. The email will be written as follows:

Dear Ethics Committee,

We hope you are doing well. We are Samya Verma, Louise Alberti, and Kenza Benkheira, students from the Graduate Studies Institute in Geneva, Switzerland. In collaboration with the Centre of Reproductive Rights, we are conducting a student research project in which we will not be earning any money from on the public health evidence of alternative birth settings in the Netherlands and Czech Republic.

We believe that including the perspectives of midwives who are members of XX and have assisted planned home births is essential to this research, as their experiences provide valuable insights into alternative birth settings and their impact. We would appreciate to hear midwives' thoughts through an interview at their convenience. The conversation will be in English and would take approximately 45 minutes, will be conducted via Zoom and will be transcribed anonymously. Therefore we are formally asking for an authorization from Professor Presern to be able to contact their members who are working as midwives.

Midwives' participation is entirely voluntary, and all information will be handled confidentially. We are also happy to share our ethical approval form and interview guide in advance as further requirement for the authorization.

Thank you for considering our request and we would truly appreciate their time and expertise.
Best regards,

Samya Verma, Louise Alberti, and Kenza Benkheira

State and justify the manner in which the participant(s) consent will be obtained (if written, include a copy of the intended consent form; if non-written please state how consent will be documented or recorded).

Additionally, we'll ask for their consent before and after the interview and ask for a written consent via email as well. See consent form attached.

Will the participant(s) be fully informed about the nature of the project and of what they will be required to do? If not, please specify why.

Yes they will be informed about the whole project and process at the beginning of the interview.

Will the participant(s) be offered the possibility to withdraw from participation?

We'll inform the interviewees at the beginning of the interview that they are free to free to withdraw from the project at any time and am free to decline to answer particular questions.

If the participant(s) are under the age of 18 years or vulnerable persons (e.g. with learning difficulties), will consent be given from the participant(s) themselves or from a third party such as a parent, guardian or "gatekeeper"?

This will not be the case, therefore nothing specific to be considered regarding this point.

Confidentiality and Data Management

Outline how data will be collected (e.g. experimental procedures, focus group, personal interviews, self-administered questionnaire, researcher-administered questionnaire, observation, survey etc…).

Several interviews are conducted in order to understand the role of midwives in the Dutch/Czech health care systems, focusing on their autonomy, obstacles, and decision-making in planned home births settings. We want to learn the point of view of midwives on safety and risks, autonomy and the choice of women. By hearing about their experiences, we hope to fill out the gaps in our desk research and understand how the healthcare systems in both countries support or limit alternative birth options.

Will the research involve gathering personal information on human subjects that is not publicly available? If so, indicate what steps will be taken to preserve the confidentiality of the participant(s).

One of the foremost concerns is confidentiality and anonymity, particularly when midwives discuss patient experiences, interactions with healthcare institutions, or conflicts with medical authorities. To avoid violations of patient confidentiality, we as researchers must instruct participants clearly to refrain from disclosing identifiable patient information. The talk on midwifery autonomy, legal constraints, and institutional barriers can be sensitive and potentially political. Therefore, it is important to ensure that interviewees should be free to refuse any question without any coercion. The confidentiality is absolute; unless specific permission is given, all identifying details must be either deleted or disguised and the data should be safely retained according to the Swiss Federal Act on Data Protection (FADP).

How will the participant(s) be informed about the confidential treatment of personal data?

The participants that take part will therefore be given full information on the objective of the research, how the data will be used, and the right that they have to quit at any time without any consequences. The consent to use their information will be asked before and after the interview.

If data is collected from public or private institutions (e.g. school, prison, hospital, government agency) state how required authorization will be obtained.

Formal approval will be obtained through written requests to the relevant members. This will include ethics committees and board members.

In case personal information on human subjects is collected, state whether, and if so how, data will be anonymized.

The researchers will not provide any personal information about the interviewee and use pseudonyms if asked by the interviewee.

State what processes are put in place to store data safely and how it will be destroyed upon completion of the project (if applicable).

All collected data will be securely stored in encrypted digital formats using password-protected institutional servers or cloud storage with appropriate access controls. There won't be any physical copies. Upon project completion, data will be permanently deleted in compliance with GDPR and institutional research data management policies.

Integrity and Safety of Researcher

State what measures are put in place to insure and protect the researchers against harm, injury or criminality. For research conducted in politically sensitive, conflictual or dangerous environments, make sure to take into consideration the insurances and tools (Planis, Webcorp) offered by the Graduate Institute's Human Resources Services.

State what measures are put in place to prevent, disclose and address potential conflicts of interest (e.g. with regard to financial gains compromising independence or objectivity).

As this is a student-led project with no external funding or affiliations with midwifery organizations, policymakers, or private healthcare providers, there are no direct conflicts of interest. Researchers will ensure objectivity by following ethical research guidelines, maintaining transparency in data collection and analysis, and acknowledging any potential personal biases. The study will adhere to the ethical oversight of the Graduate Institute to uphold research integrity.

If the research involves the investigation of illegal conduct, provide details on how you will be protected from harm or suspicion of illegal conduct.

No illegal conduct

I/we hereby confirm that the information provided above is true, accurate and complete and that I/we have read, understood and agree to abide by the *Graduate Institute Research Ethics Guidelines*.

Date and signature of the principal investigator(s), March 6th 2025

Louise Alberti _____

Samya Verma_____

Kenza Benkheira_____

Annex 4: Additional Information

Governance of Birth Settings by International Organizations

Even in global health discourse, there is little consensus over the debate between home and hospital births. International organizations (IOs) are usually seen to advocate for a kind of maternity care that would be safe, feasible, respectful, and autonomous (Nagy 2024). The WHO, for instance, provides a set of comprehensive guidelines to ensure "respectful maternity care, human dignity during labor and childbirth, privacy and confidentiality, and informed decision-making" as the cornerstones of perinatal health (ibid.). IOs also argue for giving mothers the freedom to choose how they would like to give birth, and that appropriate support should always be available during the pregnancy. They also call attention to a need for high safety standards during childbirth, regardless of the setting, and to ensure that timely transfers to hospitals can be facilitated during emergencies (ibid.). Home births are seen by them as a "good and safe alternative in obstetric care" when adequate measures are taken to ensure safety (ibid.). But these IOs still fail to "provide a definitive answer on whether they favor home births or hospital births", as with the WHO guidelines that "do not specifically recommend" either setting (ibid.).

Maternal Health for Minorities in Europe

Women belonging to minority communities in OECD Europe are a very diverse demographic. They comprise of ethnic minorities that are indigenous to the country such as Gypsy, Roma, and Traveler (GRT) communities, documented/undocumented refugees, and asylum seekers. "In many countries these women represent more than 20% of the birthing population" (Ny et al. 2021). Though the access of racial and ethnic minority mothers to maternal health in Europe can be measured along the aforementioned guidelines recommended by Miteniece et al. (2018) and WHO, yet the empirical outcomes of such an assessment are influenced by a different set of "socioeconomic and psychosocial" barriers (Fair et al. 2020). Therefore, there is a consistent trend for poorer pregnancy outcomes amongst migrant women who are at greater risk of maternal morbidity and mortality when compared to native-born women (ibid.).

According to Ny et al. (2021) minority women face difficulties in accessing maternal healthcare during the perinatal period because of "distance to health-care centers, cultural practices, lack of information, and familial suppression." They are also more likely to suffer from "poorer pregnancy outcomes such as increased risks of complications, unplanned cesarean sections, and neonatal unit admissions" (ibid.) as compared to other demographics. Further, unfamiliarity with the host country's language and healthcare system, and lack of a social netting in new areas can further bar migrant women from accessing high standards of care (Goodwin et al. 2018). Ny et al. (2021) add that a "lack of skilled

interpreters, miscommunication, use of family members as interpreters and lack of understanding from the health-care staff" all bar minority mothers' access to maternal health.

Although little data on the accessibility of non-medicalized perinatal care for minority women in OECD Europe exists, nevertheless, this literature review yielded case studies of undocumented migrants in the Netherlands and migrant Pakistani women in the United Kingdom. Both cases highlight a need for further research towards policies that can give women of color the reproductive autonomy to choose their own birth settings.

According to de Jonge et al. (2011), undocumented migrant women in the Netherlands are "more likely to give birth at home and less likely to receive maternity home care assistance". Almost 20% of undocumented mothers lack access to maternity assistants while giving birth at home (ibid.). The reasons for this include either the unaffordability of such services or the women facing cultural barriers in understanding how they can access these services and how they would be useful to them.

Birth settings – whether at home, in freestanding maternity units, or in a hospital – are found to impact maternal health. In many countries of OECD Europe, the trend of home births has experienced a marked return in recent decades, reflecting a growing interest in alternative, less interventionist approaches to childbirth. Nove et al. (2012) point out that for low-risk pregnancies, midwife-assisted home births can provide continuity of care and a more personalized experience, a notable factor driving the recent increase in home births. It was found that women opting for home births are often older and more educated, which aligns with other research suggesting that these women may have greater access to information and feel empowered to choose a home birth (ibid.). According to Sandall et al. (2024), a low-risk pregnancy is one with "minimal likelihood of complications (during) pregnancy for a healthy woman without chronic illnesses, previous pregnancy complications, or conditions like hypertension or diabetes". The study highlights that second-time mothers, particularly those who have had a previous hospital birth, are more likely to consider home births (ibid.).

Socio-cultural Beliefs and Political Histories in Maternal Healthcare

Dutch studies show that women who opt for home births in the Netherlands often share a belief in the natural process of childbirth and a desire to avoid the medicalization associated with hospital deliveries (Preis et al. 2019; Mansfield 2008; Vogels-Broeke et al. 2023). If pregnant individuals and their caregivers see childbirth as fraught with risk, there is an increased willingness to medicalize pregnancy and childbirth (Parry 2008; Green and Baston 2007; Vogels-Broeke et al. 2023). Women's decisions over where and how to give birth are strongly influenced by their perceptions of childbirth as a natural

process or a medical event, and their previous experiences of giving birth (Vogels-Broeke et al. 2023). These beliefs shape the broader patterns of care-seeking behavior and acceptance of home births in the Netherlands. Vogels-Broeke et al. (2023) show that in the Netherlands, women's childbirth experiences were the most consistent predictors of women's birth beliefs and whether they preferred home or hospital birth settings. For many women, the psychological benefits of home birth play a significant role in their decision-making. Familiarity with the home environment and a sense of control over the birthing process contribute to a more positive and empowering experience (ibid.). Further Dutch studies indicate that women who have previously had positive birth experiences are more likely to choose home births for subsequent pregnancies (Haines et al. 2012; Kringeland et al. 2010; Vogels-Broeke et al. 2023). Similarly, social influences such as the attitudes of partners, family members, and peers also strongly shape a woman's preference (Vogels-Broeke et al. 2023). In the Netherlands, community norms and a longstanding cultural acceptance of home birth further reinforce it as a valid choice.

By contrast, the Czech Republic's heavily medicalized nature of birth had its genesis in the socialist reforms of the 1950s, when "state-funded, centralized, and integrated" (maternity) healthcare was introduced as an overreach of the state into the population's reproductive health (Hresanova 2014). Women's bodies were subject to state policies aimed at ensuring healthy social reproduction, and they had little choice but to refuse hospital births unless "they wanted to subject themselves to close monitoring from social workers" (ibid.). This institutionalization of birth care continued post the introduction of neoliberal reforms in the 1990s whereupon hospitals emerged as private/commercialized business units. They now sought to portray themselves as "consumer-friendly to attract more clients and rebuilt maternity wards into an attractive home-like environment" (Hresanova 2014; Durnová and Hejzlarová 2023).

Midwives' Relations with Birthing Mothers

A major factor determining the access to women-centered healthcare for women is the relationship that they develop with their midwives over the course of their pregnancy. If cultivated well, the midwife-mother relationship can greatly boost the maternal outcomes. Alternatively, it can increase the stress and psychosocial pressures experienced by expectant mothers of color in already unfamiliar surroundings (Fontein-Kuipers et al. 2018).